

Clinical Supervision of Mental Health Practitioners: A Phenomenological Study  
of Different Approaches in Arkansas

by

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### Abstract

Clinical supervision is the foundation of mental health practice for new professionals. Within this professional relationship, new professionals find training, guidance, and support in the first years of practice. The practice of clinical supervision embodies the spirit of servant leadership where experts invest in novices to develop successful practitioners with higher order theoretical and therapeutic skills. The purpose of this phenomenological study was to explore the lived experiences of new counselors and social workers working within clinical supervision relationships. These two disciplines of mental health professionals work with similar clients often at the same practice sites but are guided by different best practices of clinical supervision. The chief differences are social workers obtain supervision from administrative supervisors at work, while counselors must contract for third-party supervision. The research questions focused on lived experiences within the supervisory relationships, perceptions of the developmental practice, and the meaning supervised professionals assigned to clinical supervision. The study employed a semi-structured interview to capture the rich experiences of the mental health professionals. Data from the study increased understanding of the meaning of clinical supervision and provided additional evidence to view clinical supervision through the lens of servant leadership.

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## Chapter 1: Introduction

Clinical supervision embodies the spirit of servant leadership as expertise is passed from master to novice mental health professional for the benefit and protection of the consumer of the services (Crunk & Barden, 2017; Spears, 2010). A common element of all mental health disciplines, clinical supervision is a foundational component during the first years of professional practice. The supervisor often assumes the roles of teacher, counselor, and consultant to provide guidance and support as new professionals develop advanced therapeutic skills (Crunk & Barden, 2017; Kiersch & Peters, 2017). Clinical supervision is simply not on-the-job training; clinical supervision is best conceptualized as a professional relationship, similar to a therapeutic relationship, which promotes individual growth and autonomy (Osterlund, 2016). Best practices for both counseling and social work recognize the need to structure this relationship to produce favorable professional results (Association for Counselor Education and Supervision [ACES], 2011; National Association of Social Workers [NASW], 2013).

In Arkansas, mental health services are provided at the master's degree level by two distinct disciplines of clinicians: Licensed Associate Counselors and Licensed Master Social Workers (Arkansas Board of Examiners in Counseling [ABEC], 2016; Arkansas Social Work Licensing Board [ASWLB], 2017). These two professionals often work side-by-side at the same clinical sites treating the same consumers, but receive clinical supervision guided by different best practices (ACES, 2011; NASW, 2013). Supervision practices begin to diverge regarding the administrative responsibility of supervisors. Social workers typically receive clinical supervision from advanced practitioners assuming dual administrative and clinical supervision roles, while counselors are prohibited from obtaining clinical supervision from work supervisors (ABEC, 2016; ASWLB, 2017). The licensing board dictates counselors contract for a board-approved,

third-party supervisor often at the counselors' own expense (ABEC, 2016). The divergent methods create a different supervisory environment for the two disciplines of practitioners with no clear understanding of the benefit or harm related to each supervision method. Since the ultimate beneficiary of clinical supervision is the mental health consumer, understanding the meaning of clinical supervision is important for each discipline of new mental health professionals.

This phenomenological study was designed to understand the meaning counselors and social workers assign to clinical supervision, and to understand the impact of the two different methods of clinical supervision on new professionals. The research helps reduce the literature gap regarding the meaning and impact of clinical supervision on new professionals and provides evidence to propose changes in the preparation of entry-level professionals for supervision in Arkansas. Sections in Chapter 1 describe the background of clinical supervision, statement of the problem, purpose of the study, significance of the study, research questions, theoretical foundation, definition of terms, assumptions, scope and delimitations, limitations, and summary.

### **Background of the Problem**

Studying the lived experiences of new professionals working within the clinical supervision relationship, regardless of approach, contributes to the understanding of the practice. A gap in the literature exists regarding the meaning and perceptions of clinical supervision. Bernard and Luke (2015) reviewed 10 years of research related to the practice of clinical supervision published in professional journals. In articles published between 2005 and 2014, Bernard and Luke (2015) looked at various aspects of clinical supervision: supervision within counseling specialties, supervisor interventions, multicultural supervision, supervisor/supervisee relationships, various client issues; technology and supervision; ethical and

legal concerns; and, supervision processes. None of the journal articles addressed the meaning of clinical supervision based on the experiences of new professionals.

Beddoe, Karvinen-Niinikoski, Ruch, and Tsui (2016) analyzed the content of research into social work supervision by experts in the field: Bogo and McKnight (2006), Carpenter, Webb, and Bostock (2013), O'Donoghue and Tsui (2015), and Mor Barak, Travis, Pyun, and Xie (2009). Each of the experts noted the lack of research exploring perception and meaning of clinical supervision for the developing social worker. Bogo and McKnight (2006) reviewed 11 journals published between 1994 and 2004, concluding research focused on theoretical and practice models. Carpenter et al. (2013) examined 21 studies between 2000-2012 and discovered limited research on the impact of clinical supervision on the client. O'Donoghue and Tsui found a connection between clinical supervision and practitioner wellness, which supported the findings of Mor Barak et al. (2009), who conducted a meta-analysis of 27 articles published from 1990 to 2007. Chapter 2 provides greater detail to this literature gap in both counseling and social work supervision practice.

Further examination of supervision research found researchers commonly used tools designed to study the counselor/client therapeutic relationship to explore the supervisor/supervisee relationship. Tangen and Borders (2016) argued these tools fail to measure the dynamics of the clinical supervision relationship. Unlike counseling, which is a change process, clinical supervision is a collaborative and developmental relationship designed for professional development (Crunk & Barden, 2017). Clinical supervision is a complex and dynamic relationship, which Tangen and Borders (2016) found to include employment and professional development, as well as safety, cultural, emotional, legal, and ethical issues.



Employment dynamics, specifically the dual roles of administrative and clinical supervisors of counselors, were examined in one study (Tromski-Klingshirn & Davis, 2007). The quantitative study of counselors in a Midwestern state identified positive and negative aspects of dual-role supervision, which Tromski-Klingshirn and Davis (2007) found to be a common practice despite ethical prohibitions for counselors (American Counseling Association [ACA], 2014). Studies of social workers (Boswell, Stark, Wilson, & Onwuegbuzie, 2017; Vito, 2015) also examined the dual role of administrative and clinical supervisors and reported positive and negative implications for the professionals. The questions raised by these studies support further research into the meaning of clinical supervision for new professionals working within the framework of this professional relationship.

### **Statement of the Problem**

The problem of this study is different approaches to clinical supervision by the two disciplines of mental health clinicians create a different work and supervisory environment for professionals who are engaged in similar clinical practice. Research is limited regarding this problem. The value of clinical supervision to train new professionals is well-accepted within the mental health community. Models of clinical supervision used to develop the supervisory relationship, theory, and technique are well-researched in both disciplines (Bernard & Luke, 2015; O'Donoghue & Tsui, 2015). Differences in counseling and social work supervision methods emerge regarding the administrative role of the supervisor, and the impact of this power differential on the professional relationship. Social work embraces the administrative supervisor as the best candidate for clinical supervision (NASW, 2013). The counseling discipline, in contrast, prohibits the practice due to this power differential, recognizing risks to open and honest exchange within supervision (ACA, 2014).

In Arkansas, master-level counselors and social workers are employed together at clinical sites with the ability to provide the same services to the same clients. Conflicting supervision practices create work differences for the two new professionals. When employed at the same facility, a licensed master social worker typically receives both clinical and administrative supervision from the clinical director, while the licensed associate counselor receives administrative supervision from the clinical director and must contract for third-party supervision from a board-approved clinical supervisor (ABEC, 2016; ASWLB, 2017). This phenomenological study explored whether differences in the delivery of clinical supervision affect the experience, perception, and meaning of the practice for new professionals in each discipline.

### **Purpose of the Study**

The purpose of this phenomenological study was to explore the lived experiences of new mental health professionals working within clinical supervision relationships. The study was important because current best practices create employment and supervision differences between counselors and social workers in Arkansas. If the study was not conducted, the lack of understanding of the experience of each professionals working under clinical supervision would continue to persist. The study used semi-structured interviews, based upon the Supervision Work Alliance Inventory (Efstation, Patton, & Kardash, 1990) to explore whether counselors and social workers perceived benefit from the experience. Results of the study will be shared with the state licensing boards, and professional associations guiding each profession.

Phenomenology as a qualitative research method increases understanding of the lived experiences of individuals engaged in the phenomenon to be studied. The approach recognizes the value of personal experiences and empowers participants to share rich experiences (Creswell

& Creswell, 2018). Phenomenology as a philosophy was first conceptualized by Edmund Husserl in the early 20<sup>th</sup> Century and was founded on the belief the individual witness to a phenomenon is expert to the moment where consciousness and experience converge (Korstjens & Moser, 2017). The phenomenological design is well suited for this study because the subjects all practice psychotherapy, which promotes the exploration of the deep thoughts and feelings for both client and professional.

### **Research Questions**

Qualitative research is a subjective process. In phenomenology, data is mined from interviews with individuals engaged in the practice to be studied (Korstjens & Moser, 2017). This phenomenological study was designed to answer these research questions:

**Research Question One:** What were the lived experiences within the supervision relationships as stated by counselors and social workers in Arkansas?

**Research Question Two:** What were the perceptions of entry-level counselors and social workers regarding clinical supervision in Arkansas?

**Research Question Three:** What meaning did counselors and social workers assign to clinical supervision in Arkansas?

### **Significance of the Study**

The significance of this study is to understand the lived experiences of new mental health professionals in Arkansas and the perceived meaning assigned to clinical supervision. The consumer of mental health services often seeks professional help during periods of great distress, and society demands professionals providing services are well-trained and regulated. Licensing of mental health professionals is one step taken to ensure protection of the public. New

professionals in both counseling and social work must work under the guidance of a clinical supervisor during the first years of professional practice. Supervision serves two purposes: the practice increases competency of new professionals and protects the consumer from potentially dangerous inexperience. In 2019, there were at least 2,200 mental health professionals working across Arkansas under clinical supervision (Lenora Erickson and Chere Johnson, personal communications, September 26, 2019). The number changes monthly as new graduates are licensed, and supervised professionals achieve full, independent licensure by each licensing board.

Clinical supervision is well-researched and is accepted to be the best method to develop higher-order skills for new professionals; however, limited research exists regarding clinical supervision from the perception of new professionals engaged in the process. Research which has been conducted in this area has produced contradictory results indicating the need for further study (Boswell et al., 2017; Tromski-Klingshirn & Davis, 2007; Vito, 2015). Since new professionals in Arkansas often work in the same facilities with the same clients, but under different clinical supervision practices, this phenomenological study provided insights into the value and limitations of each discipline's best practices. Results of the study will be shared with the two licensing boards, and respective professional organizations, to promote better understanding of clinical supervision in Arkansas.

### **Theoretical Framework**

Clinical supervision is a professional, developmental practice which closely aligns with servant leadership in which an expert professional helps a new professional develop professional autonomy (Green, Rodriguez, Wheeler, & Baggerly-Hinojosa, 2015). The ultimate beneficiaries

of the professional practice are the individual client and the broader community. The leadership practice conceptualized by Robert K. Greenleaf in 1970 promotes the power of humility, self-confidence, and emotional wellbeing (Greenleaf, n.d.; Kiersch & Peters, 2017). These qualities make servant leadership unique in the realm of leadership, and well-suited for the understanding of clinical supervision (Evans, Wright, Murphy, & Maki, 2016; Gandolfi & Stone, 2018).

Servant leaders possess 10 traits, including listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment to growth, and community building (Spears, 2010). These qualities closely align with the traits of the clinical supervisor, as described by the Supervision Work Alliance Inventory (SWAI), which was developed to measure the supervision relationship (Efstation et al., 1990). Chapter 2 contains a thorough exploration of the alignment of servant leadership and clinical supervision.

The purpose of this phenomenological study was to explore the lived experiences of six counselors and six social workers working within clinical supervision relationships. A semi-structured interview, based on the SWAI, was used to collect data from the new professionals. Phenomenology, as a research method, allowed for subjective examination of clinical supervision from the inside-out by listening to the authentic experiences of 12 randomly selected mental health professionals. The goal was to develop a better understanding of the phenomenon of clinical supervision practice through the words, thoughts, and feelings of developing mental health professionals, drawn from the counseling and social work fields (Korstjens & Moser, 2017).

### **Definition of Terms**

Clinical supervision and mental health practice, regardless of discipline, requires advanced study and the use of language unique to the field. This language includes words and

phrases, which have specific meanings not fully aligned with common usage. This phenomenological study examines the practice of clinical supervision, and includes the following terminology:

***Best practices:*** Methods, techniques, and skill sets based on tradition, research, and ethical understanding and consensus within a profession (ACES, 2011; NASW, 2013).

***Clinical supervision:*** Mentoring relationship in which expert guides novice in development of professional practice through teaching, coaching, and consultation (Crunk & Barden, 2017).

***Licensed associate counselor:*** Entry-level credential of master's level counseling professional in Arkansas working under supervision for 3,000 hours with goal of achieving independent practice (ABEC, 2016).

***Licensed master social worker:*** A social worker practicing at the master's degree level. Permitted to provide clinical mental health services under direct supervision of an advance practice social worker (ASWLB, 2017).

***Phenomenology:*** Qualitative research method which obtains data from individuals with intimate knowledge of moment consciousness and experience converge (Creswell & Creswell, 2018).

***Practitioner/Professional:*** Individual qualified through training and licensure to provide services within the scope of practice of a mental health discipline (ACES, 2011; NASW, 2013).

***Servant leadership:*** Leadership style in which leader promotes individual and organizational growth by investing in the individual development of subordinates (Greenleaf, n.d.; Spears, 2010).

### **Assumptions**

The study was designed to minimize factors which interfere with the validity and transferability of data. Assumptions were made in the course of this study which cannot be avoided, nor proven to be true. The primary assumption was counselors and social workers randomly selected for this study possess similar skills for competent entry-level practice. The use of licensed practitioners was designed to address this assumption (ABEC, 2016; ASWLB, 2017). A second assumption was these new professionals enter the clinical supervision relationship to develop high-order skills necessary for independent clinical practice. The assumption was clinical supervisors working with study participants understand the important role of clinical supervision in professional development, and are competent in the practice (Evans et al., 2016).

### **Scope and Delimitations**

The study used phenomenological methods to explore the lived experiences of a random sample of 12 master's-level professionals engaged in supervised mental health practice. These professionals included six licensed master social workers and six licensed associate counselors. The number of supervised professionals in Arkansas changes monthly due to retirements and issuance of new licenses. In September 2019, the social work licensing board reported about 1,000 licensed master social workers (Chere Johnson, personal communication, September 26, 2019); the counseling board reported about 1,200 licensed associate counselors (Lenora Erickson, personal communication, September 26, 2019).

Criteria for participation included four requirements: 1) Arkansas license to practice as an associate counselor or master social worker obtained within two years of the beginning of data collection; 2) participation in clinical supervision as required by licensing board; 3) professional

goal of independent practice; and 4) no personal or professional relationship with the researcher. Each discipline's licensing board publishes the minutes of monthly meetings, including the names of newly licensed individuals (ABEC, n.d.; ASWLB, n.d.). A random sample was selected from names published from October 2017 to October 2019. All subjects resided within the state of Arkansas, but no effort was made to further narrow geographic location. The semi-structured interviews were conducted using in-person, telephone, or video conferencing methods, depending on subject preference. All the interviews were completed in December 2019. Chapter 3 provides greater detail of research methods.

### **Limitations**

Qualitative research methods are subjective in nature (Creswell & Creswell, 2018), which means data are open to interpretation. Phenomenology was used in this research because the method allows for deep exploration of personal experiences and provides rich details of a specific phenomenon. The research method depends on the willingness of research subjects to provide honest answers. The use of several research subjects from each discipline provided saturation, which is one method to promote credibility in qualitative research (Creswell & Creswell, 2018). Credibility is essential for trust, transferability, and dependability of research. Phenomenology as a qualitative research method is limited due to its subjective nature, which requires the researcher to take specific steps to ensure the results are trusted. This study used a semi-structured interview based on SWAI, which has been determined to be a valid research instrument (Efstation et al., 1990). Dependability of study data were ensured by careful data collection, including the use of field notes, reflective journal, and member-checking of interviews. Taken together these safeguards promote integrity and limit the introduction of error



and bias into the data collection process (Creswell & Creswell, 2018). Chapter 3 includes a detailed plan to address these issues within the study.

### **Chapter Summary**

Clinical supervision is an essential leadership practice for the development for new mental health professionals (Evans et al., 2016). Supervision is well-researched as a professional practice which promotes the growth and emotional care of entry-level social workers and counselors (Tangen & Borders, 2016). Research is limited, however, regarding the perception and meaning of clinical supervision practice for new professionals who must work within the supervision framework. Better understanding is important for new professionals in Arkansas where conflicting standards create a different work environment for counselors and social workers. This phenomenological study proposed to answer research questions related to the perception, experience, and meaning of the practice for new professionals in Arkansas. Chapter 2 examines research into the practice of clinical supervision.

