

Should the Clinical Supervisor Be the Administrative Supervisor? The Ethics versus the Reality

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ABSTRACT. This article presents the clinical supervisor as administrative supervisor dual role as both an ethical issue and a current practice in counselor supervision. The author examines the two supervisor roles as well as the pros and cons of supervisors assuming the dual role with a supervisee. Finally, the author proposes how both administrative and clinical supervision can be ethically and effectively delivered in various counseling settings given their financial struggles and managed care climate. doi:10.1300/J001v25n01_05 [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2006 by The Haworth Press, Inc. All rights reserved.]

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INTRODUCTION

One of the major ethical challenges facing supervision in the counseling profession is the reality that approximately one-half of practicing

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counselors are receiving their clinical supervision from their administrative supervisors, according to the research (e.g., Tromski, 2000; Evans, 1993; Kenfield, 1993). There are numerous role conflicts and role ambiguity issues imminent for both the supervisor and supervisee when the same person functions as both the administrative supervisor and the clinical supervisor. Determining the distinctions between the roles of clinical supervision and administrative supervision has been difficult because there are no uniform definitions of “clinical supervision,” “administrative supervision,” “clinical supervisor,” or “administrative supervisor” (Bernard & Goodyear, 1998). This has made “supervision” difficult to define operationally; therefore, it is difficult to conduct quality empirical research in supervision (Stebnicki, Allen, & Janikowski, 1997).

A number of definitions have included and emphasized the roles or functions of the clinical supervisor and administrative supervisor. Loganbill, Hardy, and Delworth's (1982) definition emphasized the therapeutic functions of clinical supervision, in that the supervisor is a senior member of the profession who helps the supervisee or “junior member” develop therapeutic competence in a “one-to-one” relationship. Maki and Delworth (1995) emphasized the intervention aspect of counselor supervision, stating that counselor supervision is a specific “intervention” that requires a supervisor to have competence in various roles: educator, evaluator, therapist, and consultant. Further, Bernard and Goodyear (1998) offered a generic, broad-based definition of counselor supervision. Their definition emphasized that counselor supervisors are both the “gatekeepers of the profession” and the primary influence on a supervisee's “professional development.”

Administrative supervision should be distinguished from clinical supervision, according to Falvey (1987). Distinct definitions of *administrative supervisor* have helped to distinguish clinical and administrative supervisor roles and functions. However, these definitions also vary in content and emphasis. Disney and Stephens (1994) stated that the administrative supervisor is primarily responsible for the overall clinical program functions of the agency and ensures that these functions are being carried out effectively and ethically. Hart's (1982) definition stated that the administrative supervisor is primarily responsible for the clinician's functioning as “an employee” of the agency or other applied clinical setting.

Tromski (2000) argued that further distinction needs to be made between roles and functions of clinical supervisors and administrative supervisors in both practice and research. Tromski agreed with both Disney and Stephens's (1994) and Hart's (1982) conceptualizations of the role

and functions of the administrative supervisor. However, Tromski further defined the administrative supervisor as someone who is the clinician's "boss" in the applied counseling setting. Administrative supervision should address employee-employer issues that have a bearing on the functioning of the applied counseling setting (e.g., productivity; scheduling; paperwork issues regarding quality assurance; pay raises; hiring; disciplinary measures; supervisee termination). Tromski also agreed with the various definitions of *clinical supervisor* cited that emphasize "clinical" functions and what has a bearing on the ethical aspects of treatment delivery by counselor supervisees (e.g., professional development; being a "gatekeeper of the profession" [Bernard & Goodyear, 1998]).

The following are the distinct definitions that Tromski's (2000) study employed.

Clinical Supervision

Clinical supervision is defined as face-to-face supervision that promotes supervisee development and/or maintenance of counseling/psychotherapy skills in the following areas: the counseling relationship, client welfare, clinical assessment and intervention approaches, clinical skills, prognosis (Ohio Counselor and Social Worker Board, 1997; Powell, 1993). Clinical supervision takes place in a one-to-one individual, and/or group format.

Administrative Supervision

Administrative supervision is concerned with the promotion of the agency's clinical programs and coordination of clinical services and evaluation mechanisms (Kenfield, 1993). Administrative supervision is aimed at helping the supervisee function as an employee of an organization (Hart, 1982).

