EXPERIENCE IS THE BEST TEACHER: EXPLORING CLINICAL SUPERVISORS’ EXPERIENCES WHO RECEIVE EXCLUSIVELY ADMINISTRATIVE SUPERVISION FROM NON-LICENSED/NON-CLINICALLY TRAINED SUPERIORS

Monica Pattillo

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A Dissertation

Submitted to the School of Education

Duquesne University

In partial fulfillment of the requirements for
the degree Doctor of Education

By

Monica L. Pattillo

August 2022
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ABSTRACT

EXPERIENCE IS THE BEST TEACHER: EXPLORING CLINICAL SUPERVISORS’ EXPERIENCES WHO EXCLUSIVELY RECEIVE ADMINISTRATIVE SUPERVISION FROM NON-LICENSED/NON-CLINICALLY TRAINED SUPERIORS

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August 2022

Dissertation supervised by Dr. Debra Hyatt-Burkhart

The goals of clinical supervision are to ensure that the counselor is using skills appropriately and properly handling a client caseload, all while being mentored by an experienced professional, known as a clinical supervisor. However, little is known about the support clinical supervisors receive in their roles. If the support is inadequate, there is a potential to impact the welfare of the clients. Additionally, there are very few researchers that have looked at clinical supervisors’ experiences when receiving their own supervision. In order to add to the body of literature on clinical supervision, this study explored clinical supervisors’ experiences when receiving exclusively administrative supervision from non-licensed/non-clinically trained superiors.

This qualitative, phenomenological study was conducted through semi-structured individual interviews with 10 clinical supervisors who had at least one year of supervisory experience. Explication of data was completed using Hycner’s (1985) guidelines to
phenomenological analysis to interview data. These guidelines allowed the researcher to present meaning and to describe the common experiences amongst the participants. The results of this study identified themes that addressed Bronfenbrenner’s (2005) bioecological model of human development which consists of five environmental systems: microsystem, mesosystem, exosystem, macrosystem, and chronosystem. The five environmental systems were essential to this study because it described how clinical supervisors were persuaded by their environment.
DEDICATION

This dissertation is dedicated to my late mother, Evangelist Linda M. Pattillo. You believed in your heart that I would accomplish anything I put my mind to. Thank you for molding me into the woman I am today. I could not have asked for a better mother, role model, and best friend. Although you are profoundly missed, your unconditional love, faith, inspiration, and value of education helped me cross the finish line. Mama, I made it, and this one is for you!

To my baby girl, Sianna Grace, you are my sunshine! Thank you for simply being you. You bring me joy when I need it most. Thank you for making me a mother, you are, and will remain, the greatest accomplishment of my life. You provided the inspiration necessary for me to complete the final chapter of my academic career and sacrificed immensely along the way. I love you beyond measure. Mommy is all yours now, and, oh, the places we will go!

“Promise me you’ll always remember: You’re braver than you believe, and stronger than you seem, and smarter than you think!” - A.A. Milne
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“For I know the plans I have for you,’ declares the LORD, ‘plans to prosper you and not to harm you, plans to give you hope and a future.’” (Jeremiah 29:11 NIV). My pursuit of this doctoral degree has demonstrated that, with Jesus Christ, all things are possible. I am both humbled and honored that You chose me for such a tremendous feat and covered me with Your grace and mercy along the way.

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CHAPTER I: INTRODUCTION

Overview

Clinical supervision is a complex task that includes a precise knowledge base and unique skill set; it is an intricate process with a distinct set of demands and vulnerabilities that have an impact on the complete development of counselors (West & Hamm, 2012). In the field of counseling the primary way that the safety of clients and the growth and emotional wellbeing of clinicians is protected is through the application of clinical supervision (Wade & Jones, 2015). Supervision affords clinicians the opportunity to evaluate, reflect, and develop clinical skills and form a support system (Cummins, 2009). Other definitions of supervision explored various aspects of the supervisory relationship, critical knowledge and learning, competence, and assessment and feedback (Falendar & Shafranske 2014). According to Leddick & Bernard (1980), supervision is a process that requires the supervisor to oversee the work of the counselor and who is responsible for the quality of their work, thereby affording some measure of protection for clients. The purpose of supervision is also to safeguard the wellbeing of the counselor (Pelling et al., 2009) and to foster effective clinical practice in order to enhance patient welfare (Milne et al., 2009). Burnout (Bardhoshi et al., 2014), compassion fatigue (Knudsen et al., 2008), secondary traumatic stress (Bride et al., 2013), and vicarious trauma (Trippany et al., 2004) are all conditions that counselors may experience as a result of exposure to the trauma that their clients have directly encountered (Michalopoulos & Aparicio, 2012). The function of the supervisor is to assist the counselor in minimizing the effects of such exposure and to help prevent impairment (Newell & MacNeil, 2010) and to encourage continued professional development that ensures high quality care and services (Snowdon et al., 2019).
Supervisor training is a less developed area of inquiry (Bajad et al., 2019) because little is known about how clinical supervisors remain competent and maintain their proficiency (Tebes et al., 2011). Little is known about how, and from whom, clinical supervisors receive their own supervision (Gursoy et al., 2016). Most supervision research examines the importance of clinical supervision for counselors (Bernard & Luke, 2015). It is a common occurrence in human services that clinical supervisors often receive their supervision from individuals who are not clinically trained (West & Hamm, 2012). These managing supervisors often focus on administrative tasks and programmatic outcomes rather than clinical oversight (Kreider, 2014).

