

# Supervision

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## Supervisees' Perceptions of Their Clinical Supervision: A Study of the Dual Role of Clinical and Administrative Supervisor

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A study of 158 postdegree counselor supervisees showed that 49% had a clinical supervisor who was also their administrative supervisor. Supervisees reported overall satisfaction with clinical supervision, with no statistically significant differences between those whose supervisor served in both clinical and administrative roles and those receiving supervision from only a clinical supervisor. Furthermore, the majority of supervisees receiving clinical and administrative supervision from the same person did not view this dual supervisory role as problematic (82% of  $n = 70$ ), and 72.5% reported specific benefits. Implications for research and practice are provided, with attention given to ethical considerations.

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Data show that approximately one half of practicing counselors received their clinical supervision from persons who were also their administrative supervisors (e.g., Evans, 1993; Kenfield, 1993), exemplifying a dual role that some (e.g., Association for Counselor Education and Supervision, 1993; Falvey, 1987; Kaiser, 1997) have regarded as a potential ethical challenge. Distinguishing between the roles of clinical supervision and administrative supervision has been difficult because there have been no uniform definitions of *clinical supervision*, *administrative supervision*, *clinical supervisor*, or *administrative supervisor* (Bernard & Goodyear, 2004). This has made supervision difficult to define operationally, presenting challenges in conducting quality supervision research (Stebnicki, Allen, & Janikowski, 1997).

For this article, we reviewed existing definitions of clinical supervision and administrative supervision and determined their distinct functions. The term *clinical supervision* means face-to-face supervision that promotes supervisee development, the maintenance of counseling or psychotherapy skills, or both, in the counseling relationship, client welfare, clinical assessment and intervention approaches, clinical skills, and prognosis (Ohio Counselor and Social Worker Board, 1997; Powell, 1993). Clinical supervision takes place in a face-to-face individual and/or group format and is facilitated by a clinical supervisor (i.e., an independently licensed mental health professional who is approved by and registered with a state's counselor licensure board to supervise postdegree counselors who are seeking independent licensure). The

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clinical supervisor is the person who reviews the counselor supervisee's case records and approves the supervisee's diagnostic assessments and individualized service plans (i.e., treatment plans).

Administrative supervision focuses on the promotion of clinical programs and coordination of clinical services and evaluation mechanisms (Kenfield, 1993) and is aimed at helping the supervisee function as an employee of an organization (Hart, 1982). The overall purpose of administrative supervision is to help the organization run smoothly (Powell, 1993). Administrative supervision addresses managerial tasks such as (a) overseeing case records; (b) implementing policies and procedures regarding the continuity of care, quality assurance, and accountability; (c) hiring, firing, and reprimanding clinical staff; and (d) completing employee performance evaluations. The administrative supervisor is the person whom the counselor supervisee considers her or his "boss" at the counseling site.

### **Ethical Considerations**

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The Association for Counselor Education and Supervision's (ACES; 1993) *Ethical Guidelines for Counseling Supervisors* states,

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

Any role conflict that arises from the dual role of clinical supervisor as administrative supervisor has the potential to inadvertently affect the ethical treatment of clients. Falvey (1987) stated that supervisors should not assume this dual role, suggesting that it compromises the supervisory relationship. For instance, the supervisee may decide not to disclose problems she or he may have working with a client, fearing possible personal and/or professional consequences (e.g., not receiving a pay raise, being terminated from her or his job); however, avoiding the discussion of such a problem could be harmful to the client (Corey, Corey, & Callanan, 1998; Falvey, 1987). Ladany, Hill, Corbett, and Nutt's (1996) study on supervisee nondisclosures suggested that supervisees' nondisclosures were directly related to the supervisees' perceptions of the quality of supervision and the extent to which supervision fit their needs and facilitated their development as counselors. Thus, supervisee nondisclosures may have direct implications for client welfare because supervisees whose supervision needs are not met are presumed to have a more difficult time working with challenging client issues (Ladany et al., 1996).