Clinical Supervisor

A clinical supervisor is a clinically or independently licensed mental health professional who is approved by and registered with the Ohio Counselor and Social Worker Board to supervise clinical residents/professional counselors seeking state licensure. The clinical supervisor is the person under whose license a counselor supervisee may practice the diagnosis and treatment of mental and emotional disorders. The clinical supervisor reviews the counselor supervisees' case records and is

designated by the agency to sign the diagnostic assessments and individualized service plans (e.g., treatment plans).

Administrative Supervisor

An administrative supervisor is a designated management person who helps the supervisee function more effectively within the organization, with the overall intent of helping the organization run smoothly (Powell, 1993). The administrative supervisor addresses managerial tasks such as the following: (1) overseeing the agency's case records; (2) implementing agency policies and procedures regarding the continuity of care, quality assurance, and accountability; (3) hiring, firing, and reprimanding clinical staff; and (4) evaluating employee performance. The administrative supervisor would be the person who the counselor supervisee considers her or his "boss" at the counseling site.

Powell (1993), Carroll (1996), Kaiser (1997), and others have acknowledged the dual role counselor supervisor: one person functioning both as the clinical supervisor and the administrative supervisor of a supervisee. Studies have presented data that have revealed this phenomenon to be a current reality in applied counseling settings. In the studies by Kenfield (1993), 30%, and Evans (1993), 52% of the subjects reported that their clinical supervisor was also their administrative supervisor. However, Tromski (2000) cautioned that these results need to be interpreted cautiously, for several reasons: (1) Neither study addressed the clinical supervisor as administrative supervisor phenomenon conceptually as a variable for study. (2) The terms "clinical supervisor" and "administrative supervisor" were either undefined, as in Evans, or inadequately (i.e., vaguely) operationally defined as in Kenfield. In Tromski's (2000) study, "clinical supervisor as administrative supervisor" was the focal independent variable, wherein "clinical supervisor" and "administrative supervisor" were given distinct operational definitions, as denoted earlier. Moreover, the Tromski study confirmed the reality of the clinical supervisor as administrative supervisor among 49% of the participants, concluding that the dual role of clinical supervisor as administrator is a common practice, despite what the Association for Counselor Education and Supervision's (ACES, 1993) *Ethical Guidelines for Clinical Supervisors* have stated about avoiding this.

This article addresses the major differences between the administrative and clinical supervision and supervisor roles. What follows is a discussion of the pros and cons of one person assuming both the clinical and administrative supervisor roles with a supervisee: namely, the ethical

challenges and practical considerations that the supervisor with this dual role must consider. The author proposes suggestions for the delivery of effective and ethical supervision, taking into account the issues of limited finances, staffing challenges, and managed care considerations in community counseling agencies.

THE CLINICAL SUPERVISOR AS ADMINISTRATIVE SUPERVISOR

Dual Role: An Ethical, Relational, and Role Conflict Issue

The Association for Counselor Education and Supervision's (ACES, 1993) *Ethical Guidelines for Clinical Supervisors* state the following:

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

The ACES (1993) *Guidelines* as well as Disney and Stephens (1994) suggested that if at all possible, an individual should avoid being both the clinical supervisor and the administrative supervisor. Further, they stated if a supervisor is both clinical and administrative supervisor, then the supervisor should discuss "potential conflicts" with the supervisee. Falvey (1987) directly stated supervisors should not assume this dual role, citing literature (e.g., Patty & Austin, 1978) suggesting that this dual role compromises the "trust," "autonomy," and "dependency" of the supervisee.

Clinical supervisors, being the "gatekeepers of the profession" (Bernard & Goodyear, 1998), have the professional responsibility (ethical and legal) for the delivery of treatment by their supervisees that follows the standards of care for the profession. This requires that the clinical supervisor establish a relationship with a supervisee that facilitates supervisees to disclose what they are doing with their clients in supervision, and the supervisor to monitor the supervisees' activities. Supervisees may fear disclosing potentially problematic issues they are facing with clients to the dual role clinical supervisor-administrative

supervisor, fearing administrative consequences (e.g., not receiving a pay raise; being terminated from their job).