## Chapter 2: Literature Review

Clinical supervision is the foundation of professional practice for mental health professionals who are developing professional identity and psychotherapy skills after graduate school (O'Donoghue & Tsui, 2015; Tangen & Borders, 2016). In Arkansas, entry-level mental health practice at the master's degree level is performed by licensed master social workers and licensed associate counselors. The two disciplines do similar work, often side by side, but practice under clinical supervision is guided by different approaches. Social workers typically receive clinical supervision from administrative supervisors at the worksite (ASWLB, 2017; NASW, 2013), while counselors are generally prohibited from worksite clinical supervision, and must contract with an outside, third-party supervisor (ABEC, 2016; ACES, 2011). This study used a phenomenological approach to explore the lived experiences of practitioners in each discipline, and to develop an understanding of the meaning of the different methods (Korstjens & Moser, 2017). A literature gap exists concerning the impact of clinical supervision on mental health professionals. This literature review explored the alignment of clinical supervision and servant leadership; the foundation of clinical supervision; the role of supervision in professional development; the positive impact of clinical supervision on new professional wellness; and, limited research regarding practitioner perceptions of clinical supervision.

### **Literature Search Strategy**

The research and literature used to develop the foundation of the phenomenological study was obtained from articles in peer-reviewed journals, books, and primary sources. Digital databases available from libraries at American College of Education and the University of Arkansas at Little Rock were used to obtain the articles. Additional research was conducted at the library at the University of Arkansas for Medical Sciences, which maintains book and journal

resources related to the practice of mental health. The academic databases Questia and ResearchGate were used to obtain full-text versions of articles not available through the universities' databases. Keywords (used alone and in combination) for database searches, included: clinical social worker, clinical supervision, counseling, counselor, leadership, master social worker, mental health, mentor, mentorship, professional development, psychology, servant leadership, and social work.

### **Theoretical Framework**

Clinical supervision is closely aligned to servant leadership as expert professionals assume responsibility for guiding the development of new professionals toward the goal of independent practice (Green et al., 2015). The ultimate beneficiary of the professional relationship is the individual client and the broader community (Bell, Hagedorn, & Robinson, 2016; Crunk & Barden, 2017). Conceptualized by Robert K. Greenleaf in 1970, servant leadership promotes the power of humility, self-confidence, and emotional wellbeing (Greenleaf, n.d.; Kiersch & Peters, 2017). These qualities make servant leadership unique within the realm of leadership, and well-suited to guide the practice of clinical supervision, which is akin to professional mentorship or modern apprenticeship (Evans et al., 2016; Gandolfi & Stone, 2018). Servant leaders possess 10 traits, including listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment to growth, and community building (Spears, 2010). Table 1 illustrates the alignment of these traits with qualities of effective clinical supervisors, as described by the Supervision Work Alliance Inventory, which was developed to measure the clinical supervision relationship (Efstation et al., 1990).

Table 1

*Alignment of Servant Leadership and Clinical Supervision Traits*

<b>Effective Supervisor (Efstation et al., 1990)</b>	<b>Servant Leadership (Spears, 2010)</b>	<b>Meaning of Traits</b>
Reflective Communication	Listening	Receptively listening to what is said automatically. This allows identification and clarification of information.
Anxiety reduction	Empathy	Seeking to understand and accept others.
Comfort in professional relationship	Healing	Acknowledging human beings and the issues making them whole
Insight into client needs and behavior	Awareness	Ability to view circumstances holistically through general and self-awareness
Open to process	Persuasion	Primarily utilizing persuasion versus coercion
Working alliance	Conceptualization	Striving to activate others' ability to set goals and achieve goals
Ownership of supervision process	Foresight	Understanding the lessons from past, current realities, and the possible outcome of choices for the future
Workplace concerns	Stewardship	Committed to serving others first
Evaluation of performance and development	Commitment to growth of others	Develops the personal, professional, and spiritual growth of each person
Ability to focus on outcomes as part of bilateral relationship	Community building	Determines methods of building communities among people working within their organizations, which can provide the healing love necessary for health

## **Leadership in Clinical Supervision**

An unusual degree of professional intimacy exists within the leadership practice of clinical supervision, where the supervisor often assumes the role of teacher, consultant, and counselor (Crunk & Barden, 2017). For the mentoring relationship to be effective, the supervisor must possess both the traits and skills which inspire new professionals to follow (Evans et al., 2016). A lack of leadership skills can negatively impact the new professional who comes to doubt the value of supervision and engages in behaviors which interfere with supervision such as nondisclosure (Cook, Welfare, & Romero, 2018). Identifying the proper skill set for effective clinical supervision has been researched to assist in the training of new supervisors (Evans et al., 2016).

Leadership, like counseling, social work, and clinical supervision, is a distinct practice guided by well-developed theories (Amanchuksu, Stanley, & Ololube, 2015; Evans et al., 2016). Within the clinical supervision relationship, effective supervisors possess one or more traits identified by established leadership theories. The importance of leadership is its ability to make subordinates feel supported and respected, to promote organizational priorities, and to achieve advancement and development of individuals (Irving & Berndt, 2017; Patranchak, 2016). The one-on-one nature of clinical supervision requires the supervisor to create an atmosphere of trust and competence, which creates a sense of psychological safety for new professionals. These professionals might feel vulnerable within a relationship which deeply impacts the career path and require support building resilience (Beddoe, Davys, & Adamson, 2014). The environment in which supervision is rendered and the potential conflicts supervisors possess directly impact this professional relationship (Heuer & Holbrook, 2015).

### **Servant Leadership within Clinical Supervision**

Servant leadership has Christian influences which can produce discomfort in secular situations. Advocates of the leadership practice agree morality and ethics are important to servant leadership, but the leadership style is rooted in humility and emotional intelligence, not religion (Du Plessis, Wakelin, & Nel, 2015). Humility within the context of servant leadership is the quiet expression of confidence, competence, and expertise (Sousa & van Dierendonck, 2017). In a study of leadership styles, Anderson (2019) compared transactional, transformational, and servant leaders and argues each of these leaders share a call to leadership. Transactional leaders employ a reward system to achieve goals; transformational leaders inspire followers through charisma; and, servant leaders use leadership as a mentoring and developmental tool.

Ethical behavior, empathy, and communication are common elements of all effective leadership methods (Amanchuksu et al., 2015; Evans et al., 2016; Gandolfi & Stone, 2018; McKibben, Umstead, & Borders, 2017). These qualities, combined with humility, are the key to servant leadership. Sousa and van Dierendonck (2017) studied 232 people working in a wide range of organizations and determined there is a connection between qualities of leaders and actions of followers. While all leadership styles produce positive results, servant leadership effectively produces followers with the ambition to become leaders (Lacroix & Verdorfer, 2017; Sousa & van Dierendonck, 2017). Autonomy increases job performance and satisfaction, which supports Greenleaf's belief empowered individuals create powerful institutions which impact communities for the benefit of all (Schwarz, Newman, Cooper, & Eva, 2016).

### **Research Literature Review**

Understanding of clinical supervision and the meaning of the professional practice for new professionals, regardless of discipline, is limited by the lack of current research into the subject. Literature concerning the practice of clinical supervision of social workers, counselors, and allied professionals was reviewed. While there was ample research into theories and techniques, most of the literature focused on graduate education rather than entry-level practice. Only one study focused on the perception of clinical supervision for counselors who obtain clinical supervision from administrative supervisors (Tromski-Klingshirn & Davis, 2007). The study was quantitative, rather than qualitative, and lacked rich details of the clinical supervision experience. Information available from more contemporary research, while not holistic about clinical supervision practice, provides insights into specific practices impacting new professionals. These topics include best practices, interdisciplinary practices, training of clinical supervisors, promotion of self-care, and the role of trust within supervision.

### **Social Work Practice**

Beddoe et al. (2016) studied the focus of social work research, and analyzed research conducted by subject matter experts in the social work field: Bogo and McKnight (2006), Carpenter et al. (2013), O'Donoghue and Tsui (2015), and Mor Barak et al. (2009). Common to each review was the lack of literature regarding social worker perception of the supervision relationship. Bogo and McKnight (2006) analyzed 11 journal articles published in the United States between 1994 and 2004 and concluded clinical supervision research focused on theoretical and practice models, but often lacked translational value due to small samples and lack of reliable measures. Carpenter et al. (2013) reviewed 21 studies published between 2001-2012 and reported an absence of research addressing impact of clinical supervision on the client. Most of the literature reviewed by Carpenter et al. focused on the role of social workers in the

social welfare system. The findings of O'Donoghue and Tsui (2015) supported Carpenter et al. and concluded literature published between 1970 to 2010 addressed child welfare workers while ignoring client outcomes. O'Donoghue and Tsui concluded clinical supervision plays an essential role in supervisee wellness, which aligned with the findings of Mor Barak et al. (2009). Mor Barak et al. conducted a meta-analysis of 27 English-language articles published between 1990 and 2007 and found clinical supervision was an important factor protecting social workers from the emotional hazards of the job while promoting professional growth.

### **Counseling Practice**

Literature concerning counselor supervision aligns with social work findings (Beddoe et al., 2016). There is a remarkable literature gap concerning the perception of clinical supervision from the consumer of the practice, which is the developing mental health professional. A content analysis of a decade of research found no peer-reviewed studies conducted in the past 10 years which examined perceptions of practice. Bernard and Luke (2015) analyzed 22 counseling journals, both domestic and international, regarding clinical supervision between January 2005 and October 2014. Of the 22 journals reviewed, a total of 184 articles were identified for the content analysis, covering 223 topics (some articles included multiple topics). Three of the 184 journal articles included information related to new professional perception of the clinical supervision relationship, but none was newer than 2007 (Bernard & Luke, 2015). The 2007 study by Tromski-Klingshirn and Davis explored the impact of dual relationships on clinical supervision, and the mixed results indicate there is value in further research of the issue.

### **Dual Roles in Clinical Supervision**

Tromski-Klingshirn and Davis (2007) conducted a quantitative study of supervisee perception of the clinical supervision relationship. Specifically, the study



explored the impact of the dual role of clinical and administrative supervisors on entry-level counselors in a Midwestern state (Tromski-Klingshirn & Davis, 2007). The study indicated dual relationships (also known as multiple relationships) were common in the clinical supervision of counselors, despite ethical guidance to avoid such situations (American Counseling Association, 2014). Tromski-Klingshirn and Davis concluded most new professionals found the practice to be beneficial for career growth, which additional research supports (Boswell et al., 2017). Fear and anxiety, which interfered with the development of a positive supervision relationship, was cited by the minority of respondents who were troubled by the practice, which is the chief reason the practice is discouraged (ACA, 2014). Tromski-Klingshirn and Davis concluded satisfaction in clinical supervision was largely dependent on the qualities of the individual supervisor, and the ability of the supervisor to manage different roles within the workplace.

At the time of the study, Tromski-Klingshirn and Davis (2007) reported about half the entry-level counselors in the United States, working under the guidance of a clinical supervisor, received the supervision from an individual who performed both clinical and administrative supervision. Inconsistent state-by-state standards guide counseling the practice of clinical supervision (Evans et al., 2016; Henderson, Henricksen, Jr., Liang, & Marks, 2016). Dual-role supervision, although common within the field of counseling, can create ethical challenges, and is discouraged by national professional bodies. Tromski-Klingshirn and Davis cited 1993 ethical guidelines from the Association for Counselor Education and Supervision, which advised both supervisors and supervisees to avoid creating clinical supervision relationships when administrative and clinical supervision roles overlap. The guidance remains in the 2014 code of ethics for counselors (ACA, 2014).

The study conducted by Tromski-Klingshirn and Davis (2007) has limitations. The quantitative study had a sample of 143 counselors working under the guidance of a clinical supervisor to obtain 3,000 hours of supervision necessary for licensure for independent practice. A variety of practice sites was used, including outpatient counseling centers, substance abuse programs, private practice, hospitals, employee assistance programs, corrections programs, and schools. Spreading the sample of 143 across these seven practice sites reduces the ability to draw conclusions about any one type of practice location. Tromski-Klingshirn and Davis used two instruments in the study. One measure was a two-item questionnaire developed by Tromski-Klingshirn and Davis to explore whether the counselors received supervision from individuals with dual professional roles. The other instrument was the Modified Supervision Questionnaire, which consisted of eight questions, answered using a Likert scale from 1 (low) to 4 (high), designed to measure satisfaction in clinical supervision. Neither of the measures possessed the ability to provide a rich understanding of the supervision experience in the manner possible in a qualitative study.

Respondents were roughly equally represented between those reporting dual supervision situations ( $n = 70, 49\%$ ) and those who receive clinical supervision from a third-party provider outside of the workplace ( $n = 73, 51\%$ ) (Tromski-Klingshirn & Davis, 2007). In regard to counselors receiving supervision from individuals with dual roles, a majority ( $n = 58, 82\%$ ) reported no problems with the arrangement. In fact, 72.5% reported feeling the arrangement had benefits, including supervisor awareness of policies, advance knowledge of organizational changes, having time to address issues with an administrative supervisor. The 18% percent of respondents who characterized the dual relationship as problematic generally reported fear and anxiety issues discussed within clinical supervision sessions would negatively affect employment

status. Any factor which interferes with a favorable clinical supervision relationship has the potential to affect counselor professional development and client outcomes (Bell et al., 2016). Given the significance of negative supervision on the career of a new professional, even a minority of 18% is a remarkable number.

### **Social Work Perspective**

In direct contrast to national counseling standards, best practice in social work recommends new professionals obtain clinical supervision from administrative supervisors at the worksite (National Association of Social Workers, 2013). There is a belief the administrative supervisor possesses essential knowledge of workplace issues which contribute to the clinical supervision experience. Respondents in the Tromski-Klingshirn and Davis (2007) study indicate there are benefits related to this practice common to the social work field. Vito (2015) conducted a qualitative study of social workers in Ontario, Canada, to explore individual perceptions of the practice.

In the study of 10 supervised social workers, Vito (2015) examined the use of self and the role of reflection in clinical supervision. The study identified two themes impacting the practice of clinical supervision: power and pressure within organizations and creating safe spaces to model values. Vito concluded clinical supervision within organizations to be an essential element of professional development of social workers to develop a sense of self-awareness, which ultimately benefits clients. Barriers can exist within organizations to the effective practice of reflective supervision. The power differential social workers feel within the clinical supervision relationship is one of these barriers. One respondent in the study cited the fear violations of rules which come out in supervision sessions can negatively impact employment (Vito, 2015), which echoes the minority view in the Tromski-Klingshirn and Davis (2007) study. The second theme

which emerged in the study was an antidote to power differential, which Vito finds to be organizational leadership which supports clinical supervision and the modeling of ethical and effective social work practice. For social workers, the clinical supervisor is valued for the safe place supervisors create within larger organizations. Other studies support Vito's conclusion, including Boswell et al. (2017), which concluded the practice of dual relationships connects developing professionals with organizational leaders and can provide important career benefits.

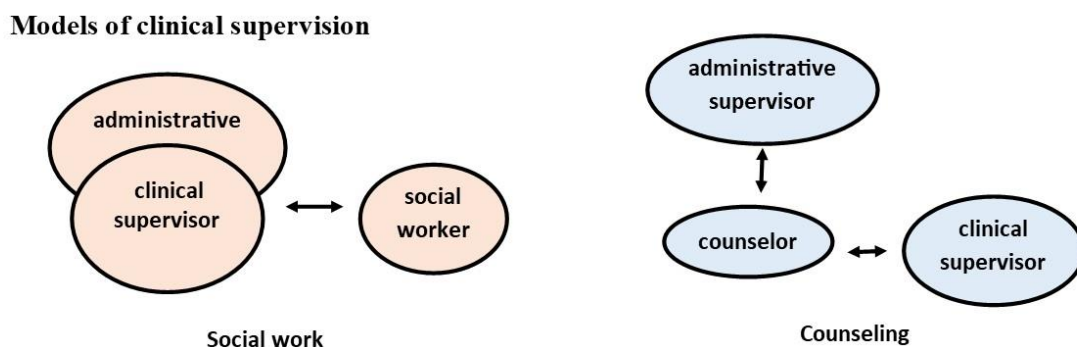
### **Best Practices in Social Work Supervision**

In the United States, the National Association of Social Workers (2013) has published guidelines outlining best practices for the practice of clinical supervision. The organization recognizes clinical supervision to be a professional relationship focused on the development of competence, demeanor, and ethical practice. Three roles of supervision are defined in the best practices standards: a) administrative, which is a management role to ensure social workers provide effective services; b) educational, focusing on the professional development and practice competencies of the social worker; and c) supportive, advocating for the supervisee while creating an atmosphere of safety and trust. The standards encourage clinical supervisors to adopt the three roles while performing duties of an administrative and clinical supervisor. The roles are teacher, counselor, and consultant which are common to supervision models (Crunk & Barden, 2017).

A Delphi study was conducted in 2016 and included 53 professionals from 15 countries to examine the relevance of research into social work supervision, and to develop a consensus for future research into international best practices for social work supervision (Beddoe et al., 2016). The study found: a) majority of respondents supported supervision for all social workers regardless of career stage ( $n = 40$ ); b) two-thirds supported

supervision requirement for licensure ( $n = 37$ ); and c) most respondents believed there is remarkable gap in literature regarding supervision in clinical practice ( $n = 42$ ), which contributed to discomfort in the term *best practice*. The results generally support clinical supervision practices in the United States (National Association of Social Workers, 2013). Respondents proposed future research regarding supervision and professional identity; costs of supervision; the impact of supervision on social worker retention; impact of supervision relationship on the social worker; efficacy of different supervision models, and supervisor training.