Kaiser's (1997) model specifically addressed the dual role of the clinical and administrative supervisor, focusing on the inherent power differential that exists between supervisor and supervisee. Kaiser contended that the context also affects the type and the amount of power the supervisor exercises over the supervisee. Kaiser asserted, for example, that "the prominence of the supervisor's role" (p. 23) is directly

linked to the amount of power vested in the supervisor by the context. Furthermore, when the magnitude of power is great, the level of trust between supervisor and supervisee may be threatened, especially if the evaluation is done either in a disrespectful manner or in the absence of “shared meaning” in the supervisory relationship. Thus, it is not the dual role of the supervisor, per se, that threatens supervisory trust but the increased power that a supervisor has in that dual role.

Additional considerations arise with the dual clinical and administrative supervisory role. Administrative supervisors have hectic schedules (Falvey, 1987). When the same person has both administrative and clinical supervision responsibilities, it can be difficult to manage and prioritize these dual roles. Clinical supervision needs to focus on clinical issues, such as clinical case review and processing counselor–client dynamics, because it is through these clinical activities that close supervision of a supervisee’s clinical skills is maintained. If a supervisee’s clinical activities and skills are not given appropriate attention during clinical supervision, there is increased risk that the supervisee will provide poor or unethical clinical treatment.

### **Supervisee Perceptions of the Dual Clinical/Administrative Supervisory Role**

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Extant research is equivocal with respect to supervisee perceptions of administrative issues being addressed during clinical supervision when the supervisor is both clinical and administrative supervisor. In Kadushin’s (1974) study, neither supervisors nor supervisees saw a conflict between the administrative–evaluative responsibilities and the educational–consultative responsibilities of social work supervision. Evans (1993) concluded that the “clinical supervisor as administrative supervisor” explained job satisfaction among chemical dependency counselors, although results reported were not convincing.

Kenfield’s (1993) study found a significant negative correlation between overall satisfaction with supervision and the administrator role ( $r = -.61$ ,  $p < .01$ ) in that the more time supervisors spent in an administrative role the less satisfied the respondents were with their supervision. Also, an independent  $t$  test indicated that respondents with a supervisor in both clinical and administrative roles were significantly less satisfied with their clinical supervision than were respondents with clinical supervisors who were not administrative supervisors,  $t(225) = 4.48$ ,  $p < .001$ . However, 61% of the supervisees with the same clinical/administrative supervisor reported that this arrangement worked well for them, whereas 24% reported problems with it. Kenfield neither asked respondents to explain their responses nor explained these results.

Evans’s (1993) and Kenfield’s (1993) studies are the only ones we located that included the clinical and administrative supervisor as a variable for empirical investigation; however, neither study addressed this variable conceptually or theoretically. Administrative issues were an important marker of dissatisfaction in Kenfield’s study, and it is certainly possible that the “unavailability/lack of time or attentiveness” (p. 104) of a supervisor was a consequence for supervisees whose supervisors assumed this dual role. Also, the percentage of

time respondents' supervisors spent in the administrator role may have been grossly overreported or underreported in Kenfield's study due to the vague definition of administrator (i.e., "promotes agency policies," p. 192) presented on the questionnaire. Evans's study failed to even define the role of clinical supervisor or administrative supervisor, and no reliability or validity data were reported for his instrument. Evans made the recommendation that substance abuse counseling agencies make their clinical supervisors administrators for the "possible benefits" (p. 107), yet failed to indicate what those possible benefits are.

### **Purpose of the Current Study**

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The aforementioned studies raise further questions regarding the dual clinical/administrative supervisory role: What are the possible benefits and disadvantages or detriments of supervisors serving in both a clinical and an administrative capacity with the same supervisees? Under what circumstances would these benefits and detriments be evident? Further and more focused study of the clinical and administrative supervisor, especially as related to supervisees' perceptions of their clinical supervision, is timely and, indeed, warranted. The primary purpose of this study was to first examine how the clinical supervisor as administrative supervisor relates to supervisees' perceptions of her or his clinical supervision. Another purpose was to determine supervisees' attitudes about and experiences with the clinical supervisor as administrative supervisor. Although Kenfield (1993) reported briefly on her participants' own experiences with this practice and asked how well this worked out for them, supervisees' overall attitudes about the clinical and administrative supervisor have not been examined in the literature to date.