**Statement of the Problem**

No studies have examined the experience of clinical supervisors being afforded non-clinically driven supervision, from a non-licensed superior, to those who provide clinically focused supervision to staff. Supervision takes place in a relational context, making the supervisory relationship quite significant (Bhat & Davis, 2007). The literature on the subject states that the absence of training and lack of exposure to theoretical models of supervision contributed to confusion regarding the supervisory relationship and process (Martin et al., 2014). The quality of the supervisory relationship is essential to effective clinical supervision and is associated with the supervisor-supervisee matching and fit (Cheon et al., 2009), satisfaction with supervision (Wilcox et al., 2021), self-efficacy (Park et al., 2019), supervisee self-disclosure of personal and professional reactions (Spence et al., 2014), including reactivity and counter transference (Falendar et al., 2018), the availability of the supervisor for support between clinical supervision sessions (Barnett & Molzon, 2014), effective evaluation (Ladany et al., 2013), protection against emotional exhaustion (Knudsen et al., 2008), and supervisory relationship, (Tangen & Borders, 2016) also known as the supervisory working alliance.
Working Alliance

The supervisory working alliance is often discussed in the literature as the principal means in supervision through which competence is enriched and supervisee development is enabled (Bilodeau et al., 2010). The supervisory working alliance is comprised of three components: supervision goals, supervision tasks, and an emotional bond (Crockett & Hays, 2015). Park et al. (2019) found that supervisees who have positive supervisory working alliances with their supervisors usually report higher levels of job satisfaction and lower levels of burnout or stress. While weaker working alliances, by contrast, consist of less trust and may weaken counselor self-efficacy (Morrison & Lent, 2018). The clinical supervision literature has explored the supervisor-counselor relationship and the characteristics that promote an effective working alliance (Park et al., 2019). Various studies have been conducted on what personal characteristics make clinical supervisors most effective (Benigno, 2016), best practices for approaches to supervision (Borders 2012), effectiveness of models of clinical supervision (Hutman & Ellis 2019), and the implications of multicultural issues upon supervisory effectiveness (Peters, 2017). There is a great deal of research that focuses on the provision of effective clinical supervision which includes using supervision as a mechanism for validation and support (McMahon & Patton, 2000), a place where learning and role modeling occur (Borders, 2014), a safe space to appraise the counselors’ skillsets (Martin et al., 2013), and an opportunity to collaborate and reflect on challenges, growth and success (Gursoy et al., 2016). Clinical supervisors are also charged with providing informal and assessment-based feedback on the performance of the counselor (Whittle et al., 2013), monitoring client progress (Kreider, 2014), ensuring that an appropriate level of clinical skills development is maintained by the clinician (Cashwell & Dooley, 2001), and ensuring competent services are provided to the public.
Research shows that clinical supervision is an essential part of the practice of counseling (Whittle et al., 2013) and this study was important because clinical supervisors who received supervision from non-licensed/non-clinically trained superiors were not receiving effective supervision.

**Parallel Process**

Parallel process suggests that occurrences in supervision can affect the way supervisees interact with clients (Lietz & Rounds, 2009). According to Morrissey & Tribe (2001) most supervisors are familiar with the parallel process that takes place in supervision, they define it as the “unconscious replication of the therapeutic relationship” (p. 103). The unconscious association with the clients gives counselors the opportunity to show their supervisors what they are experiencing in the counseling session by enacting the behavior during supervision (Ellis, 2010). The parallel process offers useful information regarding the relational patterns associated with interpersonal conflicts and psychological difficulties that take place in supervision (Falender & Shafranske, 2006). Addressing the parallel process enhances supervision and positively affects both counselors and their clients (Giordano, 2013). Non-licensed/non-clinically trained superiors may not have the understanding or awareness to identify or address when parallel processes are taking place. They may not know what questions to ask or have the ability to attend to the unconscious issues supervisors experience or encounter that could be potentially disruptive or debilitating. It is only with proper training and awareness that clinicians can acknowledge parallel processes, theoretical knowledge does not enable clinicians to avoid it (Cajvert, 2011), and failure to identify such dynamics may lead to an interruption in the working alliance (Ardito & Rabellino, 2011). Delayed conflict resolution can lead to adverse outcomes on both supervisees and clients (Grant et al., 2012).
As the field seems to have an understanding that, due to the complexities and emotional intensity of the work, clinical supervision is important for client safety and counselor growth (Smith, 2009), it stands to reason that clinical supervisors themselves might also benefit from effective clinical guidance. Clinical supervisors experience the same vicarious exposure to trauma, although one additional step removed, as do their supervisees (Thompson et al., 2011). Clinical supervisors engage in introspective practice and skill development in the same ways as their supervisees do (Knudsen et al., 2008). In order to provide effective supervision, the clinical supervisor must have the necessary training and experience to guide the counselor with the very challenging job of becoming a reflective practitioner (Bajad et al., 2019). Clinical supervisors need to be competent to confront challenges that arise during treatment and supervision (Kilminster et al., 2007). Clinical supervisors have not been given a voice in the literature to address their experiences in supervision with non-licensed/non-clinically trained superiors. The central inquiry of this study was to explore how clinical supervisors, who were themselves providing clinically-focused supervision, perceived the administrative supervision they received from their non-licensed/non-clinically trained superiors.