*Figure 1: Role of administrative and clinical supervisors within supervision models*



In regard to the practice of social worker development, clinical supervision by an administrative supervisor at the supervisee's workplace is encouraged. NASW (2013) standards recognize situations arise when supervision cannot be by the administrative supervisor, particularly when a different mental health discipline licenses the supervisor. Instead of mirroring the counselor model of two distinct supervisors addressing different supervision areas, social workers may contract for third-party supervision but encourage the supervisors to work together.

Figure 1 illustrates dynamics of supervisor relationships for social workers and counselors. Social workers are warned to avoid contracting for third-party supervision, if possible, due to potential conflicts which might arise between the two supervisors, and/or clinical supervisor and employing agency. Essentially, social work standards promote alignment of clinical and administrative supervisors where counseling standard promote alignment of counselor and clinical supervisor (ACES, 2011).

### **Off-site Social Worker Supervision**

Counselor supervision essentially occurs off-site in contrast to social work supervision (ACES, 2011). Discussion of off-site supervision on social worker development often involves the important role supervisors play in the organizational hierarchy to promote the development of social workers to meet the needs of the social worker as well as the needs of the organization (O'Donoghue & Tsui, 2015). Zuchowski (2016) conducted a phenomenological study of clinical supervisors who provided off-site supervision of social work students assigned to clinical sites which provided task supervision but lacked appropriate resources for on-site clinical supervision. The goal was to help understand the experience of off-site clinical supervision and unique issues arising within the arrangement, which is a best practice in counselor supervision (ACES, 2011). The qualitative study had a sample of 15 clinical supervisors with experience providing on-site and off-site supervision. Results indicated preference for traditional on-site supervision by administrative supervisors weigh heavily on the attitudes of clinical supervisors.

In the findings, Zuchowski (2016) reported three points which relate to the impact of off-site supervision on the practice. Clinical supervisors providing off-site supervision reported some difficulty understanding the context of the issues supervisees brought to the supervision session.

One supervisor compared the situation to being blind regarding the provision of supervision without intimate knowledge of the organization and its workforce and clients. Preparation time required for off-site clinical supervision was perceived to be greater due to the need to give thought to the developmental needs of the supervisees in the absence of ongoing knowledge of workplace dynamics. Assessment of supervisee progress was more difficult for off-site supervisors due to the lack of observations of the supervisee in the workplace. The practice of self-reports and self-assessment became more important in the assessment of social worker development with trust becoming part of the supervision dynamic for supervisors (Zuchowski, 2016). Trust within the clinical supervision relationship has been identified as an important element in the relationship for both social workers and counselors (Riechel, Webber, Chae, Kayanan, & Miller, 2018).

### **Counselor Supervision Best Practices**

Best practices for counselor supervision are outlined by the Association of Counselor Education and Supervision (2011), a division of the American Counseling Association. The standards are closely aligned with standards developed by the Council for Accreditation of Counseling and Related Education Programs, which promotes uniform education and licensing across the United States (Henderson et al., 2016). In relation to clinical practice, ethical conduct, professional relationships, counselor best practices are compatible with those established by NASW (2013) to guide social workers. The chief difference is the stance on clinical supervisors with a dual administrative or management role within the workplace. ACES (2011) discourages this practice and cites CACREP standards and ACA ethical standards, warning of ethical pitfalls associated with the practice.

Heuer and Holbrook (2015) recognize the limitations of research conducted on the impact of dual relationships between clinical supervisors and counselors. The interpersonal relationship which occurs between experienced and novice professionals within the context of clinical supervision includes complex power dynamics. Heuer and Holbrook conclude dual or multiple relationships (the term favored by the American Counseling Association) create ethical dilemmas and potential role conflict with the potential to ultimately impact the counselor's client. The ACA code of ethics and ACES standards recommend counselors and clinical supervisors avoid multiple relationships which can negatively impact the professional relationship. ACES (2011) standard 5.c.iii recognizes multiple relationships do occur, but advises clinical supervisors to avoid multiple relationships with supervisees due to the potential for harm and undue influence, According to standard F.3.a. of the ACA code of ethics (2014): Supervisors clearly outline all relationships, current and potential, personal and professional, which might affect the professional relationship, and avoids supervision when multiple relationships have potential to affect judgment and to cause harm.

### **Meaning of Supervision**

Clinical supervision is a common developmental tool in the helping professions engaged in the practice social work, counseling, and psychology; but, the meaning of supervision differs between the disciplines (Kangos et al., 2018; Lile, 2017; Lloyd-Hazlett & Heyward, 2016). Unguru and Sandu (2017) reviewed research related to the development of supervision in social work from its roots in the administrative direction of child welfare workers to the modern practice of reflective development of helping professionals, combining administrative direction, mentoring, and elements of psychotherapy. Unguru and Sandu concluded the purpose of contemporary social work supervision, includes: a) guiding proper professional development; b)



monitoring professional practice; c) reviewing cases to protect the client; d) promoting development of self-awareness; and e) ensuring adherence to organizational rules, discipline's ethical standards, and recognized legal requirements. In alignment with servant leadership, Unguru and Sandu found the supervisor works to develop the new professional with an eye to the benefit of the consumer of the social work services.

The functions of the clinical supervisor of social workers include administration, education, and support (Unguru & Sandu, 2017). Referencing Vlasa's supervision theory, the Unguru and Sandu argued clinical supervisors occupy the space between management and social workers and help facilitate communication within the organization. The middleman role clinical supervisors occupy within some social work organizations can produce a sense of discomfort for both supervisors and supervisees, according to Kadushin (1992), who described how role ambiguity can interfere with the developmental goals of social work supervision. A review of 40 years of supervision literature conducted by O'Donoghue and Tsui (2015) supports Kadushin's finding of anxiety and discomfort related to the provision of clinical supervision within the traditional hierarchy of social work organizations.

The relationship which develops between people working together to achieve a common goal is a central element of counseling and therapy, as well as the supervision of professional counselors (Osterlund, 2016). A good understanding of how elements of a positive clinical supervision relationship develop is important to the development of competent helpers (Duffey, Haberstroh, Ciepielinski, & Gonzales, 2016). Relational-Cultural Theory (RCT) is a human development model which attributes human development to authentic social connections and aligns with the servant leadership dynamic where a leader develops followers for the greater benefit of the community (Anderson, 2019; Lacroix & Verdorfer, 2017). Studying the

relationship between supervisor and new professional can help foster a greater understanding of the interpersonal dynamics which exist within the relationship, and the impact of the relationship on both supervisor and supervisee (Duffey et al., 2016).

Duffey et al. (2016) reports the goal in any professional relationship is to maintain a clear and balanced perspective (Duffey et al., 2016) through a sense of self-awareness as well as the perception of others. Duffey et al. studied a sample of 156 master's level students in a CACREP counseling program to identify positive clinical supervisor traits. The graduate students considered clinical supervisors with clear and balanced relationship skills to be the most effective. Duffey et al. concluded relationship-building behaviors occurring within clinical supervision have a direct, positive relationship to professional development. This finding provides further evidence supporting the role of the relationship between supervisor and supervisee on professional development (Lile, 2017; Tromski-Klingshirn & Davis, 2007).

Other studies of supervision in the counseling discipline support interpersonal connection as the key elements of the professional relationship (Osterlund, 2016). Supervision is considered an essential part of ego development and wisdom, which is the convergence of rational and emotional cognitive processes to master conceptualization (Lloyd-Hazlett & Heyward, 2016; Osterlund, 2016). In a mixed-method study of counseling students, Lloyd-Hazlett and Heyward (2016) reported supervision is recognized by the developing counselors to be a supportive, mentoring relationship which focuses on role development, therapeutic processes, and professional growth. These findings are not limited to the counseling field.

The value of the interpersonal relationship is recognized to be an important element of the professional development of social workers as well. In a qualitative study of 12 social work clinical supervisors in New Zealand, Pack (2015) identified clinical supervision as an essential

element of organizational support and professional development. Four themes emerged from interviews of the research subjects. The themes were: a) peer review and ongoing critique was important to the clinical supervision relationships; b) transference needs to be addressed to maintain effective practitioners; c) clinical supervision identifies gaps in training and assists in the professional development of new practitioners; and d) promotion of self-care and early intervention for social work professionals who require more intensive services provided by employee assistance programs. There is abundant literature supporting the value of these four issues in supervision, which also are important in the counseling discipline.

Experts in the field of counseling supervision reflected on the past, present, and future of clinical supervision as part of an international research symposium in 2015 to address gaps in understanding of clinical supervision and the impact of the practice on the development of mental health professionals (Goodyear et al., 2016). Issues identified by subject matter experts at the 2015 symposium as needing additional research include: ethnic and cultural issues which arise within clinical supervision, particularly gender, sexual orientation, and racial awareness sensitivity; macroaggressions within the supervision relationships; development of clinical expertise; training of clinical supervisors; utilization of constructivist models to empower supervisees to take responsibility for developing competence and independence; and understanding the common factors which make supervision an effective developmental practice.

### **Social Work Practices**

Social work is rooted in the settlement house movement of the 19th Century in the United States and England in which people of means helped people mired in poverty, and the profession remains connected to the promotion of social justice (Ruth & Marshall, 2017). Social work

education remains tethered to field experiences in which students learn by doing under the guidance of more experienced social workers (Bogo, 2015). Samson (2015) indicated the modern practice of social work is the intersection of science and art; science being the embrace of evidenced-base practice essential to contemporary clinical practice; and art is the development of interpersonal skills to develop the relationships which have been essential to social work since its foundation. The role of the clinical supervisor within this framework is to be the bridge between science and art, and exists to assist new professionals with the development of practice wisdom (Samson, 2015), which is described as a flexible and reflexive practice focused on meeting the varied needs of the client.

Clinical supervision in the field of social work embraces a model of reflection, which includes understanding thoughts and feelings, self-awareness, analysis, exploration, and new learning (Samson, 2015). Practice wisdom, an essential element of independent mental health practice, is the goal of clinical supervision. Samson (2015) argued clinical supervision changes form as the social worker advances through university field experiences into professional settings. Originally part of the education experience, supervision becomes more collaborative and reflexive as the supervised social worker moves toward independent practice. Bogo (2015) further indicated the role of supervision in social worker development helps new professionals find personal meaning in theoretical practice. There is a strong connection to the counseling discipline in the encouragement of reflective practice.

In the counseling field, Watkins, Davis and Callahan (2018) argued the importance of the development of practice wisdom, which is described in the counseling discipline as therapist identity or practice self. The supervisor uses Socratic means to help new professionals develop critical thinking skills. The journey to *practice self* begins with the clinical supervisor creating a

safe, nonjudgmental environment for the supervisee to explore sense of self under the guidance of an experienced practitioner (Watkins et al., 2018). Within this structured professional relationship, the clinical supervisor acts as teacher, counselor, and consultant to guide the entry-level professional to develop practice self, which, like practice wisdom for social workers, is the basis of independent practice (Bogo, 2015).

The clinical supervisor has the responsibility to work with the new professional to assist with professional development into emotionally mature, reflective, and skillful helping professional (Crunk & Barden, 2017). The beneficiary of these efforts is the client, who enters the therapy relationship believing the therapist (social worker or counselor) is fully competent to address mental health needs regardless of level of training. There are times when the clinical supervisor works with graduate students and new professionals who do not possess the skills necessary to treat complex cases. In these instances, according to Jorgensen, Brown-Rice, and Olson (2018), the clinical supervisor serves as the gatekeeper to the helping professions protecting the client from inexperience and incompetence.

Jorgensen et al. (2018) surveyed literature concerning the adequate preparation of new professionals and discovered universities often fail to be the gatekeepers of the helping professions. Citing Gaubatz and Vera (2011), Jorgensen et al. wrote 98% of graduate students surveyed reported awareness of peers who lacked competence for professional entry. Another study conducted by Brown-Rice and Furr (2013) indicated 65% of 389 research participants believed university faculty had not intervened to prevent substandard students from entering the helping professions (Jorgensen et al., 2018). The term gateslipping was coined by Gaubatz and Vera (2011) to describe the failure of gatekeeping by persons responsible for monitoring the competence of developing professionals. Faced with these challenges of professional

competence, clinical supervisors, regardless of professional discipline, must have the ability to recognize issues impacting professional practice, and the skills to mitigate danger to clients (Jorgensen et al., 2018).

### **Models of Clinical Supervision**

The new professional entering mental health practice, regardless of discipline, uses clinical supervision to develop high-level skills much as the tradesman uses an apprenticeship to master a craft (Jensen, McAuliffe, & Seay, 2015; Pack, 2015). Professional training in mental health practice has three distinct parts: graduate school coursework, internship for counselors and fieldwork for social workers, and post-graduate clinical supervision (Bogo, 2015). Graduate school readies the new professional for the workplace, and clinical supervision provides an incubator for professional direction (Jorgensen et al., 2018). The choice of supervisor can have career-long implications for the new professional. Work situations which inhibit choice through supervisor assignment, often due to dual role (clinical/administrative) supervision, can limit exposure to new ideas, theory, and techniques in the formative stage of professional development (Heuer & Holbrook, 2015; Vito, 2015).

Clinical supervision as a professional practice began as a psychotherapy relationship between master and novice to work through transference/countertransference and the emotional strain of mental health practice (Messina et al., 2018). The work is emotionally taxing and inexperienced practitioners, left alone, often lack the resilience to navigate the pitfalls of burnout and vicarious trauma (Cho & Song, 2017; Kuo, Connor, Landon, & Chen, 2016). From these beginnings, clinical supervision has emerged as a distinct specialty focused on the wellbeing and growth of the new professional rather than therapeutic interventions (Bloomquist, Wood, Friedmeyer-Trainor, & Kim, 2015; Lonn & Haiyasoso, 2016). Distinct models of

supervision give a sense of personality to the process and guide the professional process development. In general, models of supervision fall within developmental, integrated, orientation-specific, and reflective models. Each model places an emphasis on professional growth while offering both supervisor and supervisee a specific framework to guide the process.

**Developmental Models.** Supervision provided within this construct recognizes clinical supervision is a process of continual growth for the new professional with attention directed to: a) awareness of self and others; b) motivation; and c) autonomy (Harris, 2016). The supervisor assumes the responsibility to match growth with strengths-based strategies to maximize the growth, and within the supervision process address: intervention, competence, assessment, interpersonal relationships, conceptualization, celebrating differences, theoretical orientation, treatment goals, and ethics. The new professional emerges from the supervision relationship excited for independent practice and prepared for a career of lifelong learning (Harris, 2016).

**Integrated Models.** This approach recognizes effective mental health professionals often are not tethered to one specific theory or clinical orientation (Crunk & Barden, 2017). Instead, professionals borrow ideas and techniques from several theories and models to create an eclectic and individualized method of practice. One of the integrated models of supervision is the discrimination model in which the supervisor functions as a teacher, counselor, and consultant within the supervision relationship. Roles change between sessions, and, sometimes within sessions, based on the needs of the new professional (Crunk & Barden, 2017). New professionals are encouraged to use supervision to conceptualize cases while exploring individual needs and struggles in the professional arena.

**Orientation-specific Models.** Mental health professionals often seek to develop expertise in a specific therapy technique. Supervision offers guidance to the new professional

from a supervisor who is a recognized master in the field (Shurts, 2015). Some of the orientations include behavioral therapy used for the treatment of autism spectrum disorders, person-centered therapy, systemic therapy, and play therapy. Certification bodies for some of these orientations, such as play therapy, mandate the new professional to engage in supervision to become a recognized practitioner. The strength of this model is fidelity to a specific therapy theory and model as new professionals dive deep into the nuances of therapeutic practice (Field, 2016).

**Reflective Models.** The use of reflection in clinical supervision is an important element of both counseling and social work supervision models (Crunk & Barden, 2017; Samson, 2015). Social work embraces the reflective model of supervision, which separates content from process in the practice setting, and focuses on developing a deep understanding of process (Manthorpe, Moriarty, Hussein, Stevens, & Sharpe, 2015; Samson, 2015). Supervisors help new professionals develop an understanding of thoughts, feelings, self-awareness, analysis, and new learning (Samson, 2015). The method helps provide context to the complex process of therapy (Manthorpe et al., 2015).

### **Peer Consultation and Supervision**

Organized clinical supervision occurs in a regular, structured format has been considered by all mental health disciplines to be foundational in the development of professional competence (Golia & McGovern, 2015). Effective supervision can include peer consultation, which typically occurs in peer supervision activities and group supervision sessions. Developing peer connections early in professional practice helps mental health professionals create an enduring support system which can replace clinical supervision when the new professional meets the requirements for independent practice (Beddoe et al., 2016). Golia and McGovern



analyzed literature concerning the efficacy of peer consultation and supervision within the traditional clinical supervision relationship as well as the agency setting.