Tromski's (2000) study found that 18% of respondents reported problems with their dual role supervisors. One of the problems identified was that supervisees were less likely to share their concerns and personal information with the supervisor. Further, Ladany, Hill, Corbett, and Nutt's (1996) seminal research on supervisee nondisclosures to the supervisor was a step in the right direction for looking at the potential problem of supervisee nondisclosures and the ethical implications of these findings in counselor practice and supervision. They investigated whether supervisor approach or style was related to the amount of, content of, and reasons for, supervisee nondisclosures. Another purpose of their study was to determine whether the content of, and reasons for, supervisee nondisclosure were related to supervisees' perceived satisfaction with supervision. The results supported the hypothesis of a relationship between the content of, and reasons for, supervisee nondisclosures and supervisee satisfaction. Thus, the authors concluded that supervisees' nondisclosures seemed to be directly related to the supervisees' perception of the quality of supervision and the extent to which supervision fit their needs and facilitated their development as counselors. The implication of that study is that 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). Although the role of the supervisor was not examined in that study, it would have been interesting to have measured group differences in the number and type of disclosures between those supervisees whose clinical supervisors were also their administrators and those whose clinical supervisors did not have the administrative supervisor role. In addition to being less likely to share concerns and personal information with their dual role supervisor, Tromski's (2000) results also found supervisees to report "Conflict of Interest, Supervisor Exploitation" of the supervisee, and "Supervisor Incompetence" as specific problem areas they had experienced with their clinical supervisor also being their administrative supervisor.

Kaiser's (1997) model specifically addresses the dual role of the clinical supervisor from the aspect of the inherent power differential that exists between the clinical supervisor and supervisee. This power differential is a result of the accountability process. Kaiser defined accountability as "telling the truth to the best of one's ability and taking responsible actions" (p. 23).

Kaiser (1997) stated that supervisors have power over supervisees for two reasons: (1) Supervisors evaluate the quality of supervisees' work and (2) the supervisor's role of educator presumes he or she knows more than the supervisee, especially in the case of novice supervisees. Kaiser raised the issue of how power is used in the supervisory relationship. The assumption underlying Kaiser's discussion is that the responsible use of the supervisor's authority involves a balance between refraining from using that power in an arbitrary or destructive way and abdicating that power by failing to acknowledge its inherent existence.

It is not the dual role of the supervisor *per se* that threatens the clinical supervision, but the increase in power that a supervisor has in that dual role. It is not only the *kind* of power that each of these roles has that may be problematic to the supervisory relationship, but the *amount* of power involved: the clinical-administrative dual role of the supervisor carries "double power" with it, as each supervisory role has its own evaluative component or function with respect to the supervisee (Tromski, 2000). This has implications for the supervisory relationship, and the supervisory relationship has implications for the delivery of effective and ethical treatment of clients.

Kaiser's account of her experience with two supervision situations raised the following questions in Tromski's (2000) study: Should clinical supervisors also be administrative supervisors? In what situations does the dual supervisor role work? If it does work, is there a process in which the supervisory relationship evolves to make it work? In what situations does it not work, and why not?

Besides the ethical and relational issues already addressed, there are also contextual problems with the dual supervisor role. First, agency 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. Some supervisees reported that their clinical supervision was cancelled because the supervisor had administrative duties that took precedence over clinical supervision or that too much time was spent on issues such as productivity and billing during clinical supervision (Tromski, 2000). Therefore, the clinical supervisor who is also the administrative supervisor (e.g., the supervisee's boss) may compromise the clinical supervisory relationship, and therefore the effective and ethical delivery of treatment to clients. Clinical supervision needs to focus on *clinical issues*, such as clinical case review and processing counselor-client dynamics, as it is these clinical activities by which 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, the risk of poor or unethical treatment delivery to clients is increased.

The Rewards for Supervisees

While the argument indicates that there are problems and potential liabilities for clients and supervisees linked with the clinical supervisor also being the administrative supervisor, there is another argument and some evidence to the contrary. Ekstein (1964), Powell (1993), and Carroll (1996) have built the administrator role and functions into their models of clinical supervision. Peterson (1992) argued that the administrative-clinical dual functions, as well as the dual administrative-clinical role of the supervisor, do not present a problem because both of these roles, while different, fall within the parameters and serve the intended purposes of counselor supervision. Further, Evans (1993) concluded that there were “possible benefits” to supervisees having a supervisor with the clinical and administrative dual role. Evans did not elaborate on this claim, and according to Tromski (2000), his data collection failed to include measures of, or items related to, what those “possible benefits” might be.