The central research questions for this study were (a) What percentage of counselor supervisees have a clinical supervisor who is also their administrative supervisor? (b) Are there group differences in supervisees' ratings of their clinical supervision (e.g., between supervisees whose clinical supervisor is also their administrative supervisor and supervisees whose clinical supervisor is not their administrative supervisor)? (c) If group differences are found, what is the nature of these differences? Specifically, are there main effects and/or interaction effects of the supervisor role, supervisor gender, supervisee gender, supervisee work setting, and treatment focus of the supervisee work setting that might help explain any group differences in supervisees' ratings of their clinical supervision? (d) What are supervisees' attitudes about and experiences with clinical supervision when the same person is the clinical as well as the administrative supervisor?

### **Method**

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#### *Sample*

Included in the present study were counselor supervisees who were registered as "clinical residents" ( $N = 363$ ) with one state's licensure board. These persons were (a) postdegree counselor supervisees with a

professional counselor license, (b) currently receiving clinical supervision to diagnose and treat mental disorders, and (c) in the process of obtaining the 3,000 hours of supervised work experience required by that state's counselor licensure board to be independently licensed. A total of 363 surveys were mailed; 158 surveys were returned, yielding a 43.5% response rate. Of the 158 surveys returned, 143 were usable.

Participants were primarily Caucasian ( $n = 136$ , 95%) and female ( $n = 109$ , 76%) and ranged in age from 23 to 60 years, with a mean age of 37.9 years ( $SD = 10.15$ ). Participants reported that 54% of their supervisors were women and 46% were men, with an estimated age range of 27–65 years (mean age of 44.4 years,  $SD = 8.91$ ). The length of the supervisory relationship with their current (primary) clinical supervisor ranged from 1 to 114 months ( $M = 16.5$  months,  $SD = 16.62$ ). Supervisees reported receiving 0 to 5 hours per week of individual clinical supervision ( $M = 1.3$  hours,  $SD = 0.78$ ) and/or receiving 0 to 4 hours per week of group clinical supervision ( $M = 0.8$  hours,  $SD = 0.81$ ). The majority (97%,  $n = 138$ ) of the supervisees reported having a master's degree (5 reported having a doctoral degree), and 0.5 to 28 years of counseling practice ( $M = 4.6$  years,  $SD = 4.40$ ). Supervisees reported currently practicing in a variety of settings: 56% were practicing in outpatient community counseling centers providing primarily mental health counseling, 28% were providing alcohol/drug counseling, and 15% were in private practice. Other settings included schools (9%), hospitals (7%), business and industry employee assistance programs (EAPs) (3%), residential treatment (3%), and corrections (2%) facilities.

### *Instruments*

*Clinical Supervision Questionnaire (CSQ).* The CSQ, which was developed for this study, is a combination of Evans's (1993) and Kenfield's (1993) questionnaires and was used to measure the extent and nature of clinical supervision among counselor supervisees. Definitions of clinical supervision, clinical supervisor, primary clinical supervisor, administrative supervision, and administrative supervisor were included to ensure common usage among participants. They were asked their age, gender, ethnicity, experience (highest degree obtained, months or years providing counseling), work setting (e.g., community counseling center, private practice, schools, hospitals, business and industry EAPs, residential treatment, corrections, other), treatment focus of setting (e.g., mental health, alcohol/other drug or drugs), total hours per week the supervisee provides diagnostic and treatment services, amount (hours per week) and type (individual, group) of supervision received, information about current clinical supervisor (gender, race, estimated age, first name, and last initial), length of the supervisory relationship, and supervisory role(s). Two items (both having yes/no response choices) asked participants who reported having a clinical supervisor who was also their administrative supervisor, "Has the fact that your clinical supervisor is also your administrative supervisor ever been a problem for you in any way?" and "Has the fact that your clinical supervisor is also your administrative supervisor ever been

a benefit to you in any way?" Another item asked all respondents, "In general, what do you think about a supervisee's administrative supervisor also being that supervisee's clinical supervisor?" Response options were "Agree," "Disagree," "Undecided," "It depends on the individuals involved," or "Other." For all items, respondents were asked to explain their response.

*Modified Supervision Questionnaire (MSQ).* Bernard and Goodyear (2004) described Ladany et al.'s (1996) Supervision Questionnaire (SQ) as a measure with "established psychometric properties" (p. 301). The eight-item SQ is intended to measure supervisees' general satisfaction with supervision, their ratings of the quality of supervision, and the extent to which supervision meets their expectations and needs. Response options are on a scale from 1 (*low*) to 4 (*high*), with selections phrased according to each item. For example, the response options to the item "To what extent has this supervision fit your needs?" range from *Almost all my needs have been met* (4) to *None of my needs have been met* (1). The total score (i.e., the sum of the eight items) ranges from 8 to 32, with higher scores reflecting greater satisfaction with and perceived quality of supervision. Internal consistency (alpha) for Ladany et al.'s sample was .96, and the mean total score was 23.76 ( $SD = 6.34$ ).