Although the ultimate purpose of peer consultation and supervision is to develop effective professional relationships to assist with current and future practice, Golia and McGovern (2015) found successful implementation of the practice requires the support and facilitation of administrative and clinical supervisors. This support takes the form of time, facilities, and encouragement. Buy-in is also required of new professionals. Factors promoting peer consultation and supervision (Golia & McGovern, 2015), include a desire for professional connections and support; interest in professional development of self and others; the goal of developing supervisory skills; empathy for colleagues and clients; and, respect for profession and workplace. Beddoe, Davys and Adamson (2014) argue peer support in these areas positively impact professional practice.

### **Trust in Supervision**

Trust is a common theme in the literature concerning the practice and the success of clinical supervision as a model for the professional development of new professionals (Egan, Maidment, & Connolly, 2017). Lack of trust is one of the factors which cited as a danger of dual or multiple relationships in supervision (Tromski-Klingshirn & Davis, 2007; Vito, 2015). The sense of trust and safety which exists within the clinical supervision relationship often is directly connected to the ability of the clinical supervisor to balance power and authority with the needs of the new professional. Egan et al. (2017) cited a study of North American social workers conducted by Kadushin (1992), which indicates both supervisors and supervisees feel a sense of discomfort due to the management and authority resting with the clinical supervisor.

Egan et al. (2017) studied trust and safety within social work supervision in a study of Australian social workers. The study collected data from two sources. The first was an online survey of 675 social workers, managers, and clinical supervisors, and the survey was followed by focus groups of social workers, managers, and clinical supervisors. Practice areas of social work in the study included both child welfare and health and counseling services. Four themes were identified by participants in the study as necessary for a successful clinical supervision, including: a) ability to establish trust within clinical supervision relationship; b) importance of maintaining confidentiality and safety within clinical supervision, and impact of breaches of privacy on supervision relationship; c) impact of role ambiguity and tension created by clinical supervision within organizations; and d) positive role of reflective practice of clinical supervision. Threats to confidentiality and emotional safety and role ambiguity are issues which arise with dual supervision and can impact trust in this professional relationship, which also can negatively impact the client (Tromski-Klingshirn & Davis, 2007).

One trust-related concern is non-disclosure in supervision sessions, which limits supervisor awareness of practitioners' provision of services (Cook et al., 2018). Intentional nondisclosure in clinical supervision has the potential to cause harm to clients, and the phenomenon needs to be better understood to create supervision relationships which are effective for the supervisor, supervisee, and, ultimately, the client (Cook et al., 2018). Citing a gap in the literature concerning intentional nondisclosure, Cook et al. (2018) studied 152 graduate-level counseling interns engaged in the practice of clinical supervision. Results of the study indicated 40% of respondents reported no history of intentional nondisclosure in clinical supervision. Cook et al. reported 60% of respondents reported 11 types of nondisclosure and 13 reasons for the nondisclosure which limit the ability of clinical supervisors to effectively monitor the practice of

new professionals. Wahesh (2016) indicated this phenomenon can be harmful if supervisors need to develop interpersonal tools to overcome resistance.

### **Promoting Self-Care**

An important role of clinical supervisors in all mental health disciplines is the ability of the supervisor to monitor the new professional for signs of dangerous work stress and to promote self-care (Bloomquist et al., 2015). The mental health professional sees individuals at the time of crisis, which includes suicidal thoughts and attempts, incarceration, loss and grief, mental illness, addictions, relationship struggles, include divorce and estrangement from children, rape, abuse, and a variety of traumas. Vicarious trauma, secondary trauma, job stress, and compassion fatigue are all real dangers of the helping professions and require the competent guidance of experienced professionals as a protective factor (Bloomquist et al., 2015; Lonn & Haiyasoso, 2016).

Bloomquist et al. (2015) studied the impact of self-care practices on the reduction of secondary traumatic stress (STS), burnout, and compassion satisfaction. The study included a sample of 786 master's level social work practitioners from 42 states and the District of Columbia. Self-care activities were broken down into the realms of physical (healthy eating, sleep, hobbies, etc.), professional (supervision, peer consultation, continuing education, etc.), emotional (laughing, social interactions, personal time, etc.), psychological (mindfulness, journaling, therapy, etc.), and spiritual (praying, yoga, organized religion, etc.). The study found social workers who engaged in more professional and emotional self-care reported less burnout and more compassion satisfaction. All areas of self-care, except psychological, helped the social workers cope with STS. Bloomquist et al. (2015) reported quality of life for these social workers was higher for those professionals who practiced self-care in the realms of professional,

emotional, and spiritual. These results align closely with other studies exploring clinical supervision and the wellbeing of new professionals (Blount, Taylor, Lambie, & Anwell, 2016).

**Self-care and wellness.** The American Counseling Association code of ethics (2014) mandates awareness of self-care and wellness be part of the individual counselor's toolkit. Positive client care rests with the ability of the counselor to manage the physical and emotional obstacles common to the helping professions (Blount et al., 2016). For the entry-level counselor, clinical supervision is essential to the practice of self-care, and supervisors, due to proximity to the new professional as well as the objective stance of the professional relationship, have the ability to monitor the new professionals for threats to personal wellness, as well as to use supervision sessions to help develop greater resilience. Some of the factors which threaten the wellbeing of helping professionals include large caseloads common to practice settings of new professionals, exposure to client trauma, and lack of experiences coping with vicarious trauma (Blount et al., 2016). These are the issues social work organizations consider necessary for administrative supervisors to manage within the clinical supervision duties (NASW, 2013).

A critical goal of the clinical supervision of counselors and social workers is to develop clinician autonomy, resulting in licensure for independent practice (Jensen et al, 2015). Emotional maturity in the form of self and other awareness develops through effective clinical supervision. Jensen et al. (2015) argued the advanced ability to use reflection to perceive self and others is the hallmark of readiness for autonomy. The researcher tested this hypothesis in a quantitative study of 30 graduate students engaged in a supervised internship. Measuring the development level and skill development of these novice counselors, researchers posited higher levels of cognitive development would be correlated to higher levels of counseling skills. The

result supported strong connections between self-other awareness and practical skills required for the counseling profession (Jensen et al., 2015; Watkins et al., 2018).

**Resilience.** Lonn and Haiyasoso (2016) reviewed the research regarding the impact of vicarious trauma on mental health counselors, and the results tracked the findings identified by Bloomquist et al. (2015). Self-efficacy gained through experience and confidence is a protective factor promoting resilience to vicarious trauma. The new mental health professional often lacks this sense of self-efficacy and uses clinical supervision for psychological support to cope with the trauma clients bring to sessions (Lonn & Haiyasoso, 2016). The clinical supervisor in such situations serves as a counselor and consultant to the new professional allowing for the processing of difficult thoughts and feelings (Crunk & Barden, 2017). Resilience is understood to be one of the factors helping individuals cope with distress, and the development of resilience often is the goal of mental health work (Beddoe et al., 2014). Who promotes resilience in the social worker? Beddoe et al. (2014) sought to this answer in a qualitative study of 20 health and mental health social workers and seven social worker supervisors practicing in New Zealand.

In semi-structured interviews, Beddoe et al. (2014) asked social workers and supervisors to reflect upon practices which increase a sense of resilience. Both new practitioners and veteran social workers identified supervision, structured supervision, and informal peer consultation, as important elements in the development of resilience (Beddoe et al., 2014). One respondent stated professionals who do not recognize the value of supervision, are professionals most in need of supervision. In the study, clinical supervision helped practitioners by promoting self-care, creating supportive workplace relationships, and providing safe places within the workplace. The result of supervision was a workforce which could process thoughts and feelings related to social work practice before these issues negatively impacted performance (Lonn & Haiyasoso, 2016).

**Compassion fatigue.** Burnout or compassion fatigue has been recognized by both counseling and social work disciplines as a remarkable threat to the wellbeing of helping professionals and helping organizations (Merriman, 2015a; Merriman, 2015b). The phenomenon of compassion fatigue, according to Holliman and Muro (2015), is exacerbated by the solitary nature of the counseling session. In even the largest human services organizations, the hard work of counseling and therapy occurs one-to-one within the four walls of the professional's office. Therapy can be an exhausting journey the new professionals take several sessions per day, five days per week, often 50 weeks per year. Supervision, individually with a clinical supervisor or collectively with peer consultation, provides the new professional with respite from the isolation of the therapy session (Lonn & Haiyasoso, 2016). From the outside, supervisors and peers can offer the new professional different perspectives and strategies to combat various workplace stressors (Holliman & Muro, 2015).

### **Gap in Literature**

Clinical supervision is an essential bridge between graduate education and independent practice for entry-level mental health professionals, regardless of discipline (Vito, 2015). Despite the recognized role of clinical supervision in development and wellbeing, there is no readily available literature concerning the perception of the practice by the new professionals the practice was developed to advance (O'Donoghue & Tsui, 2015). Tromski-Klingshirn and Davis (2007) provide a glimpse into the impact of the dual supervision of counselors, but the age of the study and its quantitative methods limit the ability to translate the findings. These findings also lack the rich detail and deep meaning, which is possible through a phenomenological examination of the practice. There is abundant literature concerning the theory and practice of clinical supervision, and the role of the practice on protecting the emotional wellbeing of new

professionals (Kuo et al., 2016; Lile, 2017; Lonn & Haiyasoso, 2016). Understanding these issues also raises interesting questions about the meaning of the practice for new professionals.

### **Chapter Summary**

Clinical supervision is an important element of professional development for mental health professionals, both social workers and counselors (Bell et al., 2016; Pack, 2015). Within this professional relationship, the new professional develops a sense of self, described as practice wisdom for social workers and practice identity for counselors, which is the hallmark of readiness for professional autonomy. The clinical supervisor, reflecting the concept of servant leadership (Sousa & van Dierendonck, 2017), is charged with helping the new professional achieve autonomy by assuming the role of teacher, counselor, and consultant to create a safe place for personal and professional growth within the first years of mental health practice. There is a lack of research concerning individual perceptions of clinical supervision and how supervision is delivered (Bernard & Luke, 2015). Literature concerning the clinical supervision supports the practice particularly for professional development and self-care issues which tend to impact new professionals disproportionately. Chapter 3 describes a phenomenological study of master's level social workers and counselors in Arkansas to explore perceptions and meaning of clinical supervision.

### Chapter 3: Methodology

The purpose of this phenomenological study was to explore the lived experiences of new mental health professionals working within clinical supervision relationships. In Arkansas, master's level counselors and social workers do the same work at the same locations, but receive clinical supervision guided by different rules and expectations. The primary difference is social workers typically receive clinical supervision at the worksite by an administrative supervisor (NASW, 2013), while counselors must contract with a board-approved third-party supervisor. The use of a third-party supervisor avoids multiple relationships which arise from combined administrative and clinical supervision (ABEC, 2016; ACES, 2011). The perception of these two different approaches for clinical supervision on the professional development of mental health professionals has not been studied. The study addressed these research questions:

**Research Question One:** What were the lived experiences within the supervision relationships as stated by counselors and social workers in Arkansas?

**Research Question Two:** What were the perceptions of entry-level counselors and social workers regarding clinical supervision in Arkansas?

**Research Question Three:** What meaning did counselors and social workers assign to clinical supervision in Arkansas?

Phenomenology as a qualitative research method allows for an inside-out examination of clinical supervision and the meaning new professionals assign to the practice. Clinical supervision is a servant leadership and mentoring practice in which the supervisor often assumes the role of teacher, counselor, and consultant for the benefit of the new professional, and



ultimately, the new professional's clients (Crunk & Barden, 2017; Spears, 2010). By exploring the experiences of professionals from each discipline, this phenomenological study was designed to assess the factors, tangible and intangible, contributing to and detracting from the clinical supervision experience (Korstjens, & Moser, 2017). This phenomenological study used a semi-structured interview to capture the experiences of these new professionals in their own voices. Major sections of Chapter 3 detail the research design and rationale for the phenomenological study; role of the researcher; population and sample selection; instrumentation; data collection, analysis, and preparation; reliability and validity; and ethical considerations.

### **Research Design and Rationale**

Phenomenology as a qualitative research method opens a window into the lived experiences of individuals engaged in the phenomenon to be studied. The approach recognizes the intimacy the eyewitness experiences in relation to phenomenon and empowers participants to share stories of these rich experiences (Creswell & Creswell, 2018). Phenomenology was first conceptualized in the early 20th Century by Edmund Husserl in Germany. The philosophy was rooted in the Husserl's belief the individual was expert to the moment where consciousness and experience converge (Korstjens & Moser, 2017). The history of phenomenology can be linked to the development of psychotherapy. In neighboring Austria, Sigmund Freud, a contemporary of Husserl, was using the personal narrative in psychotherapy to help individuals look inward for better understanding (Wertz, 1993). Both Husserl and Freud understood the power of personal narrative and are connected by hermeneutics, which is the interpretation of narrative to find deeper meaning and understanding (Fischer, Laubscher, & Roger, 2016). The phenomenological design is well suited for this study because the subjects all practice psychotherapy, which requires education and training into the power of personal narrative. Professional understanding

of the role of the narrative in psychotherapy as well as phenomenological research provided a great degree of comfort for these subjects in the research process (Alase, 2017; Rizq & Target, 2008).

In contemporary applications, the phenomenological method provides the social scientist with first-person data, which is rich in thoughts, feeling, experiences, and context (Creswell & Creswell, 2018). In 1974, Thomas Nagel, author of "What Is It Like to Be a Bat?," concluded the only true window into existence is through individual experience (De Preester, 2007). Qualitative research in the form of phenomenology seeks to articulate the extraordinary of the ordinary, and to explore the meaning of personal experience (Korstjens & Moser, 2017). Phenomenology as a research method is appropriate to apply to individuals engaged in clinical supervision, a professional practice akin to psychotherapy. The ability to create interpersonal connections is necessary for both psychotherapy and phenomenological research (Alase, 2017; Rizq & Target, 2008). Understanding the process will promote comfort among the mental health professionals who participate in the study. Other advantages and benefits of phenomenological research include: a) perceptions of phenomenon come directly from individuals experiencing the process; b) voices of research subjects captured in data; c) interplay between researcher and subject is important for data collection; and d) field notes record data collection process to add dimension to study (Bevan, 2014; Creswell & Creswell, 2018; Korstjens & Moser, 2017).

This phenomenological study used a semi-structured interview (Appendix C) to capture the experience of clinical supervision through the voices of 12 new professionals, six social workers and six counselors, engaged in supervised mental health practice. Research into phenomenological methods has determined a small sample is appropriate because the rich personal details collected in interviews provides the saturation necessary for study validity

(Creswell & Creswell, 2018). Data were collected through recorded in-person, telephone, or video conference interviews (dependent on subject preference), member-checking, and researcher field notes. Triangulation of data included the recorded interview, member-checking, and field notes. The interviews were transcribed, member-checked, and coded to identify themes in clinical supervision experiences of research subjects (Bevan, 2014). The words of the research subjects were used to identify naturally occurring themes and the meaning of those themes for the individual.

### **Role of the Researcher**

The researcher plays a key role in the collection of data and the exploration of meaning from interviews conducted in phenomenological studies (Miles, Huberman, & Saldana, 2014). In phenomenology, the researcher is both observer and participant in data collection (Creswell & Creswell, 2018). Procedures employed to promote ethical data collection, and to manage and to control variables included: a) no interviews were conducted at research subjects' worksites; b) research subjects had no prior personal or professional relationships with the researcher; c) research subjects were allowed to determine interview times and method; and d) consent procedures outlined potential risks, the voluntary nature of study, and clearly stated how to exit the study (Sanjari, Bahramnezhad, Fomani, Shoghi, & Cheraghi, 2014).

Phenomenology as a qualitative research method relies on the interplay between researcher and subject to explore the thoughts, feelings, behaviors, and context of the phenomenon to be studied (Korstjens & Moser, 2017; Park & Park, 2016). The researcher can be considered a tool in the data collection process, and expertise in counseling and interviewing will assist in the data collection process. The researcher in this study is a licensed professional counselor who is the clinical director of a non-profit human service agency and possesses

expertise in interpersonal interactions and has been trained in Motivational Interviewing. Motivational Interviewing uses open-ended questions, reflection, and summarization to help clients find meaning in the narrative of counseling sessions (Al-Ubaidi, 2017). Potential biases resulting from the researcher's own experience with clinical supervision were bracketed in the data collection process (Creswell & Creswell, 2018). To bracket potential biases in the researcher's own perception of clinical supervision, the researcher provided answers to the semi-structured interview using personal experiences. A transcript of the researcher's interview was analyzed for units of meaning, but not included in the study.

### **Research Procedures**

This phenomenological study adheres to recognized ethics and norms related to qualitative research, which includes providing for the safety and confidentiality of all research subjects. A semi-structured interview was administered to 12 research subjects, six counselors and six social workers, randomly selected from publicly available lists of licensed professionals. Data from the interviews was analyzed with field notes to obtain an understanding of clinical supervision for these new professionals. This section outlines and provides greater detail related to population and subject selection, instrumentation, data collection, data preparation, bracketing and triangulation, and confirmability and reflexivity.