Tromski’s study reported that 73% of supervisees who had a dual role supervisor indicated benefiting “either personally and/or professionally” (p. 91) from it; some also indicated ways clients and/or the agency benefited. Tromski summarized these specific benefits as the following: (1) qualities of a good supervisor being used effectively in both roles; (2) consistency; (3) broader perspective brought to supervision; (4) supervisee may receive additional professional opportunities, support, and knowledge; (5) convenience; (6) closer relationship between supervisor and supervisee; and (7) administrative supervisor gets better sense of clinical issues and supervisee’s cases. Having a supervisor in the administrator role to help the supervisee be more resourceful in helping clients for example, and also to evaluate first-hand the supervisee’s work for annual evaluation (e.g., pay increases).

While it is certainly comforting that a majority of supervisees see benefits in having their clinical supervisor also be their administrative supervisor, this may lead supervisees and their supervisors to not even acknowledge or address the critical ethical issues that are inherent, or that may arise. Given the current commonplace reality of dual role supervisors in practice and a perception of this arrangement being nonproblematic or beneficial, it is even more critical that safeguards are in place

to proactively address the issues suggested in the ACES *Ethical Guidelines for Clinical Supervisors*.

Implications for Best Supervision Practice

Despite the ACES (1993) ethical guidelines as well as Disney and Stephens' (1994) suggestion that the same person should not be both clinical and administrative supervisor, the reality is that the clinical supervisor is also the administrative supervisor in many applied counseling settings. Further, studies such as Tromski (2000) have found that while having the same person function as both the clinical supervisor and the administrative supervisor can be a problem for some supervisees, the majority of supervisees experience this as either not a problem, or even as a benefit to themselves, the clients, and/or the practice setting.

In terms of counselor supervision practice it seems there is an inherent dilemma: the ethics appear to be in conflict with current practice reality, in that nearly half of the clinical supervisors are also administrative supervisors. Ideally, being in compliance with supervision ethics means that a clinical supervisor should maintain the role of "clinical supervisor" only, and do only those supervision activities that Tromski (2000) defined as "clinical supervision." To maintain a clinical supervisor-only role, a supervisor needs to do several things. First, a supervisor must make an ethical, professional decision to maintain the clinical supervisor role no matter what. Second, the supervisor must understand and be able to communicate clearly the role and function of a clinical supervisor to supervisees and administrators. This involves being able to differentiate the roles and tasks of clinical versus administrative supervisor/supervision. Tromski's definitions are very applicable and would be useful in this pursuit.

In times of financial burden (Falvey, 1987) on private nonprofit counseling agencies, it appears to be the most feasible decision to have the same person function as both the clinical and administrative supervisor. However, a cost-effective way to keep the supervisory positions separate is to have a full-time administrative supervisor do the administrative supervision and a contract clinical supervisor come in and do just clinical supervision. Support for this scenario may be found in Itzhaky's (2001) study, where supervisees perceived "external supervisors" to provide more constructive criticism, to use more appropriate and necessary confrontation, and to have more "expert-based authority," while using less formal authority than "internal supervisors." Another scenario would be to have two Full-Time-Equivalent (FTE) positions: one for a

full-time administrative supervisor; a second for a person to do both clinical supervision and clinical counseling. No studies have examined this particular clinical supervision scenario.

Group supervision in addition to, or instead of, individual supervision appears to be another more cost-effective way to deliver clinical supervision. Group supervision has not been widely studied in the literature (Bernard & Goodyear, 1998). It seems that a combination of individual supervision and group supervision is a good cost-saving measure for agencies as well as beneficial for supervisees. The group supervision experience has the potential to enhance professional development by having supervisees give and receive feedback about their cases in addition to professional support. With managed care requiring timely and effective, yet ethical treatment of clients, group supervision can also be a venue for discussing standards of care, brief therapies, and the outcome studies on brief therapy interventions.