We obtained permission to modify Ladany et al.'s (1996) SQ by placing "clinical" before "supervision" and "(primary) clinical" before "supervisor" in each item. We also added "current" and changed appropriate verbs to the present tense. We inserted "Please explain your response" in all eight items. Narrative data allowed us to distinguish among numeric ratings on particular items. Interitem correlations ranged from .38 to .83, and Cronbach's alpha reliability coefficient ( $r = .938$ ) was only slightly lower than Ladany et al.'s sample.

### *Procedure*

We contacted by telephone a midwestern state's counselor licensure board and obtained the most current list of counselor clinical residents ( $N = 363$ ). We sent a cover letter via postal mail describing the study to all counselor clinical residents in the state, along with the CSQ and MSQ. We requested that the clinical residents reply within 2 weeks and that they also return separately an enclosed postage-paid response card indicating one or more of the following: completion of the surveys, refusal to participate, independent or provisional independent licensure status (therefore no longer a "clinical resident"), and request for the results of the study. Approximately 3 weeks later, we mailed follow-up cards to individuals who had not responded. We assigned an alpha-numeric code to each survey, response card, and follow-up card to identify the respondent to the first author.

We sorted the responses by work site first and then by supervisor gender. From each supervisor gender substratum, we sorted the first name and last initial of each clinical supervisor indicated on the respondent's survey. When a clinical supervisor's name was indicated on more than one survey, we randomly selected one survey to be included in the study to ensure independent observations. We

excluded returned surveys that were incomplete or otherwise ineligible for inclusion (e.g., no longer a clinical resident, not providing either mental health or chemical dependency treatment in their counseling setting, not listing a clinical supervisor).

### *Data Analyses*

Two 3-way analyses of variance (ANOVAs) were run to test the main and interaction effects of supervisory role (combined clinical and administrative, CLIN-ADMIN; clinical only, CLIN-ONLY) and other independent variables measured by the CSQ (e.g., gender, work setting, and treatment focus) on supervisees' perceptions of their clinical supervision (i.e., MSQ, dependent variable). The first ANOVA assessed Role of the Clinical Supervisor (CLIN-ADMIN, CLIN-ONLY)  $\times$  Supervisee Gender  $\times$  Supervisor Gender. The second ANOVA tested Role of the Clinical Supervisor  $\times$  Supervisee Counseling Setting (Inpatient, Outpatient)  $\times$  Treatment Focus of Setting (Mental Health, Alcohol and Other Drug). The probability level was set at .05, and a medium effect size of .25, per Cohen's (1988) conventions to maintain .81 power, was determined.

Content analysis was completed on responses provided to the question, "Please explain your response" on the CSQ. For each of the items, respondents were separated into two groups: those whose supervisor served in both the clinical and administrative supervisor role and those whose supervisor was solely their clinical supervisor. Frequencies were calculated for yes and no responses, and content categories were developed for the narrative responses to "Please explain your response," using the discovery-oriented exploratory approach described in Ladany et al. (1996). Two independent judges (one having a master's degree in psychology, the other a supervisor with a master's degree in social work) first reviewed a portion of the data, sorted the responses into categories, and then assigned labels to the categories. The research team, which included the two judges, the two authors, and two educational research consultants (one with a doctoral degree, the other with only a master's degree) organized (first individually, then collectively) these response categories into a preliminary category system. When consensus was reached on the final categories, the two judges coded the remaining narrative responses for each item into one of the content categories. For the MSQ, the respondents were first separated into two groups according to supervisory role. Responses to each of the eight MSQ items were then sorted by ranked response (i.e., 1, 2, 3, 4). The discovery-oriented exploratory approach was then used for the qualitative responses to "Please explain your answer."