### **Population and Sample Selection**

The phenomenological study explored the lived experiences (Korstjens & Moser, 2017) of a random sample of 12 master's-level mental health professionals, six social workers and six counselors, who are licensed to practice supervised mental health practice. In September 2019, the social work licensing board reported about 1,000 licensed master social workers (Chere Johnson, personal communication, September 26, 2019); the counseling board reported

about 1,200 licensed associate counselors (Lenora Erickson, personal communication, September 26, 2019). This random sample provided adequate saturation of themes when data were analyzed (Creswell & Creswell, 2018). There was no need to expand the sample as themes emerged in analysis.

Steps were taken in the sampling process to minimize differences between participants from the two mental health disciplines (ABEC, n.d.; ASWLB, n.d.). Criteria for participation in the study included four requirements: 1) Arkansas license to practice as an associate counselor or master social worker obtained within two years of the beginning of data collection; 2) participation in clinical supervision at rate required by respective licensing board; 3) professional goal of independent clinical mental health practice; and 4) no personal or professional relationship with researcher. The failure to meet any one of these requirements would have disqualified subjects. The study excluded provisionally licensed master social workers. The Arkansas Social Work Licensing Board (2017) allows for the provisional license (PLMSW) status of new graduates, who become licensed master social workers when the licensing exam is passed. Provisional social workers were excluded from the study due to the transitional nature of the license status (ASWLB, 2017).

Each of the Arkansas licensing boards publishes the minutes of monthly meetings, which include the names of newly licensed individuals (ABEC, n.d.; ASWLB, n.d.). A random sample was selected from names published from October 2017 to October 2019. All the research subjects resided within the state of Arkansas, but no effort was made to narrow geographic location. Recruitment began with email and phone contact with the randomly selected research subjects (Appendix B). Informed consent information was provided during this initial contact.

The informed consent (Appendix A) addresses the voluntary nature of the study, confidentiality issues, review of potential risks, and the fact no compensation will be provided for participations. All subjects were provided information on how they could leave the study at any time without repercussions. Participation in the study began only after the subjects signed consent for participation. Anonymity of the research subjects was protected through the assignment of pseudonyms to recorded interviews. This pseudonym identifier was in the data analysis phase of the study. To fully ensure confidentiality, a document matching subjects with these identifiers was locked in a file cabinet, separate from study data.

### **Instrumentation**

A semi-structured interview (Appendix C) using open-ended and follow-up questions was developed based on the Supervisory Working Alliance Inventory (SWAI) (Efstation et al., 1990) (Appendix D). Permission to use the research tool was granted by the American Psychological Association (Appendix E). The interviews were recorded and transcribed to develop units of meaning to explore themes consistent with SWAI (Efstation et al., 1990; Tangen & Borders, 2016). Other themes, which emerged from the review of transcripts were noted and included in the data. All data gathered in the course of the study have been placed in a locked filing cabinet, available only to the researcher. Data will remain stored under lock in a secure location for at least three years following completion of the study to meet applicable university and federal research guidelines (ACE, 2018).

Efstation et al. (1990) indicated the SWAI was developed to specifically measure the relationship between supervisor and supervisee within the clinical supervision relationship. Previous tools used in the research of clinical supervision relied on tools designed to measure the therapeutic relationship between therapist and client (Efstation et al., 1990). The authors (1990)

report an internal consistency alpha coefficient of .90 on the rapport scale, and .77 on the client focus scale of the tool. The SWAI uses a seven-item Likert scale. This study used the SWAI as the basis for developing open-ended questions to provide the detailed personal responses necessary for phenomenological analysis.

Field notes of the interview sessions included both objective and subjective information, including date, time, setting, body language, facial expressions, completeness of answers, need for additional prompting and follow-up questions (Groenewald, 2004; McLeod, 2017). These notes added rich details about themes emerging during the data collection process. The ability to identify such details is the hallmark of an effective phenomenological study (Creswell & Creswell, 2018; McLeod, 2017). Information from the field notes was coded and included in the data analysis of the study for triangulation purposes. A reflex journal was maintained to note personal experiences in the research process.

### **Data Collection**

Data collection occurred in the following steps after study approval by the Institutional Review Board of American College of Education: random selection of sample; e-mail and phone contact with potential subjects; collection of informed consent forms; assignment of pseudonyms to protect confidentiality; and, scheduling of interview times. Email invitations were sent to potential participants identified through random sampling of counselors and social workers who met requirements for the study. This initial contact provided an outline of the study, including the voluntary nature of the participation, and included an informed consent form (Appendix A). At first contact, potential subjects were encouraged to discuss any questions or concerns related to participation. A total of 12 subjects, evenly representing counselors and social workers, was selected for interviews.

## **Data Preparation**

The study used Hycner's (1999) five step process to find meaning within the collected data (Groenewald, 2004). Analysis was achieved through the assistance of a web-based research tool, Dedoose. Hycner's steps, include: bracketing and reduction to identify researcher bias and to be conscious of research subjects' unique voice within the data; delineating units of meaning to provide and to maintain a sense of context for data; identifying themes emerging from the interviews; summarizing interviews, and member-checking to ensure validity; and, comparing all interviews to identify general and unique themes. The semi-structured interviews were about 30-45 minutes in length and were recorded using two audio-recording devices. Each of the recorded interviews was reviewed to ensure the recordings were complete and technologically sound. The recordings were transcribed using a computer-assisted transcription service. Transcribed interviews were emailed to research subjects for member-checking (Ghirotto, 2016; Miles et al., 2014).

In the member-checking phase, subjects were asked to comment on the accuracy of the transcript and asked to make any necessary edits. Additional information and comments could be added to the transcripts at this time. The member-checking process was limited to three days, and no research subject used the process to add information. Transcribed interviews, assigned a pseudonym for anonymity, were then uploaded into the web-based program Dedoose for analysis. These pseudonyms were used for the remainder of the study for research subject confidentiality and data integrity. Dedoose, a secure, web-based program was used for the analysis of data. The service is password protected and encrypted to protect data (Dedoose, n.d.).



Original recordings and transcripts will remain stored in a locked filing cabinet in the researcher's office for three years to meet university and federal guidelines (ACE, 2018), after which time the materials will be destroyed.

### **Data Analysis**

The Supervisory Working Alliance Inventory (Efstation et al., 1990) identifies themes which emerge in clinical supervision (Appendix D). These include working alliance; communication; comfort; anxiety reduction; reflection; ability for direction; workplace; ethics; feelings (positive and negative); and ownership and participation in the process. Words and phrases associated with each of these themes, as well as any naturally occurring themes which emerged through review of transcripts, were entered into Dedoose to allow for the analysis of the transcribed interviews. A transcript of the researcher's own interview answers was used to identify and bracket any potential bias.

Themes emerging from observations regarding the interview process were noted and included in the study results. Dedoose allowed for the analysis of data based on the three research questions. Once themes related to SWAI were explored, further analysis was conducted to identify naturally occurring themes emerging from interviews with the 12 mental health professionals. This included the separate examination of servant leadership in clinical supervision as themes consistent with the leadership practice emerged in the analysis process.

### **Reliability and Validity**

Several steps were taken to ensure the reliability and validity of the phenomenological study. First, the study was guided by the principle which finds research only has value if results are transparent and methods can be replicated (Leung, 2015). The thick descriptions found in recorded, transcribed, and member-checked interviews and field notes will assist in the

transferability of the study (Creswell & Creswell, 2018). The chief research instrument, a semi-structured interview was designed using the Supervision Working Alliance Inventory, which has been well-researched and determined to be a valid research tool (Efstation et al., 1990). The study employed research methods, such as bracketing, triangulation, and web-based analysis software, to ensure the integrity of the data, data collection, and data analysis.

### **Bracketing and Triangulation**

Bracketing helps achieve epoche (Creswell & Creswell, 2018; Ghirrotto, 2016), a term Hessrl used to describe the authentic voice and experience, which results from the removal of the researcher's views and potential bias from a phenomenological study. Triangulation helps ensure reliability and validity by using different methods to collect research data (Creswell & Creswell, 2018). This phenomenological study used a semi-structured interview, member-checking, and field notes for triangulation. Dedoose was used to analyze themes identified in transcribed interviews and field notes. Research participants were contacted by email for member checking, and allowed three days to review, to correct, and to expand upon information in provided in the interviews.

### **Confirmability and Reflexibility**

A reflex journal of research activities was maintained to provide a log of recruitment, interviews, and other data collecting activities. This journal provided a degree of confirmability and transparency related to research activities. In addition to previously discussed bracketing, the journal provided a second check on potential bias by allowing the researcher to process thoughts, feelings, and observations about the research process. Self-awareness obtained through reflexivity added another layer of credibility to qualitative research (Jootun, 2009). This information was reviewed to support the sense of epoche considered important for

phenomenological research (Ghirotto, 2016).

### **Inter-coder Reliability**

The study employed a code-recode strategy during the data analysis phase of the study to ensure reliability of the study (Creswell & Creswell, 2018). The information was coded and then set aside. The transcripts were coded a second time and compared to the initial results. Creswell and Creswell (2018) indicates the process promotes a sense of trust in the coding process. In addition to code-recode, a peer review (doctoral candidate with knowledge of mental health professions and clinical supervision) was used to review the data coding to provide input into the coding process. Since coding is subjective, the ability to obtain independent review of the coding process added an important layer of credibility to the process (Miles et al., 2014). In addition to this coding review, this study used the web-based program, Dedoose, for data analysis to reduce the potential for human error. Code-recode, peer review, and Dedoose, used together provided a greater degree of reliability and validity of the study.

### **Ethical Procedures**

All activities related to this phenomenological study abided by ethical guidelines established by American College of Education to meet federal guidelines for human research by (ACE, 2018). No research activities began until the study has been approved by the Institutional Review Board. Strict adherence to National Institute of Health training regarding the use of human subjects will guide the study. All participation was voluntary, and any potential risks and benefits were outlined in the informed consent materials (Creswell & Creswell, 2018). The identify and privacy of all research subjects has been protected using pseudonyms, passwords, encryption, and locked files. Member-checking was used to ensure the accuracy of interview data. Subjects were informed of the ability to withdraw from the study at any time. All data have

been locked in a location for three years to meet federal and university requirements (ACE, 2018), and will be destroyed.

### **Chapter Summary**

Phenomenology is a qualitative research method which allows an inside-out view of phenomena through the perspective and lived experiences of research subjects. The method is well-tested and appropriate for research focused on the human experience (Creswell & Creswell, 2018; Korstjens & Moser, 2017). In this study, data from interviews and field notes were collected to give voice to research subjects engaged in clinical supervision. Data was evaluated to identify themes to provide rich, personal insights into the phenomenon being studied. This study used sample of 12 mental health professionals, equally divided between counselors and social workers, working within clinical supervision. The sample was interviewed to determine the perception of clinical supervision experience in Arkansas. The interviews were transcribed and coded to compare with themes identified by SWAI (Efstation et al., 1990), which identifies themes important to effective clinical supervision. Each section of the chapter, research design, role of the researcher; population and sample selection; instrumentation; data collection, analysis, and preparation; reliability and validity; and, ethical considerations, details the efforts to achieve the goals of the phenomenological study. Information presented in this chapter provides a framework of understanding for the treatment of data in Chapter 4.

## Chapter 4: Research Findings and Data Analysis Results

The purpose of this phenomenological study was to explore the lived experiences of 12 entry-level mental health professionals in Arkansas working under clinical supervision. The study used semi-structured interviews, based upon the Supervision Work Alliance Inventory (Efstation et al., 1990), to explore how counselors and social workers experience supervision and what value these professionals assign to the professional relationship. Chapter 4 provides details of the process by which the 12 research subjects were selected and interviewed for the study. The findings which emerged from the analysis of the semi-structured interviews administered to the six counselors and six social workers are presented. The research collection plan outlined in Chapter 3 was followed in the selection of subjects; data collection; and data analysis. The study was guided by the following research questions:

**Research Question One:** What were the lived experiences within the supervision relationships as stated by counselors and social workers in Arkansas?

**Research Question Two:** What were the perceptions of entry-level counselors and social workers regarding clinical supervision in Arkansas?

**Research Question Three:** What meaning did counselors and social workers assign to clinical supervision in Arkansas?

### Data Collection

The Institutional Review Board at the American College of Education approved data collection for the study in November 2019. Upon receiving IRB approval, public websites for the Arkansas Board of Examiners for Counseling (n.d.) and the Arkansas Social Work Licensing Board (n.d.) and were accessed to develop a list of potential research subjects. This step was guided by previously established inclusion criteria for the study, which included: 1) license to

practice as an associate counselor or master social worker obtained within two years of the beginning of data collection; 2) active participation in clinical supervision; 3) professional goal of independent clinical mental health practice; and 4) no personal or professional relationship with researcher.

Names collected from the two websites for professionals licensed between October 2017 to October 2019 were numbered. The total population was 328 counselors and 453 social workers. An Internet-based random number generator was used to select 20 counselors and 20 counselors for recruitment by email (see Appendix B). The counseling board website provided email addresses for all licensed individuals. The social work board does not provide contact information. The public National Provider Identifier database (NPPES, n.d.) was used to obtain contact information for the social workers. No replies were received within seven days for the initial round of recruitment emails, and a second round of recruitment emails were determined to be necessary.

A second round of recruitment emails were sent to 50 counselors and 50 social workers, which were selected by random number generator using the previously identified population. Within seven days, six counselors and six social workers responded to indicate interest in participation in the study. Three additional counselors and two additional social workers replied after the sample was selected. These individuals were contacted and waitlisted for potential inclusion if the initial sample did not provide saturation (Creswell & Creswell, 2018). Saturation was achieved so additional participants were not needed. Signed consent forms (see Appendix A) were collected and secured in a locked file cabinet at the researcher's office, before interviews were conducted. The interviews were conducted during a two-week period in December 2019 (see Table 2).

Table 2

*Participant Interview Date, Location, and Duration*

<b>Participant</b>	<b>Date</b>	<b>Location</b>	<b>Duration (minutes)</b>
Angela	12/13	Zoom	35
Beth	12/12	Telephone	42
Carl	12/17	Office	37
Edward	12/11	Office	45
Ellen	12/10	Office	35
Eric	12/19	Office	32
Jake	12/9	Telephone	36
Julie	12/19	Telephone	45
Karen	12/14	Office	34
Mary	12/16	Office	32
Rebecca	12/17	Telephone	40
Samantha	12/13	Office	46

Interview sites and methods were based on sample preference. The interviews were audio recorded for later transcription using secure, web-based transcription software. Transcripts were reviewed individually to remove identifying information such as names, universities, and worksites. Extraneous words and utterances common to informal speech such as *um*, *like*, *I mean*, *you know*, and *OK*, which did not contribute to the understanding of the interview, were removed from the transcripts. Member-checking allowed participants the option of clarifying, removing and/or adding information within a three-day window. No research subjects objected to the transcribed interviews.

## Research Subjects

The 12 mental health professionals randomly selected for the phenomenological study represented a cross-section of entry-level practitioners in Arkansas (see Table 3). Subjects included four men and eight women ranging in age from 26 to 46 years old, practicing under clinical supervision as licensed associate counselors or licensed master social workers. The professionals indicated employment at residential, outpatient, and school-based practice sites. Several of the licensed associate counselors also reported providing services in private practices. Licensed master social workers, unlike licensed associate counselors, cannot engage in private practice until achieving an independent, clinical license post-supervision.

Table 3

### *Counselor and Social Work Research Participants*

<b>Pseudonym</b>	<b>Age</b>	<b>Gender</b>	<b>Discipline</b>	<b>Supervision</b>	<b>License date</b>
Angela	26	Female	Counselor	Off-site	2019
Beth	26	Female	Social Worker	On-site	2018
Carl	27	Male	Social Worker	On-site	2018
Edward	32	Male	Counselor	Off-site	2018
Ellen	37	Female	Counselor	Off-site	2017
Eric	42	Male	Counselor	Off-site	2018
Jake	29	Male	Counselor	Off-site	2018
Julie	27	Female	Counselor	Off-site	2017
Karen	31	Female	Social Worker	On-site	2019
Mary	26	Female	Social Worker	On-site	2019
Rebecca	30	Female	Social Worker	Off-site	2018
Samantha	46	Female	Social Worker	On-site	2017



## Data Analysis and Results

The data analysis process followed the steps outlined in Chapter 3. A five-step process developed by Hycner (1999) was employed for analysis of the transcribed interviews, using deductive units of meaning based upon the Supervision Working Alliance Inventory (Efstation et al., 1990), and emergent units of meaning which naturally emerged through careful reading, and re-reading of the transcripts. The five steps, included: 1) bracketing to identify researcher's bias and to increase awareness of each subject's voice within the data; 2) delineating units of meaning to provide a sense of context for the data; 3) identifying themes emerging from the interviews; 4) summarizing interviews and member-checking for validity; and, 5) comparing all interviews to identify general and unique themes.

For bracketing purposes, the researcher provided answers to the semi-structured interview to increase awareness of views and biases regarding clinical supervision. These views and biases, as well as corresponding alternative and opposite views, were available during the coding process. The bracketing process was designed to reduce bias which might interfere with the voice and experiences of research subjects emerging during the analysis process. The interviews were first analyzed after the final interview was transcribed, using deductive units of meaning aligned with SWAI (Efstation et al., 1990), including reflective communication, anxiety reduction, insight into client needs and behavior, constructive criticism, creating a supportive environment, working alliance, ownership of supervision process, professional and identity development, and focus on outcomes related to bidirectional relationship (See table 4). Reduction of the transcribed interviews based on these themes confirmed the sampling process achieved saturation with the random sample (Creswell & Creswell, 2018).