**Purpose of the Study**

When supervision is of good quality and delivered properly and effectively it can positively impact the counselor’s professional development, client welfare, and the broader treatment field (Lund & Schultz, 2015). Quality clinical supervision protects against emotional exhaustion and helps with counselor retention (Knudsen et al, 2008). It is challenging for counselors to feel effective when experiencing a lack of support (Cashwell & Dooley, 2001). Poor supervision can result in increased stress levels, burn out, a decrease in confidence in abilities, and an actual decline in counseling skills; counselors who lack enthusiasm for their
work and compassion for their clients may cause harm to their clients (Thompson et al., 2011). When a counselor’s clinical activities and skills are not given proper consideration during clinical supervision, there is increased risk that the counselor will provide poor and unethical clinical treatment (Tromski-Klingsirm & Davis, 2007). Quality supervision and poor supervision can impact all parts of the counseling structure from the managing supervisor, through the clinical supervisor, and eventually may be manifested in the progress, or lack thereof, of the client (Sweeny & Creaner, 2014). The primary purpose of this study was to investigate how clinical supervisors who were providing clinically focused supervision experienced the administrative supervision they received from their non-licensed/non-clinically trained superiors.

**Research Question**

The research question for this qualitative study was developed after a thorough review of the existing literature on clinical supervision. Much of the existing literature has focused on the importance of effective supervision (West & Hamm, 2012), the benefits of quality supervision (Gallon & Hausotter, 2005), the costs of poor supervision (Ellis et al., 2014), supervisor competence (ACES, 2011), and the need for specialized training for clinical supervisors (Tebes et al., 2011). What has been overlooked is the focus on clinical supervisors’ experiences when receiving solely administrative supervision from non-licensed/non-clinically trained superiors. The guiding question for this qualitative study was:

1. How do clinical supervisors who are providing clinically focused supervision experience the administrative supervision they receive from their non-licensed/non-clinically trained superiors?
Statement of Potential Significance

Clinical supervisors serve as the gatekeepers to protect the public (Bernard & Goodyear, 2004), the purpose of supervision is to oversee the growth and development of the supervisee as a professional counselor and thereby ensure the stability and welfare of the clients (Schultz et al., 2002). Quality supervision protects against burnout and emotional exhaustion and can serve as a potential buffer against a variety of negative job experiences (Knudsen et al., 2008), while insufficient, minimal, or no clinical supervision can lead to a decrease in job performance (Cashwell & Dooley, 2001), and possible burnout which can cause harm to the clients (Thompson et al., 2011). A poor supervisory experience can harm a trainee personally as well as professionally (Shaffer & Friedlander, 2015). The supervisory relationship has been found to be an essential factor of the actual counseling process and the outcome, which means clinical supervision at all levels of experience deserve attention (Park et al., 2019).

Despite being recognized as a fundamental activity and a crucial method in the training of new clinicians, clinical supervision has been overlooked in the post-educational setting and has remained largely neglected in the counseling literature (Weigelt, 2016). Supervision includes mentoring, guiding, and shaping the next generation of competent therapists (Grant et al., 2012). Inexperienced supervisors may be uncomfortable addressing conflict in supervision, yet they acknowledge that it is critical and extremely productive to confront instantaneously (Cajvert, 2011). Managing difficulties in supervision is an intricate process that experienced supervisors have the ability to manage the delicate balance between support and challenge when helping supervisees develop in the areas they lack proficiency in, this level of expertise in the supervisory process require significant errors, painful experiences and the ability to reflect deeply on such events so they substantially improve their practice as supervisors (Grant et al.,
Because of the lack of literature in this area, and its potential impact on the supervisory relationship, supervisees and clients, an organized body of knowledge needs to be developed (West & Hamm, 2012). This study aimed to expand that body of knowledge to include:

- The focus of administrative supervision
- The effectiveness of receiving solely administrative supervision
- How the administrative supervision impacted the clinical supervisors’ work with their staff
- How administrative supervision helped or hindered the clinical supervisors with managing their own vicarious experiences
- How clinically focused issues were addressed outside of supervision
- How other areas of the clinical supervisors’ lives were impacted
- What was helpful about receiving solely administrative supervision
- What trainings might be beneficial for the non-licensed/non-clinically trained superiors
- How experienced clinicians needed to receive clinical supervision

The addition of this information offered a better explanation on how the lack of clinically focused supervision influenced clinical supervisors’ self-efficacy, work-life balance, what was a necessity when receiving supervision, the desire to remain in or leave the field, how long experienced clinicians need and can benefit from clinical supervision, why supervision was important to clinicians but ultimately how client welfare was impacted.

**Theoretical Foundation**

This study integrated the theoretical framework of Hycner’s (1985) guidelines to phenomenological analysis of interview data and Bronfenbrenner’s (2005) bioecological model for human development. The theoretical framework of the study was significant because it created an understanding using relevant models and concepts.
Bioecological Model for Human Development

The bioecological model for human development was created by Urie Bronfenbrenner. Bronfenbrenner’s (2005) model was essential to this study because it described how clinical supervisors were persuaded by their environment. The bioecological model for human development focuses “on the importance of the individual–context relations and how these relations influence the individual’s quest for development” (Smith et al., 2013, p.1), and consists of five environmental systems: microsystem, mesosystem, exosystem, macrosystem, and chronosystem. All five systems were applicable to this study.