While ideally being in compliance with supervision ethics means that the clinical supervisor and the administrative supervisor should be two different people, the Association for Counselor Education and Supervision's (ACES, 1993) *Ethical Guidelines for Clinical Supervisors* suggests two actions that supervisors take "where this is not possible": (1) "supervisees should minimize potential conflicts" and (2) "careful explanation should be conveyed to the supervis[e]es as to the expectations and responsibilities associated with each supervisory role" (Guideline 2.09). Best practices for the clinical supervisor as administrative supervisor dual role supervisors can be made addressing these ethical guidelines and the four types of problems that supervisees who had dual role supervisors identified in Tromski's (2000) study.

What I suggested about role clarity for supervisors wishing to be clinical supervisors only is also applicable to, and especially critical for, supervisors who are, or are considering, being both a clinical and administrative supervisor to a supervisee. Using Tromski's definitions of *clinical supervisor*, *clinical supervision*, *administrative supervisor*, and *administrative supervision* would be most helpful in differentiating between the clinical supervisor and administrative supervisor roles and functions, and in establishing how to keep clinical supervisory issues and sessions separate from administrative supervisory issues and sessions.

This alone would help minimize what Tromski's (2000) study identified as "Conflict of Interest" problems identified by supervisees with the dual role clinical-administrative supervisor.

Further minimizing the potential conflicts is the use of a supervision contract. It can even be argued that the written supervision contract is

the ultimate “best practice” for any clinical supervisor, whether in the clinical-supervisor-only role, or in the clinical-administrative supervisor dual role. It has been established by Osborn and Davis (1996) that the written supervision contract is an ethical imperative for supervisors. While it did not speak to the clinical supervisor as administrative supervisor dual role *per se*, the article presented *reasons for a contract, guidelines for the development of a contract*, and a proposed supervision contract, whose content areas would address, and could help prevent Tromski’s (2000) four categories of identified problems of supervisees having the dual role supervisor: (1) less likely to share concerns/personal information; (2) conflict of interest; (3) supervisor exploitation; and (4) supervisor incompetence.

The six content areas in The Supervision Contract, as proposed in Osborn and Davis (1996) can, and should, be designed to include parameters and issues important to clinical supervision when the clinical supervisor is also the administrative supervisor. Emphasizing the collaboration of the written contract between supervisor and supervisee (Osborn & Davis, 1996), the issues of the clinical supervisor as administrative supervisor phenomenon must be discussed when formulating the written supervision contract.

1. *Purpose, Goals, and Objectives.* According to Osborn and Davis (1996), “The *expectations* of *both* the supervisor and supervisee for the supervision process and the supervisory relationship should also be documented” (Teitelbaum, 1990, p. 128). Here the purpose, goals, and objectives of both clinical supervision and administrative supervision, using Tromski’s (2000) definitions of *clinical supervision* and *administrative*, for example, can be delineated.

2. *Context of Supervision Services.* In addition to what Osborn and Davis suggested (e.g., the amount and length of supervision sessions; setting or modality such as individual and/or group supervision; educational and monitoring activities; supervision model(s) used), it would be important to set the schedule and map out the context of clinical supervision sessions and administrative supervision sessions separately. Using Tromski’s (2000) definitions of *clinical supervision* and *administrative supervision* to outline the context of each type of supervision session would help to alleviate the “Conflict of Interest” problem identified by him, in that it would be clear which issues, when, and how much time is spent on clinical versus administrative issues.

3. *Method of Evaluation.* Osborn and Davis (1996) stated, “Supervisees should be told the amount, type (formal or informal, written or verbal), *timing*, and *frequency* of evaluation procedures to be used. . . .

[H]ow it will be *used*” (p. 129). Here it is important for the clinical-administrative supervisor to clearly communicate what exactly is evaluated in clinical supervision (e.g., clinical skills) and in what way, that is, how much bearing this will have on the supervisee’s administrative evaluation (e.g., annual employee evaluation). Doing this should help offset three potential problems outlined by Tromski: (1) Less Likely to Share Concerns/Personal Information; (2) Conflict of Interest; and (3) Supervisor Exploitation.