Table 4

*SWAI Deductive Units of Meaning Occurring with Interviews*

<b>Counselors</b>	<b>Anxiety reduction</b>	<b>Reflective communication</b>	<b>Insight into client</b>	<b>Feedback</b>	<b>Supportive</b>	<b>Working Alliance</b>	<b>Ownership of process</b>	<b>Workplace issues</b>	<b>Professional growth</b>	<b>Bi-directional relationship</b>
Angela	6	4	5	4	5	4	4	1	8	4
Edward	3	4	4	3	8	5	2	2	6	6
Ellen	3	4	5	3	9	10	3	2	4	8
Eric	6	4	4	4	2	4	1	1	4	5
Jake	3	7	3	4	2	5	5	5	5	3
Julie	7	6	3	5	7	6	5	5	5	7
<b>Social workers</b>										
Beth	5	5	7	5	2	7	1	1	5	8
Carl	4	8	3	7	8	8	1	2	3	5
Karen	4	5	4	5	10	10	1	6	5	8
Mary	5	4	2	5	5	5	1	1	3	7
Rebecca	5	6	3	4	10	7	3	2	5	8
Samantha	6	6	4	5	8	9	1	2	5	9

The deductive SWAI themes were determined to be too broad and cumbersome to develop a rich, detailed understanding of the clinical supervision relationship. Each transcript was read and reread at least five times to identify naturally occurring units of meaning which were used for further analysis of the data. These repeated readings and the code, re-code process was helpful in the discovery of naturally occurring units of meaning which aligned with the three research questions to gain deeper insight into the phenomenon of clinical supervision. Table 5 illustrates how units of meaning were applied to the transcribed interviews to better understand the lived experiences, perceptions, and meaning of clinical supervision.

Table 5

*Deductive Themes from Supervision Working Alliance Inventory (Efstation et al., 1990)*

<b>Deductive units of meaning</b>	<b>Emergent units of meaning</b>	<b>Representative examples</b>
Reflective Communication	Listening Questioning Reflection	“It is just the way he stretches my mind.” “She is very, very direct with no pulled punches.”
Anxiety reduction	Therapeutic Trust Empathy Personal	“My fear is doing something wrong ... she’s always helped me work through that.” “He asks, ‘What are you doing to take care of yourself?’ “ “I trust her, and I believe she trusts me.”
Insight into client needs and behavior	Treatment Interventions Awareness	“He will often put himself in the client’s shoes.”
Constructive criticism	Direct Honest Socratic Persuasion	“I am able to discuss mistakes I made as a clinician.” “He’s honest with me ... he asks me, ‘where do you think you are in this area?’ “
Creating a supportive environment	Supportive Collaboration Respect Self-care	“When I am interested in something clinically, she really digs into it with me, so I learn and grow.” “He’ll always check in and say: ‘Tell me about what you’re doing.’”
Working alliance	Boundaries Frequency Prior relationship Teaching	“When something positive happens, we can experience joy together.” “I had worked with him... I thought he would a be a good person to give me guidance.”
Ownership of supervision process	Agenda Structure	“Can we meet for dinner? I want to talk to you about this.”
Addressing practice/workplace concerns	Ethics Independence Community	“In an ethical situation I have never been in before, I like to seek his input.” “We look at how I approach things, versus how he would approach things.”
Promoting professional development	Best practices Board Rules Roles	“I think a supervisor is a great boss.” “I like having a supervisor away from the job... I feel able to be more open.”
Ability to focus on outcomes as part of bilateral relationship	Relationship Leadership Growth	“She looks to me for things too, which is flattering.” “He always sees the opportunity to grow and get better.”

Dedoose, a secure, web-based program was employed to assist with data analysis. The program allows for qualitative examination of transcripts by organizing excerpts by units of meaning. The program allows for the use of descriptors based on research participant demographics to develop a deeper understanding of the data (Dedoose, n.d.). Transcripts of the 12 mental health professionals were further analyzed with variables related to gender, discipline, workplace, supervision site, and license date. These variables provided greater understanding of the data. For example, initial analysis of the data using deductive units of meaning indicated counselors and social workers have very different experiences regarding ownership of process (see Table 4). Further analysis of data using the variable of on-site vs. off-site supervision found the provision of supervision on-site vs. off-site better explained the phenomenon since responses from Rebecca, a social worker who receives off-site supervision, were more similar to responses of the counselors who are provided off-site supervision than the other social workers, who receive on-site supervision (see Table 6).

Table 6

*Average of Theme Occurrences Based on Supervision Provision*

<b>Supervision</b>	<b>Anxiety reduction</b>	<b>Reflective communication</b>	<b>Insight into client</b>	<b>Feedback</b>	<b>Supportive</b>	<b>Working Alliance</b>	<b>Ownership of process</b>	<b>Workplace issues</b>	<b>Professional growth</b>	<b>Bi-directional relationship</b>
<b>Off-site</b>	4.7	5.0	4.0	3.8	5.1	5.8	3.2	2.5	5.2	5.8
<b>On-site</b>	4.8	5.6	4.0	5.4	6.6	7.8	1.0	2.4	4.2	7.4

The three research questions were used as an effective outline for both analysis of the data and presentation of the findings. The research questions addressed lived experiences,

perceptions, and meaning assigned to clinical supervision. To organize findings, lived experiences were defined as the objective elements of the developmental process; perceptions as the more subjective themes which emerged from the transcripts; and meaning as the special significance the new professionals assign to clinical supervision.

### **RQ1: Lived Experiences within Clinical Supervision**

The lived experiences of mental health professions working under clinical supervision was defined as the objective elements of the relationship for data analysis purposes. This included understanding of best practices, licensing board rules, location of supervision, supervision method, and cost of supervision. Deductive and emergent units of meaning were used in the analysis of data.

#### **Best Practices**

Both disciplines of mental health professionals in the study use clinical supervision in the formative years of clinical practice to support the professional development of master's level counselors and social workers. Ethical practice, professional guidance, and practice development are common elements of best practices in each discipline (Beddoe et al., 2016; Bernard & Luke, 2015; Bogo, 2015). Best practices of each discipline diverge regarding relationship with the clinical supervisor. Counselors are advised to avoid dual relationships with the contracted clinical supervisor, specifically supervisors with administrative or management roles which can potentially impact employment (ACES, 2011). Social workers, in contrast, generally receive clinical supervision at the workplace from a supervisor with a direct administrative or management role.

Most mental health professionals from each discipline reported a basic understanding of best practices which guide clinical supervision. This includes the foundation of the relationship

to promote learning, professional development, and ethical practice. Three social workers reported limited knowledge of best practices of the discipline. One social worker diverged from best practices and chose to contract with an off-site supervisor, citing the freedom to honestly explore work issues within supervision sessions. No other social worker indicated feeling constrained to discuss workplace concerns during supervision sessions.

All the counselors acknowledged understanding of best practices. Each reported contracting with an off-site supervisor. While best practices encourage the avoidance of multiple or dual roles within clinical supervision, supervisor selection often was based on past relationship with the supervisor, usually in an academic setting. Three counselors reported a prior relationship influenced the decision regarding a clinical supervisor. Julie reports changing supervisors due to poor interpersonal connection:

I've had a supervisor, who I didn't like, and I did not really click with. He was a nice guy, but I didn't feel like I was learning a lot. So, when I switched supervisors, I was happy to find someone I knew and who made counseling sound easy.

Three of the 12 mental health professionals interviewed for the study had experienced a change in clinical supervisors. Julie changed supervisors due to comfort and professional development. Samantha, a social worker, reported a supervision change due to job change. Edward changed supervisors due to the sudden death of the clinical supervisor. The death resulted in a sense of personal and professional loss for Edward, who stated the clinical supervisor had previously been a graduate school professor who was instrumental in professional development and career choice.

## **Licensing Board Rules**

Licensed associate counselors must be supervised during the first three years of clinical practice, which is defined as 3,000 hours of direct client contact (ABEC, 2016). The ratio of supervision to client contact is 1:10 for the first 500 hours, and 1:20 for the duration of supervision. Within those three years, the counselor and supervisor must log 175 hours of supervision, at least half of which must be conducted individually and face-to-face. Group and technology-assisted supervision sessions are allowed for 50% of supervision hours after completion of the first 500 hours of clinical practice. Licensed Master Social Workers, working to achieve independent clinical practice, must be supervised for at least 48 months. Sessions are generally face-to-face, but group sessions can be used for 50% of the weekly sessions (ASWLB, 2017).

All the interviewed mental health professionals report meeting supervision guidelines established by respective licensing boards. The counselors reported supervision requirements based on variable clinical service hours rather than constant work hours increased the difficulty of meeting the supervision requirement. The five social workers who are supervised at the workplace report no concerns meeting the requirement for weekly contact. Each of the social workers reported formal weekly sessions, and informal contacts between sessions. Carl stated supervision is a daily process with regular interactions, which address any practice concerns. Obtaining supervision off-site does not limited daily interaction. Two counselors and one social worker reported regular telephone or text contact between supervision sessions as client and practice concerns arise.

## Regular Sessions

Formal clinical supervision sessions occur both in private office and workplace settings as well as public settings, mostly at coffee shops or restaurants, for both counselors and social workers. Six of the professionals indicated regular weekly sessions occur at public places. Karen, a social worker, who obtains supervision on-site, states supervision sessions occur at home to avoid work interruptions. Only one supervised professional suggested the public meetings hindered open communication. Jake stated meeting weekly at restaurants make him feel uncomfortable: “because of the setting, I feel a little reserved at times.” Other respondents indicated public sessions supported the interpersonal relationship with the clinical supervisor and promoted a sense of connection.

Unstructured sessions were described as the norm among all the respondents, regardless of discipline. Bringing issues to discuss and to review in supervision was generally described as a shared duty. The social workers indicated the sessions often addressed workplace issues, while the counselors reported discussion of practice and client issues, with limited focus on workplace concerns. Social workers did not make a distinction between practice and work in the interviews.

Two of the respondents, Julie, a counselor, and Samantha, a social worker, report engaging in regular group supervision sessions. Both professionals state participating in supervision with peers assisted in professional development, particularly regarding how to address practice issues. Samantha found the method to be more supportive than individual sessions. Julie indicated group sessions produced feelings of anxiety due to competition between group members for attention, and the inability to obtain individualized feedback from the clinical supervisor.

Two of the counselors indicate experience with clinical supervisors who are unable to be



physically present for sessions. Edward reports telephone and video communication methods to contact a clinical supervisor who maintained a residence in a foreign country. Julie reports driving three hours one time each month to meet four hours with a clinical supervisor. Both counselors indicated telephone or video conferencing contact was maintained between face-to-face sessions. These supervision situations technically met the Arkansas Board of Examiners for Counseling supervision rules, which allow 50% of supervision to be conducted with technology assisted means. Edward indicated the arrangement interfered with communication, comfort, and working alliance. “When he was overseas, it would be 4 o’clock my time, and it’d be 11 o’clock his time. There were times he’d be a little out of sync, it’d be past his bedtime.”

### **Cost of Supervision**

Licensed associate counselors must contract with a third-party clinical supervisor in order to meet licensing board rules, often at personal expense (ABEC, 2016). Social workers, in contrast, generally receive clinical supervisor at the worksite as an employment benefit. Despite expense of contracting with a supervisor, no counselors indicated the cost of supervision was a burden. Ellen noted her supervisor’s charges were very fair and appropriate. The subject of cost as a potential barrier was identified by one social worker, Rebecca, who receives free supervision, off-site, by a former colleague. Rebecca shared a belief new professionals often make career decisions based on supervision cost and stated receiving free supervision allowed for personal employment at a nonprofit organization.

### **RQ2: Perceptions of Clinical Supervision**

Universal support for clinical supervision was acknowledged by the 12 mental health professionals interviewed for the phenomenological study. In each interview, individual

professionals shared positive experiences working with clinical supervisors to grow as people and as professionals. Describing perception of clinical supervision, Edward states:

I think having a supervisor that you can lean on and point you in the right direction to support you and tell you that you're doing well is important. Sometimes, I ask myself, am I doing what I'm supposed to be doing? Is this the best I can do for these clients?

Sometimes you just need somebody to kind of uplift you a little bit.

Edward cites collaboration, feelings, feedback, growth, and relationship which are among the units of meaning used to analyze the perception of clinical supervision among the research subjects. Unlike lived experiences, the exploration of perception requires the evaluation of more subjective elements of the professional relationship.

### **Transformational Experience**

Interviews indicated the role which supervised professional assign to self within the construct of clinical supervision changes with duration of supervision. Each subject was asked to label current role in supervision as student, subordinate, or colleague. None of the subjects used the word subordinate to describe the situation. Most of the respondents in this study used both the words *student* and *colleague* to describe roles within supervision. None of the professionals identified solely as student, and the combination of student and colleague within context of the interviews indicated an openness to professional development within supervision. These words often were paired with statements about the supervisor, which included the words: trust, respect, and collaboration. Some of the new professionals further described themselves as teacher within clinical supervision.

Three social workers and one counselor reported taking on a leadership role within clinical supervision. Mary, who is bilingual and works with Hispanic youth at a school-based

practice, often uses clinical supervision to advocate for Hispanic clients and to inform the clinical supervisor who also has administrative duties of the needs specific to Hispanic youth. The three social workers have daily contact with supervisors. This proximity contributes to the leadership and teaching role perceived to have developed within the professional relationship. Beth describes the change as part of professional development:

When I started there was a lot of observing her work, asking her tons of questions, all the time, about how to do, even menial tasks, as we worked alongside each other. Now I am able to pick up work she has outside of sessions with clients. [I am] talking about more administrative things that I am able to pick up off her plate, and vice-versa, where we're really helping each other out.

### **Addressing Feelings in Supervision**

Feelings of anxiety and anxiety reduction are common elements of clinical supervision (Bloomquist et al., 2015; Blount et al., 2016). Initial deductive analysis of the interviews found all research subjects addressed the issue several times. Eric and Ellen, both counselors, indicated feelings of anxiety arise from understanding the gravity of working in a helping profession. Both counselors reported clinical supervision was an important to anxiety reduction.

Social workers who receive clinical supervision at the worksite reported stronger belief in the supportive environment created by clinical supervisors. These social workers cited proximity and workplace interactions as an important factor. Carl states clinical supervision allows immediate resolution to stressful practice issues which routinely arise. Beth reports her clinical supervisor regularly monitors emotionally difficult cases at work.

While the social workers were more likely to describe supervision as supportive, five counselors and three social workers used *therapeutic* to describe the relationship. The difference

between supportive and therapeutic is supportive focuses on environment created by the supervisor while therapeutic describes actions taken by the supervisor to provide a sense of healing. The therapeutic nature of supervision included teaching self-care practices as well as working through difficult life challenges. Julie shared “my mom was diagnosed with breast cancer and [my supervisor] cared how it affected me as a therapist. We would talk through my own personal things, which connected us, because it wasn't just about clients, it was about me as well.”

### **Feedback**

Constructive criticism, respect and trust were important elements within the theme of feedback. Each of the 12 mental health professionals described clinical supervision as a reflective relationship in which a trusted and respected supervisor provided honest and direct evaluation. The professionals described feedback as direct, straight-forward, honest, and helpful. Acceptance of feedback reflected the positive nature of these professional relationships as none of the interviewed professionals resisted the feedback. Jake described feedback as sarcastic, “but not necessarily unwelcome.”

Social workers reported feedback often was built into supervision sessions with regular review of workplace issues. Clinical supervisors critiqued observations of observed practice and client situations. In contrast, counselors reported seeking out feedback within the supervision process. This sense of ownership was reflected in the deductive analysis of the transcripts. Counselors reported using supervision ready to share difficulties and asking for guidance. Ellen reports feedback and constructive criticism occurs within the framework of professional growth: “She's real, very real about it. If she feels like I need a little extra work, she'll encourage me and give me places to get it.”

### **Growth within Supervision**

License date was instrumental in understanding perception of growth among the professionals. The 12 mental health professionals interviewed for this study included individuals licensed within the past two years, and the perception of supervision evolved with time. Two were licensed in 2017, seven were licensed in 2018, and three were licensed in 2019. The senior members of the research sample, Samantha and Ellen were both licensed in 2017 and expressed feelings of independence and autonomy within the clinical supervision relationship. The two professionals reported sessions focused on professional development and long-term needs rather than immediate practice concerns. Samantha, a social worker, and Ellen, a counselor, both reported supervisions contributed to a sense of confidence in professional practice. In contrast, the three professionals licensed within the past 12 months indicated supervision was most helpful for dealing with immediate practice and workplace concerns. The word collaborative was regularly used to describe the working alliance for the newer professionals. These individuals also recognized the need for expert guidance during this early stage of development. Angela, licensed in 2019, described being “a baby” in the early stages of development.

### **Sense of Connection**

Sense of connection, both personal and professional, was cited by all 12 mental health professionals as an essential element of successful clinical supervision. The length of commitment to the process was cited as a reason for the need for connection. Mental health professionals work within clinical supervisors for the first years of clinical practice. Social workers are required to complete at least 48 months of supervision, and counselors must complete three years, which is defined as 3,000 direct contact hours. Julie fired one supervisor and hired another because interpersonal connection was perceived to be very important to

professional development. Seven subjects reported having a prior relationship with supervisors before entering a clinical supervision relationship.