Hycner’s Guidelines to Phenomenological Analysis of Interview Data

To unveil the clinical supervisors’ experiences not covered in previous literature the researcher used Hycner’s (1985) guidelines to phenomenological analysis of interview data to further examine the clinical supervisors’ experiences. These guidelines allowed the researcher to present meanings and to describe the common experiences amongst the participants. This process began with collecting data through semi-structured individual interviews using the Zoom application and the researcher’s journal notes. During this process the researcher transcribed the Zoom interviews, and they were explicated using Hycner’s (1985) guidelines for phenomenological analysis of interview data. There were eight steps that were used to explicate the data, each step was meant to ensure that the explication unearthed the lived experiences of the participants.

Summary of the Methodology

As there was no clear understanding of the phenomenon of clinical supervisors who were receiving exclusively administrative supervision from non-licensed/non-clinically trained superiors, the proposed study sought to examine clinical supervisors’ experiences and was
therefore a qualitative study in its design. A qualitative study focuses on the meaning people make of their experiences and how that process influences their behavior (Creswell, 2013).

The target population of this study were clinical supervisors who had received a master’s degree or higher in one of the behavioral health fields, which included but were not limited to psychology, social work, mental health counseling, marriage and family therapy, art therapy, and drug and alcohol counseling. Participants were required to have a minimum of one year of supervisory experience. Recruitment was limited to supervisors who reported they had or were currently receiving administrative supervision solely from non-licensed/non-clinically trained superiors. The researcher recruited participants from several universities and social service agencies in Pennsylvania, New York, Illinois, and Virginia using employee and university listservs, the Counselor Education and Supervision Network-Listserv, and social media platforms that included Facebook and LinkedIn. Data was collected through semi-structured individual interviews that were conducted and recorded using the Zoom application. The Zoom meetings were password protected, participants were required to stay in the waiting rooms until they were given permission to enter, the meetings were locked after each participant joined, and the share screen function was disabled. The interviews were saved in a secure file on the researcher’s personal computer which was password protected. After data collection was complete, all data was transcribed using Otter.ai, an artificial intelligence transcription service, in preparation for data explication, which was completed using Hycner’s (1985) guidelines to phenomenological analysis of interview data. The recordings were destroyed once the study was completed.

Limitations

As with any study, there are potential limitations. The study’s primary means of gathering information was based on the data collected from the Zoom video interviews that
involved first time interactions, which made building a rapport limited, and possibly impacted the amount of self-disclosure that took place. Another limitation was interview format which did not allow the researcher to engage in conversation whereas a focus group might have been much more useful. Another possible limitation included the researcher’s personal bias when creating the questions despite the use of the reflective journal. The semi-structured approach may have limited some of the data the researcher could have received.

**Definition of Key Terms**

To provide clear and consistent definitions throughout the study, the following terms will be defined as:

- **Clinical supervision**: An intervention performed by a more senior member of the counseling profession that includes an evaluative component, extends over time, and assists in enhancing functioning of clinicians.

- **Clinical Supervisors**: Individuals with a master’s degree in one of the behavioral health fields (Psychology, Social Work, Mental Health Counseling, Marriage and Family Therapy, Art Therapy, and Drug and Alcohol Counseling) and have a minimum of one year of supervisory experience.

- **Non-licensed/Non-clinically Trained Superiors**: Supervising managers who did not receive a master’s degree in the behavioral health field and were not clinically trained.
Overview of the Dissertation

Chapter One reviewed the highlights of the study’s background, the study’s focus of problem, the purpose of the topic, and its significance. Chapter Two reviewed the current literature, as organized by the following categories: history of supervision; types of supervision; dual roles in supervision; importance of clinical supervision; relationship issues in clinical supervision; quality clinical supervision; benefits of clinical supervision to counselors; costs of poor supervision; qualification/training requirements; supervisors need supervision; and peer supervision. Chapter Three contained a breakdown of the design and methodology that shaped the study. Chapter Four provided the results that the study yielded. Finally, Chapter Five provided the discussion of the data explication and analysis of the study’s data. It also discussed implications for the field and suggested areas for further research.
CHAPTER II: REVIEW OF THE LITERATURE

Clinical Supervision

The field of supervision dates back as far as the mid-nineteenth century where it began as a process of inspecting the head teachers in schools (Bahner, 1993). The practice of clinical supervision as a model for refining training has a recent history in the United States (Pajack, 1995). What is now called clinical supervision did not surface until the 1950s and early 1960s when educators were looking for ways to help novice and experienced teachers grow in skill and understanding (Bahner, 1993). Morris Cogan of Harvard University is acknowledged as the first person to conceive the idea of clinical supervision and is credited with developing the first multi-stage cycle of clinical supervision (Bahner, 1993). Robert Goldhammer was one of Cogan’s doctoral advisees and later Cogan’s colleague at the University of Pittsburgh (Bahner, 1993). Goldhammer and Cogan borrowed the term “clinical supervision” from the medical field, both of their interests were motivated by frustrations they encountered as supervisors at Harvard University trying to assist novice teachers to succeed (Pajak, 1995). Goldhammer wrote a book in 1969 entitled, “Clinical Supervision” and Cogan wrote a book with the same title in 1973 (Miller & Miller, 1987). In Cogan’s book, written in 1973, he discusses the difficulties he experienced when trying to “get the adjective ‘clinical’ accepted in view of its sometimes-negative medical connotations” (Bahner, 1993, p.7). Goldhammer’s book, written in 1969, gave clinical supervision “its first visibility and in effect launched a generation of both commentary and practice” (Bahner, 1993, p.9).