4. *Duties and Responsibilities of Supervisor-Supervisee*. This section of the contract is where Osborn and Davis (1996) stated that “the parameters of the supervisory relationship” be addressed in order to avoid “problematic dual relationships” (p. 130). Again, referring to Tromski’s (2000) *clinical supervisor* and *administrative supervisor* concepts, here the supervisor and supervisee can discuss both the clinical supervisor-supervisee relationship and the administrative supervisor-supervisee relationship, what potential benefits, and what potential conflicts might come from this dual supervisor role with the supervisee.

5. *Procedural Considerations*. According to Osborn and Davis (1996), these include the “*kind of information* the supervisee will be expected to discuss in supervisory sessions. . . . The procedure to be followed when *conflicts* arise between supervisor and supervisee should be outlined in the contract” (p. 130). It would be critical for both the supervisor and supervisee to each have an appropriate third party to discuss any conflicts in the supervisor-supervisee relationship, whether it be related to the clinical supervisory relationship or the administrative supervisory relationship. Also, a suggestion for handling a potential problem area identified in the Tromski study, “Less Likely to Share Concerns/Personal Information” is that the supervisee and supervisor should agree on a third party to whom the supervisee can go to for supervision on a particular issue which the supervisee feels reluctant to share with the clinical-administrative supervisor. However, it would be important for the supervisor to make clear to the supervisee that if the supervisee is not disclosing to the supervisor to the point of compromising the supervisee’s effective and ethical treatment of her/his client(s), then the supervisee should discuss this with the supervisor, and together they should evaluate whether another person should function as the clinical supervisor for that supervisee. All these conditions and terms should be written into the supervision contract.

6. *Supervisor’s Scope of Competence*. Osborn and Davis reiterated the 1993 ACES guidelines, which state the supervisors practice (e.g., supervise) only within their scope of competence, and that supervisors

state clearly their areas of professional competence. In addition, it is the supervisor's ethical duty to receive "timely and appropriate consultation" and training to expand her/his expertise. In addressing the fourth problem identified in Tromski's study, "Supervisor Incompetence," any administrative supervisor doing clinical supervision needs to be clinically supervising only in the areas in which he or she has clinical expertise, or it is clearly a breach of supervision ethics.

CONCLUSIONS AND RECOMMENDATIONS

The inherent dilemma of what the supervision ethics convey versus what the reality is regarding the clinical supervisor as administrative supervisor phenomenon was examined. To answer the question, "Should the clinical supervisor be the administrative supervisor?" I maintain what the ACES's (1993) *Ethical Guidelines for Clinical Supervisors* and others have emphasized that the clinical supervisor and the administrative supervisor be different persons. Cost-saving suggestions for agencies to employ separate clinical and administrative supervisors can be implemented without sacrificing quality in nonprofit counseling agencies. Tromski (2000) distinguishes the roles and functions of clinical and administrative supervisors, as well as clinical and administrative supervision. The ACES (1993) *Ethical Guidelines for Clinical Supervisors* has emphasized what should be done in cases where one person assumes both the clinical and administrative supervisory roles with a supervisee: that potential conflicts be minimized and that the roles and responsibilities be clearly explained to the supervisee. A written supervision contract is the best way to ensure mutual understanding, agreement, and accountability of the supervision roles and responsibilities for both the supervisor and supervisee. Using the supervision contract proposed by Osborn and Davis (1996) as a format to implement important contract terms and conditions related to supervision, when the clinical supervisor is also the administrative supervisor, can avoid or reduce the likelihood of the four potential problems identified in Tromski (2000).

Research in the area of counselor supervision also needs to distinguish and establish the working definitions of "clinical supervision," "administrative supervision," "clinical supervisor," and "administrative supervisor." I propose the definitions that Tromski's (2000) study employed. Whether there is ever consistency in the definitions and roles of counselor supervision, or resolution to the dual versus singular role of the clinical supervisor, it is imperative that clinical supervisors and

administrative supervisors remember that ethical practice is paramount to clients' treatment, to the credibility of professionals who do counseling, and to the survival of the professions that provide counseling to clients. Therefore, supervision research such as Ladany et al. (1996) needs to continue, but with specific attention to the single versus dual supervisor role as a variable for study. Training for supervisors absolutely needs to include the inherent risks in choosing to assume the dual role as well as how to effectively and ethically navigate the dual roles and responsibilities.

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