### **Results**

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Forty-nine percent of the respondents ( $n = 70$ ) reported that their (primary) clinical supervisors were also their administrative supervisors, and 51% ( $n = 73$ ) reported that their clinical supervisor was not their administrative supervisor. No statistically significant group differences were found,  $F(1, 2.70) = .099$ ,  $p = .753$ . Mean Total MSQ score for

supervisees with CLIN-ADMIN supervisors was 26.10, and mean Total MSQ score was 26.81 for supervisees with CLIN-ONLY supervisors. There was no significant three-way interaction for the first ANOVA,  $F(1, 135) = .486, p > .05$ , Cohen effect size  $< .10$ . The second ANOVA could not be calculated, because  $N = 6$  for the inpatient group.

The request to explain responses to MSQ items elicited specific information. Supervisor “availability,” “knowledge,” “experience,” and “helpfulness” to the supervisee were prominent characteristics respondents used to describe how they rated their supervisors. “Consistency” of and “time allowed” for supervision, and references to both “individual” and “group” supervision were prominent words and phrases used when explaining the quality of their supervision. “Trust,” “kindness,” and “comfort level” were used to describe the supervisory relationship.

The majority of supervisees reported that having a clinical supervisor who also served as administrative supervisor was not problematic for them ( $n = 58, 82\%$ ). Examples of supervisee explanations to “Please explain your response” appeared to encompass context issues (e.g., “Management is simple. The supervisor makes the rules, and we follow—simple”), supervisor characteristics (e.g., “My supervisor keeps information disclosed in supervision confidential if I request,” “able to balance straightforwardness with kindness,” and “very open to receive feedback and/or answer questions”), and specific advantages (e.g., “[Supervisor] provides both mentoring and administrative supervision,” “has a broader understanding of agency administrative, as well as clinical, issues that impact therapists,” and “has a more thorough perspective of how I work and what my skills are”). Individuals who reported that having a supervisor in the combined clinical and administrative role was a problem for them ( $n = 13, 18\%$ ) gave reasons that appeared to encompass supervisee fears (e.g., “fear of retaliation” and “I’m reluctant to process any countertransference issues I may have with my supervisor for knowing how this may affect my employment”), supervisor conflict of interest (e.g., “This person is also in charge of my annual evaluations from which pay increases are based; sometimes this seems to be a conflict of interest”), and supervisor exploitation (e.g., “My supervisor uses information from me against other individuals to build a case against them, usually by taking my reports out of context”).

Specific benefits were reported by 72.5% ( $n = 50$ ) of the respondents whose supervisors served in both the clinical and administrative supervisor role. This was in response to the question, “Has the fact that your clinical supervisor is also your administrative supervisor ever been a benefit to you in any way?” Reported benefits included expediency/efficiency (e.g., “continuity within clinical and professional/business aspects of the work site”; “fewer people to deal with in solving problems”; “I am made more aware of changes, and [supervisor] is knowledgeable of policies, rules, regulations”; and “[Supervisor has] increased awareness of daily activities and routines”) personal and/or professional benefits to the supervisee (e.g., “I have more time discussing problems with my supervisor than other employees do,” “I have an opportunity to learn more about policies of the company and the

work environment and appropriate behaviors,” and “This benefits my status in the agency [e.g., promotion, raise]”), and benefits to clients (e.g., “There have been times when she has been able to help ‘bend’ an administrative policy in order to best meet the individualized needs of a client”). Of the 27.5% of the respondents who answered no, their explanations centered on contextual issues (e.g., “I work in a small private practice where management is minimal”), supervisor’s conflicting priorities (e.g., “My supervisor often chooses administrative priorities over clinical priorities” and “Sometimes my clinical supervision gets cancelled because my supervisor has to handle something administrative”), supervisee dissatisfaction (e.g., “Sometimes I don’t feel my needs really are being met in supervision”); neither a benefit nor a problem (e.g., “I don’t really think it’s a benefit or a problem”).

The CSI also asked all respondents what they thought, in general, about a supervisee’s administrative supervisor also being the clinical supervisor. Almost half (48%) responded, “It depends on the individuals involved,” followed by “Agree” (18%), “Other” (15%), “Disagree” (10%), and “Undecided” (9%). Those who responded “It depends on the individuals involved,” gave reasons related to the quality of the supervisor–supervisee relationship (e.g., “If the relationship is good and the supervision is valuable”; “If clear boundaries were set and open communication were established, it could work”; “If styles of treatment and theoretical perspectives are too different, this can create an environment for the supervisee that is unbearable”; and “It depends on the egos involved”), supervisor characteristics (e.g., “Could the supervisor handle having the two roles?”), and respondents’ own experience with the clinical and administrative supervisor (e.g., “I have a great respect for my supervisor. Although we don’t always agree on strategy, she lets me use my own ideas when appropriate. She would not abuse her power”; and “My prior agency was small, and I had no problem with my boss being the administrative and clinical supervisor. In my current agency, there are too many responsibilities involved to combine the jobs”).