Original Model of Clinical Supervision

Morris Cogan is commonly recognized with developing the original model of clinical supervision in the mid 1950s and over time many researchers have created several new
supervision models that mirror his original work (Pajak, 1995). The term clinical supervision survived although in its current usage it identifies a number of other direct observation-based systems that differ from Cogan’s original model (Bahner, 1993). Present day terms such as, “coaching, peer supervision, reflective practice, and action research” are transformations of what Cogan began (Pajak, 1995). Goldhammer used the word clinical to describe the “close observation, detailed observational data, face-to-face interaction between the supervisor and teacher, and the intensity of focus that binds the two together in an intimate professional relationship” (Miller & Miller, 1987, p. 18). Today, supervision has changed from looking for deficiency to improvement, the purpose now is to evaluate performance and success (Kayikci et al., 2017).

Types of Supervision

Clinical Supervision

Multiple definitions of clinical supervision have been proposed and these definitions vary depending on the experience of giving and/or receiving supervision, training, professional experience, personal preference, and style (Darongkamas et al., 2014). Bernard and Goodyear (1998) described supervision as an intervention that is provided by a more experienced professional to a less experienced member or members of that same profession. The supervisory relationship is evaluative, extends over time, and has multiple purposes that include enhancing the professional skills of the counselor, monitoring the quality of services provided, and serving as a gatekeeper (Gallon & Hausotter, 2005). Gallon & Hausotter (2005) define clinical supervision as a “disciplined, tutorial process, wherein principles are transformed into practical skills, with four overlapping foci: administrative, evaluative, clinical and supportive” (p. 1). Tromski-Klingshirn & Davis (2007) describe supervision as a “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” (p. 294). Nelson et al. (2008) define supervision as the “oversight of clinical work of a counselor or therapist by a more senior professional. This oversight is characterized by both professional and personal development as well as the monitoring of the supervisee’s work in the interest of clients’ welfare.” (p. 172). Tebes et al. (2011) depicts supervision as, “a supportive professional relationship in which one individual has responsibility for and authority over the work and work life of another” (p. 190). Smith (2009) identifies supervision as the “practice of observing, assisting, and receiving feedback.” (p. 1). Finally, Keenan (2020) outlines supervision as the “formal relationship in which a more experienced member of a profession provides oversight and guidance to a junior member of the same profession. Most clinical supervisory relationships occur between individuals who work for the same organization. Clinical supervision is mostly used in the fields of mental health counseling, substance abuse counseling, and psychotherapy” (Keenan, 2020, p. 1). The overall purpose of clinical supervision is to provide support, education, and protection.

Administrative Supervision

Clinical supervision and administrative supervision are often grouped together when in fact they are two distinct practices (Dill & Bongo, 2009). Clinical supervision focuses on the supervisee’s competence while administrative supervision concentrates on organizational demands and expectations such as “performance reviews, workload planning and management, and general problem solving and decision-making regarding staff whom they supervise” (Whittle et al., 2013, p. 4). Tromski-Klingshirn & Davis (2007) outlined administrative supervision as a list of tasks that include “(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.” (p. 295). Southwood et al. (2009) defined administrative supervision as an, “indirect service to counseling clients, meaning that it is carried out on their behalf, but its focus is on the working professionals” (p. 3). The primary goal of administrative supervision is to create and uphold work environments committed to achieving the agency’s objectives and adherence to its policies and rules (Southwood et al., 2009). Kreider (2014) believed administrative supervision is largely concerned with the “supervisee’s functioning as an employee, evaluation of supervisee work practices, and the clinical programs of the organization within which the supervisor and supervisee operate” (p. 258). The overall purpose of administrative supervision is focused on the organization running smoothly.

**Dual Roles in Supervision**

A dual role occurs when one person operates as both the administrative and clinical supervisor and despite the challenges it may present about half of supervisees receive dual-roled supervision (Kreider, 2014). Tromski-Klingshirn & Davis (2007) found that a half of counselors receive clinical supervision from a professional who is also their administrative supervisor which demonstrates a potential ethical dilemma. The Association for Counselor Education and Supervision’s Ethical Guidelines for Counseling Supervisors states, “The supervisor clearly defines the boundaries of the supervisory relationship and avoids multiple roles or dual relationships with the supervisee that my negatively influence the supervisee or the supervisory relationship. When this is not possible, the supervisor actively manages the multiplicity of roles to prevent harm to the supervisee and maintain objectivity in working with and evaluating the supervisee” (ACES, 2011, p. 8). Although dual-roled supervision is sometimes unavoidable it is
imperative that clear boundaries are set and sustained. It is important to note that participants in the current study have supervisors that provide exclusively administrative supervision.