Beth developed a personal relationship with current clinical supervisor during an undergraduate experience. Carl returned to a former internship site for a first job, declaring “a supervisor is a great boss.” Edward chose a clinical supervisor who had been a graduate school professor. Julie chose a former colleague after firing an ineffective supervisor. Karen had worked as a paraprofessional for the individual chosen for clinical supervision. Rebecca receives free supervision from a former colleague.

### **RQ3: Meaning of Clinical Supervision**

Meaning for the purpose of this exploration of clinical supervision focuses on the *special significance* the 12 new professionals assign to the clinical supervision relationship. Some of the units of meaning which naturally emerged during the semi-structured interviews included words and phrases related to the themes of awareness, clients, empathy, healing, persuasion, and growth. Each interview included a discussion of three distinct individuals: the new professional, the clinical supervisor, and the client. This interconnected, triangular relationship which emerged in the 12 interviews is the essence of servant leadership (see Table 7). Chapter 1 began by stating clinical supervision embodies the spirit of servant leadership as expertise is passed from master to novice mental health professional for the benefit and protection of the consumer of the services (Crunk & Barden, 2017; Spears, 2010). The findings in Chapter 4 support those words.

Table 7

*Traits Associated with Servant Leadership (Spears, 2010)*

<b>Trait</b>	<b>Definition</b>	<b>Application of trait</b>
Listening	Deep commitment to understanding what is said and what is unsaid	“He uses a lot of questions, and he allows me to do more of the talking.”
Empathy	To accept, to understand, and to relate deeply with others	“The way he can connect with people makes him just relatable. He was just a very easy person to trust.”
Healing	To use the relationship as a force for transformation to achieve wholeness	“She first asks how I'm doing as a person, knowing that how I'm doing personally could be affecting my work.”
Awareness	Understanding self and others	“[Supervisor] can help me see progress that I might not otherwise see.”
Persuasion	Leadership harnessing power of collaboration rather than authority	“She may ask, ‘Oh, well I wonder what it might look like if, you know, you were to approach it this way.’”
Conceptualization	Ability to use abstract thinking to reach goals	“She will say, ‘you have look at it through their eyes,’ and then really look at their emotions.”
Foresight	The ability to apply lessons of the past to the future	“He asks, ‘Is that working? Have you tried this? What happened with that?’”
Stewardship	A commitment to serving the needs of others	“He challenges my perceptions. Sometimes I can get caught up in what I think is best for a client rather than what the client believes is best.”
Commitment to growth	Reaching organizational goals by helping individuals achieve personal goals	“She knows where my passion is, and she encourages me.”
Community building	Using individual talents for the greater good	“I was able to talk to them in their language, and it allowed her to see the other side of the problem.”

*Note: Representative examples from participant transcripts were selected for illustrative purposes, and do not include all relevant participant responses*

## **Stewardship and Community Building**

Clinical supervision lays the foundation for the mental health professions by investing time and experience in the development of new professionals. The beneficiaries of the relationship are the new professional, the clients, the professions, and the larger community. Spears (2010) identified 10 traits of clinical supervision. These traits include listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment to growth of others, and community building. The findings related to lived experiences and perceptions of clinical supervision addressed how listening, empathy, healing, awareness, persuasion, conceptualization, foresight, and growth of others are essential elements of the clinical supervision relationship for professionals interviewed for this study.

## **Beyond Clinical Supervision**

Foresight, stewardship, and community building are elements of clinical supervision which are forward-looking and extend beyond the supervision session. Foresight is defined as the ability to use lessons of the past and apply them to the future. Stewardship focuses on making a commitment to self and to others for the benefit of all. Community building as a servant leadership trait recognizes a connection to a larger community, and a duty to be a positive element of the greater community.

The developmental focus of clinical supervision makes the professional relationship a forward-looking process. Each of the interviewed professionals discussed using the clinical supervision process to develop into better professionals in service of clients. The practice itself demonstrates a commitment to the profession. Six professionals, both counselors and social workers, specifically reported regular review of ethical issues in supervision which benefits both



client and the profession. All the professionals reported throughout the interviews a strong desire to increase skill development to meet the needs of the clients. The data indicate a universal awareness of self and the need for self-improvement emerging in these supportive relationships. Julie's words describe these dynamics: "I would always say, 'I want your brain. I need your brain. And he'd say, yours is better.'"

### **Reliability and Validity**

Research subject selection and data analysis was conducted in a manner consistent with the steps outlined in Chapter 3, which was designed to ensure credibility, transferability, dependability, and confirmability. These were determined to be important to protect the integrity of the research product. The first step taken to meet these rigors was the selection of a random sample meeting the inclusion standards established for the study and approved by IRB. These 12 mental health professions, six counselors and six social workers, have personal insights into clinical supervision gained from lived experiences. The participants are experts in the phenomenon and these lived experiences guided the study. Interviews were conducted in the manner and location best suited to meet the needs of these professionals. After careful transcription of the interviews, the professionals, through the member-check process, were provided a window of time to review, to revise, to remove, and to add to information provided. None of the research subjects objected to the transcribed data. Data analysis carefully observed the process outlined in Chapter 3, and there were no deviations to the process.

### **Chapter Summary**

Chapter 4 reviewed data collection, data analysis, and findings of the study. The random sample of 12 mental health professionals selected for this study shared insights gained into the clinical supervision relationship, which can only be gained by first-hand participation in the

long-term developmental relationships. These professionals all met inclusion criteria, which included licensure with the past two years, active participation in clinical supervision, goal of independent clinical practice, and no relationship with the researcher. Careful and systematic analysis of data resulting from these semi-structured interviews opened a window into the professional, developmental relationship. The lived experiences and perceptions of the process indicated a great respect among all professionals for supervisors, clients, and respective professions. These findings capture the essence of clinical supervision, which the respondents report to embody the spirit of servant leadership, which describes process in which an expert invests in a novice for the benefit of all (Greenleaf, n.d.; Spears, 2010).

## Chapter 5: Summary and Conclusion

The purpose of this phenomenological study was to develop an understanding of the lived experiences of mental health professionals working under clinical supervision. In Arkansas, mental health practice at the master's degree level is performed by two distinct professions, counseling and social work, which are guided by different supervision practices (ABEC, 2016; ASWLB, 2017). This study was designed to explore whether these different approaches affect the perception of the practice and the meaning new professionals assign to clinical supervision. All professionals interviewed for the study, regardless of discipline, identified clinical supervision as a vital element of professional development; however, differences in the two approaches had a remarkable impact on the process.

Existing literature supports clinical supervision as a bridge between graduate school and independent practice (Beddoe et al., 2016; Bernard & Luke, 2015; Crunk & Barden, 2017). The problem is master's-level counselors and social workers in Arkansas, working side-by-side with similar clients, are guided by different supervision practices with limited understanding of how the differences impact professional development (ACES, 2011; NASW, 2013). The primary difference is social workers generally receive clinical supervision from administrative supervisors at work, while counselors must contract for supervision from board-approved practitioners away from work (ACES, 2011; NASW, 2013). Twelve entry-level professionals were interviewed for the phenomenological study to develop an inside-out view of clinical supervision (Korstjens & Moser, 2017). The findings help narrow the literature gap regarding the meaning new professionals assign to clinical supervision. The study focused on three research questions:

**Research Question One:** What were the lived experiences within the supervision relationships as stated by counselors and social workers in Arkansas?

**Research Question Two:** What were the perceptions of entry-level counselors and social workers regarding clinical supervision in Arkansas?

**Research Question Three:** What meaning did counselors and social workers assign to clinical supervision in Arkansas?

### **Findings, Interpretations, Conclusions**

The study used a semi-structured interview based upon the Supervision Working Alliance Inventory (Efstation et al., 1990), which addresses traits accepted to be important for effective supervision. Twelve professionals, six counselors and six social workers, were randomly selected from publicly available lists of professionals licensed within 24 months of data collection. Interviews were conducted in person, by telephone, and by video conference. Transcripts of the interviews were analyzed with deductive units of meaning based on SWAI. The initial review found the deductive units of meaning were too broad to fully capture the experience described in the 12 interviews. Further review of the transcripts identified naturally occurring units of meaning. The results of the analysis of transcribed interviews were organized by the three research questions.

Servant leadership served as a theory to guide the research. In this interpersonal leadership practice, an expert works closely with a novice to promote professional development for the ultimate benefit of the client and community (Greenleaf, n.d.; Spears, 2010). Clinical supervision often is described as a mentoring or apprenticeship process, which both contribute to professional development; but servant leadership is both deeper and broader in focus (Evans et al., 2016; Gandolfi & Stone, 2018; Green et al., 2015). Chapter 4 found the professionals

interviewed for this study identified self, profession, client, and the greater community as the beneficiaries of clinical supervision.

Chapter 5 presents a summary of findings related to the three research questions. Interpretations, conclusions, limitations, and recommendations follow discussion of the research questions. The chapter concludes with a discussion of the implications for leadership.

### **Research Question One**

What are the lived experiences within the supervision relationships as stated by counselors and social workers in Arkansas? For this study, lived experiences were interpreted to address the objective issues related to clinical supervision. Issues addressed included best practices, board rules, location of supervision, supervision structure, and cost of supervision. Responses from the six counselors and six social workers indicated individual experiences in these areas are related to how supervision is provided.

#### **Best Practices**

Best practice of clinical supervision of counselors is guided by the code of ethics of the American Counseling Association (2014) and the Association for Counselor Education and Supervision (2011). Both organizations focus on professional identity and ethical practice. Clinical supervision is defined as a distinct specialty within the counseling profession, which requires graduate-level training to protect the new professional, the profession, and the community. Dual relationships between supervisors and new professionals are ethically prohibited to reduce the power differential existing within the organizational hierarchy, which can interfere with honest and authentic communication between expert and novice (ACA, 2014; ACES, 2011).

Social work takes an opposite approach to this dual relationship. Best practices in social work promote the use of administrative supervisors for the delivery of clinical supervision (NASW, 2013). The discipline sees the overlap between administrative and clinical supervision duties to be an important element of professional development. Licensing board rules for both disciplines in Arkansas codify the respective best practices (ABEC, 2016; ASWLB, 2017). Analysis of data in Chapter 4 indicated clinical supervision in Arkansas is conducted in a manner which meets the best practices of each discipline.

### **Relationship Boundaries**

The literature reviewed in Chapter 2 addressed employment dynamics associated with clinical supervision, and three studies were identified which specifically addressed overlapping supervisory roles. Tromski-Klingshirn and Davis (2007) analyzed the dual-role supervision of counselors, and Boswell et al. (2017) and Vito (2015) studied how overlapping administrative and clinical supervision affected the development of social workers. Tromski-Klingshirn and Davis (2007) found the process to be common in counselor supervision and generally benign; however, a minority of respondents stated the practice negatively impacted trust and communication. The two social work studies found the overlapping relationships to be important for professional development. Minority voices captured within these two social work studies report negative consequences related to the imbalance of power (Boswell et al., 2017; Vito, 2015). The three studies were analyzed in greater detail in Chapter 2.

All six counselors interviewed for this study had separate clinical and administrative supervisors. Five of the six social workers reported using clinical supervisors at the workplace with overlapping roles. One social worker in this study chose to contract for off-site supervision and reported the potential for role conflict to be a reason for establishing a boundary between

workplace and supervision. This social worker echoed the reservations social workers voiced about overlapping roles in the existing literature (Boswell et al., 2017; Vito, 2015).

### **Session Structure**

While observing discipline-specific best practices, both counselors and social workers interviewed for the study reported blurred lines between professional and personal relationships. Seven of the 12 professionals interviewed in the study reported a previous relationship with the selected clinical supervisor. These professionals chose supervisors from former professors, past supervisors, colleagues, and personal acquaintances. In each of these cases, according to Chapter 4 findings, the professionals reported these prior relationships added a sense of depth to the interpersonal connection which existed with the clinical supervisor.

The structure of supervision sessions for both counselors and social workers was described in the interviews as informal in most cases. Counselors reported supervision sessions often occurred at public places due to the free-lance nature of third-party supervision. Social workers who obtained supervision from on-site supervisors also reported meeting at off-site locations. In both cases, the new professionals indicated these informal settings enhanced the interpersonal relationship between professional and supervisor and removed distracting work elements from the sessions.

### **Board Rules**

Counselors interviewed for the study reported difficulty meeting the supervision to practice hour ratio set by the licensing board. The ratio is 1:10 for the first 500 hours, and 1:20 for the remaining 2,500 hours (ABEC, 2016). Five of six counselors reported difficulty meeting the requirement, with time and location cited as common barriers. Evening and lunch-time

appointments and the use of telephone and video conferencing, within board guidelines, were used by counselors to meet the requirement.

Arkansas counseling board rules (2017) require entry-level counselors to contract for third-party supervision, which generally is a fee-for-service arrangement. Social workers typically receive supervision at the worksite as part of employment (NASW, 2013). Despite the difference, no counselors raised the issue of cost of supervision as a problem. One social worker, who contracts for free off-site supervision, indicated paying for the supervision could interfere with the ability to work at the nonprofit organization.

### **Research Question Two**

What are the perceptions of entry-level counselors and social workers regarding clinical supervision in Arkansas? The perception of clinical supervision was approached as the subjective elements of the developmental relationship. Each of the counselors and social workers interviewed for the study reported supervision to be an important part of professional development and personal growth. Counselors and social workers reported different experiences in clinical supervision based on discipline and established best practices. This summary of Chapter 4 findings included impact of supervision site; belief of supervision to be supportive or therapeutic; ownership of the process; and the role of peers in supervision.

#### **Off-site vs. On-site Supervision**

One of the primary differences between counseling and social work supervision is whether the supervisor is located off-site or on-site (ACES, 2011; NASW, 2013). All six counselors and one social worker reported off-site supervision. The five other social workers worked on-site with supervisors. Table 6 in Chapter 4 illustrates how this factor impacts perception of supervision, regarding the elements of support, working alliance, relationship,



professional growth, and ownership of supervision. Professionals who worked with on-site supervisors indicated the practice increased feelings of support, working alliance, and relationship. In contrast, the seven professionals who received off-site supervision reported a greater sense of ownership within the supervision process and a perception of greater professional growth.

### **Professional Support**

The five social workers who received supervision on-site described the clinical supervision experience to be supportive. In contrast, the seven professionals who received supervision off-site, which included one social worker and all six counselors, described supervision as therapeutic in nature. The difference between supportive and therapeutic was explored in Chapter 4. Supportive referred to the environment created by the supervisor while therapeutic referred to healing actions taken by the supervisor.

Eight of the professionals, including all six counselors, reported the supervision relationship to be therapeutic. In interviews, these professionals shared details of how clinical supervisors helped process difficult personal and professional issues affecting the ability to provide clinical services. Five of the social workers in this study reported using on-site supervision as a respite to workplace stresses. Workplace issues, client challenges, and work/life balance concerns typically were addressed in these sessions. Social workers reported these sessions provided important feedback regarding workplace concerns. The supportive nature of social work supervision was described by the interviewed professionals as one of the positive elements of the developmental process.

### **Ownership of Supervision**

All professionals interviewed for this study reported an appreciation for clinical supervision. Perceived ownership of the process differed between counselors and social workers and was related to whether the supervisor was off-site or on-site. The social workers interviewed for this study reported supervisors usually set the agenda for supervision sessions, which included review of client and work concerns, skill building, and self-care issues. Findings reported in Chapter 4 indicated these social work professionals did not report a sense of ownership over the process. In contrast, the seven professionals who contracted for off-site supervision, including all six counselors, reported feeling a sense of control over agenda and process. Control over the process included meeting times, location, and practice issues to be discussed.

### **Group Work and Peer Consultation**

Findings of this study indicated the clinical supervision experience in Arkansas departed from established norms regarding group supervision. Using group work to promote peer connections has been recognized as an important element of clinical supervision which can lead to the development of important peer relationships extending into independent practice (Beddoe et al., 2016; Golia & McGovern, 2015). Only two respondents in the study, one professional from each discipline, reported supervisors used group work as part of supervision. The practice produced mixed results with one professional reporting group supervision to be a source of important understanding and support, while the other professional reported feeling lost to peer competition within the group. These findings support the need for further research in this area.

### **Research Question Three**

What meaning do counselors and social workers assign to clinical supervision in Arkansas? The meaning of clinical supervision was defined as the special significance assigned to the developmental practice. Clinical supervision is a common element of the development of mental health professionals, regardless of discipline, and extends far beyond counseling and social work into the realms of medicine, psychology, and nursing (Bogo, 2015; Jensen et al., 2015; Jorgensen et al., 2018; Pack, 2015). All 12 professionals reported a sense of respect for the developmental process, and findings in Chapter 4 indicated the experience evolves in time as professionals move through the process. Newer professionals with only months of clinical experience reported a nurturing experience while professionals approaching independent practice described emerging as teachers and leaders within the supervision relationship.