## Discussion

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Similar to the findings in Evans’s (1993) and Kenfield’s (1993) studies, almost half the supervisees in the current study reported having clinical supervisors who were also their administrative supervisors. Supervisees in this study were generally very satisfied with the quality of their clinical supervision. Furthermore, there were no statistically significant differences in supervisees’ perceptions of their clinical supervision based on supervisor role, supervisor gender, or supervisee gender.

The results of the content analysis are especially illuminating regarding supervisees’ attitudes about and experiences with clinical supervision conducted by administrative supervisors. Most supervisees whose clinical supervisor was also their administrator found this to be a benefit, either to themselves, their supervision experience, and/or their clients. Respondents who found the dual supervisory role to be a problem indicated either fearing possible negative consequences, having actually experienced negative consequences from it in the work setting, or having observed their supervisor’s conflicting priori-

ties (e.g., administrative vs. clinical). Some did not see it either as a problem or a benefit.

In general, what supervisees thought about the dual clinical and administrative supervisory role had much to do with the individuals involved (i.e., the supervisor and supervisee), the quality of their relationship, and their own experience with supervision and supervisors. Essentially, what seemed to be most important was the quality of supervision that a particular supervisor provided a supervisee and that particular relationship dynamic, not the dual role of the supervisor.

A limitation of this study is that the sample sizes were too small in the inpatient group, thus limiting the tests of specific group differences in supervisees' ratings of their clinical supervision. In addition, results may be generalizable only to the degree that they apply to postdegree counselors who are under supervision as they pursue independent counselor licensure and who share similar demographics (i.e., predominantly White female supervisees). Also, it is unclear whether the nonrespondents would have rated their clinical supervision worse, similar, or better than those who participated.

### **Implications and Recommendations for Further Research**

This investigation is a preliminary study of Kaiser's (1997) model of counselor supervision and of others calling for a comprehensive model that combines individual, relationship, and context variables. Two such models are those of Holloway (1995) and Rigazio-DiGilio (1998). Our study focused on supervisees' perceptions of their clinical supervision and the role of the supervisor, particularly clinical supervisors who were also administrative supervisors. However, studies are needed of the supervisor-supervisee relationship, including the effect of the combined clinical and administrative supervisory role and its specific impact on client treatment.

Another suggestion for research is to study more closely the impact of gender, counseling setting, and treatment focus on supervisees' perceptions of their clinical supervision. These variables had no statistically significant impact on supervisees' perceptions of their clinical supervision in the current study. However, using content analysis to examine supervisees' experiences with and perceptions of the combined clinical and administrative supervisory practice (e.g., asking questions regarding benefits or problems with it), revealed important data. Therefore, asking supervisees these same questions about gender and context issues may provide more information than statistical data alone can provide.

A study of supervisors and their perceptions of their own clinical supervision would further this line of inquiry, especially looking at differences between clinical-only and clinical/administrative supervisors. Comparing supervisors' perceptions with those of their supervisees would contribute to the ongoing study of counselor supervision theory and process. Given that clinical supervisors today may also be administrative supervisors in various counseling settings, future research needs to test whether or not supervisors and supervisees even view this as an ethical issue. Our study did

not ask this directly, in order to prevent biased responses on the instruments used.

The majority of supervisees in the current study did not experience or view the same person being both the clinical and administrative supervisor as a problem, and most also found that it was a benefit. However, there were some comments that raised ethical issues about supervisory relationships and supervision practices (e.g., clinical supervision being cancelled, supervisee fears about how disclosures may be, or have been, used against them and/or other employees). These ethical issues, whether potential or actual, cannot, and should not, be ignored. Future studies about the clinical and administrative supervisory role would help to determine whether more training in counselor supervision courses needs to focus on specific ethical practice guidelines for supervisors who either are, or those who are contemplating being, both the clinical and administrative supervisor.

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