**Importance of Clinical Supervision**

Clinical supervision is central to the counseling process because it fosters competence in the supervisee and safeguards the integrity of the clinical services provided (Bucky et al., 2010). The clinical supervisor’s role is to help the counselor develop a precise set of skills that will support clients’ needs appropriately and serve as the gatekeeper that protects the well-being of the client, the counselor, and the profession (West & Hamm, 2012). Supervision ensures that clients are trained skillfully which in turn “increases treatment effectiveness, client retention, and staff satisfaction” (Center for Substance Abuse Treatment, 2014, p. 3). Clinical supervision proposes structure, allows for feedback, and provides essential support that enables the counselor to grow professionally and incorporate their skills with theories while working through real-life situations (Cashwell & Dooley, 2001). The education and supervision that counselors receive have been recognized as critical aspects of supervision that contribute to effective practice (Bogo & McKnight, 2006) and are essential to helping counseling programs use their resources efficiently (Kayicki et al., 2017).

**Relationship Issues in Clinical Supervision**

**Working Alliance**

The supervisory relationship is the foundation of clinical supervision and is known as the working alliance, created by Edward Bordin, that consists of the supervisory tasks, supervisory bond, and supervisory goals (Park et al., 2019). The supervisory tasks represent behaviors within the supervisory relationship that both the supervisee and supervisor consider relevant, effective and accept responsibility for; the supervisory bond refers to attachment bonds that are formed
based on a foundation of mutual trust, acceptance, and confidence; and the supervisory goals represent interventions mutually agreed upon by supervisee and supervisor (Dickson et al., 2010). The supervisory working alliance is essential because it “affects and is affected by all factors within the realm of supervision” (White & Queener, 2003, p. 203). The success of supervision essentially depends upon the quality of the relationship between supervisor and supervisee, a strong supervisory relationship has been found to be an important contributor to positive outcomes in counseling (Buckey et al., 2010), while weaker working alliances, by contrast, may be interpreted as implying less faith in the therapist’s capabilities which may weaken counseling self-efficacy (Morrison & Lent, 2018). Bordin believed the quality of the supervisory relationship influenced the element of disclosure and helped guide difficult conversations, the information that supervisees do not disclose may have as much, if not more, influence on their development as the information that is disclosed during supervision (Sweeny & Creaner, 2014).

**Parallel Process**

Parallel process concentrates on the potential transference and countertransference issues that take place in psychotherapy and supervision (Thacker & Diambra, 2019), this is a result of the similarities between treatment and supervision (Nahmani et al., 1992). Harold F. Searles is credited for uncovering the parallel process which happens when the supervisee unknowingly enact the issues they have been experiencing with their client (Miehls, 2010). Searles found that the relationship between the client and supervisee could be reflected in the relationship between the supervisee and the supervisor, he believed the supervisees were involuntarily communicating their clients’ challenges to their supervisor (Arnaud, 2017). “The unconscious identification with clients allows counselors to show their supervisors what they are experiencing in the counseling
session by enacting the behavior during supervision and thus ask for help” (Giordano 2013, p. 15). MJ Gross Doehrman’s doctoral work introduced the idea that parallel process was not necessarily evidence of difficulties within the analytic or supervisory relationships but was a natural part of every treatment relationship (Miehls, 2010). Parallel process suggests that what transpires in supervision can influence the way supervisees interact with clients (Lietz & Rounds, 2009). The supervisor is responsible for addressing parallel process during supervision, identifying parallel process improves supervision and positively affects both counselors and their clients (Giordano et al, 2013).

**Quality Clinical Supervision**

Quality supervision protects against burnout and emotional exhaustion (Knudsen et al, 2008), while simultaneously addressing professional development and critical issues in the broader treatment field (Lund & Schultz, 2015). Quality supervision involves a competency-based approach that requires supervisors to have the knowledge, skills, and attitudes to use professional models, theories, and practices during supervision (APA, 2014). Supervision is effective when supervisors select a model of practice that supports their professional style, principles, organizational requirements and their supervisees needs (Whittle et al., 2013). The Association for Counselor Education and Supervision (ACES), a division of the American Counseling Association, provided specific guidelines for supervision that are organized around 12 domains; *Initiating Supervision; Goal-Setting; Giving Feedback; Conducting Supervision; Supervisory Relationship; Diversity and Advocacy Considerations; Ethical Considerations; Documentation; Evaluation; Supervision Format; The Supervisor*; and *Supervisor Preparation: Supervision Training and Supervision of Supervision*. All 12 domains are best practices and vital
for “professional preparation of counselors and those responsible for the ongoing supervision of post-degree counselors” (ACES, 2011, p. 1).

Benefits of Clinical Supervision for Counselors

Clinical supervision has countless benefits for supervisors, supervisees, and the organization for which they work; supervisors experience increased communication because of the robust supervisory relationship, supervisees receive guidance in their professional development, and the organizations tend to have higher morale and longer tenure (Keenan, 2020). Counselors’ desire clinical supervision to address their learning and support needs (McMahon & Patton, 2000), to increase self-awareness, confidence, and knowledge (Bajad et al, 2019), and to receive feedback that will help them gain more complex clinical skills over time (Keenan, 2020). The purpose of the clinical supervision is to develop and encourage the counselor’s clinical skills; supervision, when available and done correctly, is a valuable experience that can lead to increased professional growth and confidence (Gallon & Hausotter, 2005).