#### **Naturally Occurring Phenomena**

Themes emerging from the review of transcripts during data analysis indicated clinical supervision is a transformational process which naturally aligns with servant leadership (Kiersch & Peters, 2017; Spears, 2010). The connection between clinical supervision, servant leadership, and interview responses is illustrated in Table 7 in Chapter 4. Both supervisors and new professionals possess clinical skills gained through academic study. These clinical skills often are referred to soft skills in leadership literature, and include communication, emotional maturity, empathy, and interpersonal connection. This study finds the application of these soft skills within supervision sessions produce an environment of growth which has important implications for the new professional, the client, the organization, and the community (Kiersch & Peters, 2017).

One emergent theme which connected all 12 professionals working within clinical supervision was the focus on the wellbeing of the client. Each of the professionals reported an awareness of the needs of the client, and how the process of clinical supervision helped meet those needs. Not all developmental relationships include a focus on the client: mentoring and apprenticeship as developmental practices focus solely on the transfer of knowledge and skill from expert to novice (Siddiqui, 2014). Focus on the client, and the development of skills for the benefit of others, are hallmarks of servant leadership, and each of the 12 professionals interviewed in this study indicated this was an important element of clinical supervision.

### **Limitations**

This study focused on the lived experiences of 12 mental health professionals, six counselors, and six social workers, working under clinical supervision in Arkansas to develop an understanding of perceptions and meaning of the developmental relationship. The study had limitations due to the small sample size common to qualitative research (Creswell & Creswell, 2018). Qualitative studies use smaller samples to develop a rich understanding of phenomena through insights developed from the lived experiences of individuals. Since these findings rely on individual experiences, another sample of 12 mental health professionals might produce different findings using the same semi-structured interview.

Great care was taken during the research design to assure the validity, reliability, and credibility of the study by carefully following research procedures outlined in Chapter 3. Recruitment for the study included identification of 140 potential research subjects randomly selected from a pool of 781 counselors and social workers licensed within the past 24 months. The 12 interviewed professionals were selected from 15 professionals who responded to recruitment emails. This 10.7% response rate falls within established norms for unsolicited

surveys (Saleh & Bista, 2017). Table 2 in Chapter 4 indicated the random sample achieved saturation regarding the deductive themes initially identified for the study. Saturation is an element used to confirm an adequate sample size (Creswell & Creswell, 2018).

### **Recommendations**

The findings of this study confirm clinical supervision is an important interpersonal tool for the development of competent, independent professionals. Until the new professionals achieve independent licensure, clinical supervision ensures new professionals and clients benefit from the wisdom and experiences of veteran professionals. All professionals interviewed for the study reported great respect for clinical supervision as a developmental process. Differences in best practices between counseling and social work resulted in different experiences, but no professionals interviewed for the study expressed dissatisfaction with the process.

No recommendation for systemic changes emerged from this study. The study finds best practices, although different, effectively guide the develop of professionals in each discipline. This study helped narrow the understanding of the perception of the process and the meaning new professionals assign to clinical supervision. However, further research is warranted. A more comprehensive study using quantitative or mixed-method design would be appropriate to confirm these findings. Such a study could address areas in which the Arkansas experience differences from established research such as the use of group supervision. Another avenue of potential research would be the impact of leadership education on the provision of clinical supervision.

Individuals ready to begin clinical supervision are encouraged to identify specific personal and professional needs before beginning clinical supervision. This includes interviewing potential clinical supervisors about supervision method, communication style, and

expectations. Existing best practices and licensing board rules in both counseling and social work allow for some latitude for developing a clinical supervision relationship tailored to individual needs. The new professional must step forward and take ownership of the process to assure those needs are met. Three professionals interviewed for this study indicated in Chapter 4 a lack of awareness of best practices. Graduate schools, preparing the next generation of professionals, must promote better understanding of supervision practices and how to achieve full benefit.

### **Implications for Leadership**

Leadership generally is a top-down practice which defined by power differential; in contrast, servant leadership is defined by soft skills and occurs as a conscious practice with leaders adept at using humility to promote personal and professional growth (Greenleaf, n.d.; Spears, 2010). This study finds servant leadership can develop as a naturally occurring phenomenon, if provided the proper environment. The 12 mental health professionals interviewed for this study were working within the construct of clinical supervision and described an experience aligned with servant leadership. None of the interview questions were designed to explore supervision as a distinct leadership practice.

Strong motivation to join the ranks of the helping professions as well as the academic training provided these mental health professions with the soft skills which promoted an atmosphere of servant leadership. Spears (2010) identified 10 traits of servant leadership. These traits align well with elements of effective clinical supervision, which were identified by Efstation et al. (1990). This has important implications for both clinical supervision and servant leadership. Training models for clinical supervisors could benefit from better understanding of servant leadership due to the proven ability of the leadership practice to affect positive change (Cook et al., 2018). Equally important, individuals who aspire to practice effective servant

leadership should investigate these two helping professions to identify and to develop effective interpersonal tools.

### **Conclusion**

Clinical supervision has long been recognized as a developmental relationship which provides the first-years foundation for effective mental health practice (Beddoe et al., 2016; Bernard & Luke, 2015). The 12 professionals interviewed for this study confirm the practice as an essential bridge between academic and professional excellence. The study finds the developmental practice is resilient and produces desired results regardless of method used to deliver clinical supervisions. Counselors and social workers in Arkansas are guided by different best practices for clinical supervision (ABEC, 2016; ASWLB, 2017). The six counselors and six social workers interviewed for this study provide evidence the practice produces competent practitioners regardless of the best practices which guide supervision.

All 12 mental health professionals interviewed for the study acknowledged remarkable growth within clinical supervision, which occurred due to collaboration between new professional and supervisor. None of the professionals described the process as a top-down leadership process in which supervisor provide direction for the new professional. Instead, each of the new professionals interviewed, described a supportive relationship which produced authentic growth and nurtured development in an empathetic environment. Most importantly, the respondents describe a practice which resembles servant leadership. The ultimate focus on client and community which a majority of respondents described clearly elevates clinical supervision from simple mentoring to servant leadership. Understanding the practice from this perspective will guide further study of the professional practice.

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## **Appendix A: Informed Consent**

### **Clinical Supervision of Mental Health Practitioners: A Phenomenological Study of Different Approaches in Arkansas**

**Prospective Research Participant:** Read this consent form carefully and ask as many questions as you like before you decide whether you want to participate in this research study. You are free to ask questions at any time before, during, or after your participation in this research.

#### **Project Information**

**Project Title:** Clinical Supervision of Mental Health Practitioners: A Phenomenological Study of Different Approaches in Arkansas

**Researcher:** J. Andrew McCullough

**Organization:** American College of Education

**Email:** jdrewmc@gmail.com

**Telephone:** 501-366-5278

**Researcher's Faculty Member:** Dr. Cathy McKay

**Organization and Position:** American College of Education, dissertation chair

**Email:** cathy.mckay@ace.edu

#### **Introduction**

I am J. Andrew McCullough, and I am a doctoral candidate student at American College of Education. I am doing research under the guidance and supervision of my Chair, Dr. Cathy McKay. I am asking for your participation in a phenomenological study of clinical supervision of mental health professionals in Arkansas.

#### **Purpose of the Research**

This study will explore the experiences of master's degree-level counselors and social workers who engage in clinical supervision as part of regular professional development. Counselors and social workers often work with similar clients, often at the same locations, but receive clinical supervision guided by different standards. The study intends to use the experiences of counselors and social workers to explore how these differences impact perceptions of clinical supervision.

#### **Research Design and Procedures**

The study will use a qualitative methodology and phenomenological research design. The phenomenological study will comprise of 10-20 participants, randomly selected, who will participate in a test of the semi-structured interview. The study will involve a 60-90-minute interview to be conducted at site most convenient for participants. The interview will be transcribed and emailed to you for comments. If you wish to comment or add information to the interview, please do so within three days.

**Participant selection**

You are being invited to take part in this research because of your experience as a mental health profession who can understand the experience of clinical supervision, which meets the criteria for this study. Participant selection criteria: licensed counselor or social worker in Arkansas in first two years of practice working under clinical supervision.

**Voluntary Participation**

Your participation in this research is entirely voluntary. It is your choice whether to participate. If you choose not to participate, there will be no punitive repercussions and you do not have to participate. If you select to participate in this study, you may change your mind later and stop participating even if you agreed earlier.

**Procedures**

We are inviting you to participate in this research study. If you agree, you will be asked to participate in an in-person, or, if you choose, a telephone interview. The interviews will be audio recorded. The type of questions asked will explore thoughts, feelings, and experiences related to clinical supervision.

**Duration**

The interview portion of the research study will require approximately 60-90 minutes to complete. The time expected will be a maximum of 90 minutes. If you choose to provide feedback on the transcribed interview, the time required for the activity will be determined by you.

**Risks**

The researcher will ask you to share personal and confidential information, and you may feel uncomfortable talking about some of the topics. You do not have to answer any question or take part in the discussion if you don't wish to do so. You do not have to give any reason for not responding to any question.

**Benefits**

While there will be no direct financial benefit to you, your participation is likely to help us find out more about professional development of counselors and social workers engaged in clinical supervision in Arkansas. The potential benefits of this study will aid the understanding of best practices.

**Reimbursement**

As a result of your participation in this research study, you will receive no compensation.

**Confidentiality**

I will not share information about you or anything you say to anyone not involved in the research study. During the defense of the doctoral dissertation, data collected will be presented to the dissertation committee. The data collected will be kept in a locked file cabinet or encrypted computer file. Any information about you will be coded and will not have a direct correlation,

which directly identifies you as the participant. Only I will know what your code is, and I will secure your information.

### **Sharing the Results**

At the end of the research study, the results will be available for each participant. It is anticipated that I will publish the results so other interested people may learn from the research.

### **Right to Refuse or Withdraw**

Participation is voluntary. At any time, you wish to end your participation in the research study, and you may do so without repercussions.

### **Questions About the Study**

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact: J. Andrew McCullough at 501-366-5278. This research plan has been reviewed and approved by the Institutional Review Board of American College of Education. This is a committee whose role is to make sure research participants are protected from harm. If you wish to ask questions of this group, email IRB@ace.edu.

### **Certificate of Consent**

I have read the information about this study, or it has been read to me. I acknowledge why I have been asked to be a participant in the research study. I have been provided the opportunity to ask questions about the study, and any questions have been answered to my satisfaction. I certify I am at least 18 years of age. I consent voluntarily to be a participant in this study.

Print or Type Name of Participant: \_\_\_\_\_

Signature of Participant: \_\_\_\_\_

Date: \_\_\_\_\_

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily. A copy of this Consent Form has been provided to the participant.

Print or type name of lead researcher: J. Andrew McCullough

Signature of lead researcher: \_\_\_\_\_

I have accurately read or witnessed the accurate reading of the assent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm the individual has freely given assent.

Print or type name of lead researcher: J. Andrew McCullough

Signature of lead researcher: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of faculty member: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE KEEP THIS INFORMED CONSENT FORM FOR YOUR RECORDS.**



## Appendix B: Recruitment email

Dear Mental Health Professional,

I am a doctoral candidate at American College of Education. I am writing to invite you to participate in a dissertation research study about perceptions and experiences related to clinical supervision. I obtained your name from published lists of licensed professionals posted on Internet by your licensing board.

This is a phenomenological study, which means it intends to explore the meaning of clinical supervision to the professionals engaged in the process. The study will explore the clinical supervision experience for both counselors and social workers. Professionals who often work with similar clients at the same locations, but receive clinical supervision guided by different approaches.

Criteria for participation is a license for master's level mental health practice obtained within 24 months, active engagement in clinical supervision, and professional goal of independent clinical practice. Participation is voluntary and research subjects may withdraw at any time without any negative repercussions. All participation will be confidential.

Attached to interview is informed consent information. Please feel free to reply to this email, if you have any questions. I may also be reached at 501-366-5278.

Thank you in advance,

J. Andrew McCullough  
Principal Investigator

Dr. Cathy McKay  
Dissertation Chair

### Appendix C: Semi-structured Interview

- 1) Is your discipline counseling or social work, and how long have you been practicing?
- 2) Tell me about your practice location (hospital, outpatient, school, church, etc....)?
- 3) Does your clinical supervisor have an administrative and/or management role in the organization?
- 4) Are you aware of your disciplines best practices concerning clinical supervision?
- 5) What is your understanding of licensing board rules regarding clinical supervision?
- 6) Does your relationship with your clinical supervisor allow you to meet these rules? Please explain.
- 7) How often do you meet with your clinical supervisor?
- 8) Where do these meetings typically take place?
- 9) Tell me about the relationship you have with your supervisor.
- 10) Describe the level of comfort that exists for you and your supervisor within supervision?
- 11) Do you feel your supervisor welcomes your explanations about clients' behavior? Please explain.
- 12) What steps does your supervisor take to make an effort to understand you?
- 13) Describe how your supervisors encourages you to talk about work with clients in session.
- 14) How does your supervisor address issues regarding your performance?
- 15) How does your supervisor encourage the formulation of your own interventions with your clients?
- 16) Do you feel able to speak freely in supervision? Please explain.
- 17) Do you feel your supervisor stays in tune with you in supervision? Please explain.
- 18) Do you feel that you and your supervisor share views of client behavior and treatment techniques? Please explain.
- 19) How do you address feelings (positive and negative) that emerge between you and your supervisor?
- 20) What do you perceive your role to be in supervision: student, subordinate, colleague? Please explain.
- 21) What feelings emerge in session when you discuss your difficulties with clients and practice situations?
- 22) Do you feel your supervisor places a high priority on the understanding of the clients' perspective? Please explain.
- 23) Do you feel your supervisor encourages you to take time to understand what the client is saying and doing? Please explain.

- 24) What is your supervisor's style? Does supervisor carefully and systematically consider the issues you bring to supervision?
- 25) How does your supervisor express differences regarding client care, and are alternative interventions offered?
- 26) Does your supervisor work with you on specific treatment plans for clients? Is this beneficial? Please explain.
- 27) How does your supervisor manage supervision sessions?
- 28) Do you work with your supervisor on specific goals during supervision? Please explain.
- 29) What else might I need to know about your perception of supervision for inclusion in this study?

### Appendix D: Supervisor Working Alliance Inventory

#### Supervisory working alliance inventory (SWAI) – Supervisee (Efstation et al., 1990)

The SWAI is designed to measure the working alliance in supervision from both a supervisor and supervisee perspective. Higher scores are generally indicative of alliances that are more effective. The SWAI can be used as an ongoing repeated measure of the SWA.

Instructions: Indicate the frequency with which the behavior described in each of the following items seems characteristic of your work with your supervisor (or how you would like to work with a supervisee). Estimate the frequency of occurrence within supervision on the seven-point scale from almost never to almost always							
Scale:	<b>1</b> almost never	<b>2</b> rarely	<b>3</b> occasionally	<b>4</b> sometimes	<b>5</b> often	<b>6</b> very often	<b>7</b> almost always

Rapport	Circle most relevant						
1. I feel comfortable working with my supervisor.	1	2	3	4	5	6	7
2. My supervisor welcomes my explanations about the clients' behavior.	1	2	3	4	5	6	7
3. My supervisor makes the effort to understand me.	1	2	3	4	5	6	7
4. My supervisor encourages me to talk about my work with clients in ways that are comfortable for me.	1	2	3	4	5	6	7
5. My supervisor is tactful when commenting about my performance.	1	2	3	4	5	6	7
6. My supervisor encourages me to formulate my own interventions with the client.	1	2	3	4	5	6	7
7. My supervisor helps me talk freely in our sessions.	1	2	3	4	5	6	7
8. My supervisor stays in tune with me during supervisions.	1	2	3	4	5	6	7
9. I understand client behavior and treatment technique similar to the way my supervisor does.	1	2	3	4	5	6	7
10. I would feel free to mention to my supervisor any troublesome feelings I might have about him/her.	1	2	3	4	5	6	7
11. My supervisor treats me like a colleague in our supervisory sessions.	1	2	3	4	5	6	7
12. In supervision, I am more curious than anxious when discussing difficulties with clients.	1	2	3	4	5	6	7

Rapport	Circle most relevant						
13. In supervision, my supervisor places a high priority on our understanding the clients' perspective.	1	2	3	4	5	6	7
14. My supervisor encourages me to take time to understand what the client is saying and doing.	1	2	3	4	5	6	7
15. My supervisor's style is to carefully and systematically consider the material I bring to supervision.	1	2	3	4	5	6	7
16. When correcting my errors with a client, my supervisor offers alternative ways of intervening with that client.	1	2	3	4	5	6	7
17. My supervisor helps me work within a specific treatment plan with my clients.	1	2	3	4	5	6	7
18. My supervisor helps me stay on track during our meetings.	1	2	3	4	5	6	7
19. I work with my supervisor on specific goals in the supervisory session.	1	2	3	4	5	6	7

Scoring
Rapport: sum items 1 through 12, then divide by 12
Client focus: sum items 13 to 19, and then divide by 6
The subscales can also be combined (due to high correlation between scales) to give an overall score of the alliance from the supervisee's perspective. Higher scores on each of the subscales and overall are indicative of alliances that are most effective.
Norms derived from the Efstation et al. (1990) study for supervisee version; 5.85 for Client focus and 5.44 for Rapport.

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