Counselor Self-Efficacy

Albert Bandura proposed the theory of self-efficacy which is based on a person’s belief that they have both the necessary knowledge and appropriate skillset to accomplish certain tasks; these beliefs are based (a) if the person tried the task, (b) the amount of effort the person uses to complete the task, and (c) how long the person takes to achieve the task (Cashwell & Dooley, 2001). Self-efficacy beliefs are influenced by four primary sources, “performance accomplishments, or the pattern of one’s prior success and failure experiences; vicarious learning (observing others perform a particular task); verbal persuasion (social messages regarding one’s
capabilities); and physiological states and affective reactions (e.g., task-specific anxiety, which can diminish self-efficacy)” (Morrison & Lent, 2018, p. 512).

Clinical supervision decreases counselor anxiety and increases counselors’ clinical judgment and performance (Tan & Chou, 2018). Clinical supervision encourages positive self-efficacy for counselors in training and counselors working in the field; counselor development consists of training but also considers the counselor’s beliefs in their own abilities (Cashwell & Dooley, 2001). Self-efficacy develops over the course of training and as therapy experience increases (Morrison & Lent, 2018, p. 513). Clinical supervision provides counselors the opportunity to use the theories and skills they acquired in their training program when confronting real-life situations; self-efficacy also has a positive impression on client outcome (Tan & Chou, 2018). A lack of supervision or inadequate supervision can result in a decline in confidence in abilities and in counseling skills; developing a strong sense of self-efficacy may be as significant as developing good counseling skills (Cashwell & Dooley, 2001).

Costs of Poor Supervision

Learning comes with challenges and the counselor needs support when confronted with those challenges (McMahon & Patton, 2000). Ongoing stress that is not addressed with the appropriate support can harm the emotional well-being and health of counselors, and in turn interrupt their work with clients (McMahon & Patton, 2000). Counselors who receive insufficient, minimal, or no clinical supervision may experience a decrease in their counseling performance (Cashwell & Dooley, 2001). The phenomenon of “clinical supervision that goes badly” has received rising attention; a five-year review of the clinical supervision literature discovered that the greatest number of articles were related to harmful supervision (Ellis et al., 2014). Harmful supervision transpires as a result of “psychological, emotional, and/or physical
harm or trauma to the supervisee,” bad supervision occurs because no attention is given to the supervisee’s concerns or challenges (Ellis et al., 2014). Counselors periodically experience the “imposter syndrome” when they feel inadequately skilled in taking on the role of therapist, which can lead to self-doubt, shame and limit disclosure and interrupt the learning process (Sweeney & Creaner, 2014). If the supervisor avoids addressing the “imposter syndrome,” the counselor’s professional development may further be impacted (Sweeney & Creaner, 2014, p. 211). Gallon & Hausotter (2005) found that supervisors should intervene to “improve performance, not to be unnecessarily critical or arbitrary” (p. 2). One reason some supervisors may neglect or mishandle conflict is that they may lack important skills required to address it appropriately (Nelson et al., 2008).

**Counselor Burnout**

Burnout has been recognized as an ongoing concern affecting individual and organizational performance in the human services field (Knudsen et al., 2013). The term burnout was first created by Herbert Freudenberger in the 1970s and was used to describe a “clinical syndrome encompassing symptoms of job-related stress” (Bardhoshi et al., 2014, p. 426). Burnout is demonstrated in individuals emotionally and physically (Lee et al., 2007), and is defined by three core dimensions: “emotional exhaustion, depersonalization and reduced personal accomplishment” (Bardhoshi et al., 2014, p. 426). Counselors who are unable to address their diminished capacity because they are unaware may be operating with compromised professional competence, which infringes on ethical responsibilities to do no harm (Thompson et al., 2011). Clinical supervision can act as a shield against burnout (Knudsen et al., 2013), it is vital that supervisors teach and model self-care and explore practical and effective coping strategies (Thompson et al, 2011).
Supervision of the Supervisor

Qualification/Training Requirements

Supervision is no longer considered a “natural extension” of therapeutic work, supervising is a distinct and separate skillset with specific competencies. (Darongkamas et al., 2014). It is not appropriate to presume the supervisor is competent, a focus needs to be placed on “defining, assessing, or evaluating supervisor competence” (APA, 2014, p.4). Historically it was assumed that the amount of counselor experience was suitable and could transfer to the role of a supervisor (Granello et al., 2008). However, effective supervision is a result of “formalized training, knowledge of contracts, ethical and legal issues, policies and procedures” (Bajad et al., 2019, p. 91). Tebes et al. (2011) found that effective supervisor training consists of “learning strategies and evaluation procedures” that hold supervisors accountable (p. 191). Professional bodies require supervisors to “regularly pursue continuing education activities” that include supervision topics and skills (Lund & Schultz, 2015). Supervisor training and competence are vital components to ensuring the protection of the public (APA, 2014).

Supervisors Need for Supervision

Peer Supervision

The concept of “supervision of supervisor” where clinicians make their own informal arrangements with peers and has taken on more of a formal nature (Power, 2013). Peer supervision is another form of supervision for clinicians and practitioners wanting to develop their professional identity; it provides counselors with skills and benefits outside of traditional supervision (Golia & McGovern, 2013). Benshoff (1994) defined peer supervision as a, “process through which counselors or counselor trainees assist each other to become more effective and skillful helpers by using their relationships and professional skills” (p. 90). The goal of peer
supervision is enriched self-awareness and a more profound understanding of the intricacies of counseling (Granello et al., 2008). Peer supervision is utilized when supervision is not available or when administrators do not have time (Remley et al., 1987); it provides continued support, consultation for challenging cases, it combats isolation and potential burnout, and offers networking, marketing, and professional development opportunities (Counselman & Weber, 2004); provides continued professional growth, feedback on counseling performance, suggestions for working with difficult clients, and addressing ethical issues (Borders, 1991); and opportunities for learning from parallel process (Counselman & Weber, 2004). Peer supervision groups are encouraged for counselors at all experience levels, it offers something different for each experience level (Borders, 1991), and for counselors who are no longer receiving formal training and do not have access to ongoing evaluation and expert guidance (Granello et al., 2008).

**Chapter Summary**

The purpose of the study is to gain a better understanding of clinical supervisors’ experiences when receiving administrative supervision from non-licensed/non-clinically trained superiors. Previous studies have investigated various aspects of supervision including the history of clinical supervision, differences between clinical and administrative supervision, dual roles in supervision, the importance of supervision, the supervisory working alliance, parallel process in supervision, effective supervision, the benefits of supervision, peer supervision, self-efficacy, poor supervision, burnout, and compassion fatigue. However, no research has been conducted on clinical supervisors receiving solely administrative supervision from non-licensed/non-clinically trained superiors. The most recent literature has been included in chapter two and will provide an overview of the phenomena to be studied in this qualitative study. It is important to address the
phenomena in Chapter Two of this study to provide an overall picture of clinical supervisors' experiences in supervision, good, bad or indifferent. The following chapter describes the methodology behind this research study.
CHAPTER III: METHODOLOGY

Introduction

This qualitative study used Hycner’s phenomenological approach to gather and analyze the data. This design was chosen after a thorough review of the clinical supervision literature. Much of the existing literature focuses on different aspects of supervision which include critical incidents in clinical supervision (Ellis, 1991); the supervisory working alliance (White & Queener, 2003); emotional exhaustion and emotional burnout (Knudsen et al., 2008); dual roles and relationships in supervision (Tromski-Klingshirn & Davis, 2007); race and racial identity in supervisory dyads (Bhat & Davis, 2007); peer supervision (Granello et al., 2008); conflict management during supervision (Grant et al., 2012); non-disclosure in supervision (Sweeny & Creaner, 2014); positive client outcomes as a result of supervision (Darongkamas et al, 2014); supervisor and supervisee mindfulness in supervision (Daniel et al., 2015); counselor self-efficacy (Loeb, 2016); models of supervision (Gursoy et al., 2016); effective supervision (Benigno, 2016); supervisor competence and training (Falender, 2018); and parallel process in supervision (Zetzer et al., 2020). Gaps in the literature exist regarding supervision of the supervisor. Therefore, the phenomenon to be explored in this study are clinical supervisors and their experiences when receiving exclusively administrative supervision from non-licensed/non-clinically trained superiors.

Purpose of the Study

The researcher chose to conduct a qualitative study, as the focus of this study was to understand the experiences that clinical supervisors had encountered during supervision, which could not be obtained through quantitative methods. There is a generous amount of research that discusses the supervisor and supervisee relationship, however, there is limited research on the
clinical supervisors’ experiences with their non-licensed/non-clinically trained superiors. This study aimed to uncover clinical supervisors who receive solely administrative supervision; the challenges, successes or indifferences, specifically regarding their experiences with their non-licensed/non-clinically trained superiors.

**Research Design**

Using a qualitative research design, this study sought to offer a unique opportunity to understand clinical supervisors’ real-life experiences when receiving exclusively administrative supervision and capture their perceptions of their non-licensed/non-clinically trained superiors. Hycner’s (1985) guidelines for phenomenological analysis for interview data was used to analyze the research transcriptions. With qualitative data explication, themes were identified that can later be examined using quantitative designs.

**Qualitative Inquiry**

This phenomenon was best examined through a qualitative method since little is known regarding the subject and there is nothing yet to be measured. Therefore, a qualitative approach was selected to provide participants with an opportunity to describe their experiences using their own words. Qualitative methodology focuses on meanings, symbols, metaphors, and concepts (Berg, 2009). This qualitative study will explore the meaning of a phenomenon that has been overlooked throughout the clinical supervision literature. A qualitative approach is used to make a specific phenomenon clear and to gain understanding and interpretation of how participants construct the phenomenon (Glesne, 2006). From the interviews that were conducted in this study, the researcher was able to interpret and gather specific meanings (Neuman, 2007).
Sample

Purposeful sampling and snowball sampling methods were used to recruit self-identified clinical supervisors for this study. As opposed to quantitative research, which often uses random sampling methods, qualitative researchers typically use purposeful sampling, in order for researchers to choose the best cases (Patton, 2002). The purpose of qualitative research is not to generalize information to larger populations, but to learn about the principal focus of the phenomenon being studied (Patton, 2002). To expand recruitment, snowball-sampling methods were also used.

Purposeful sampling. Purposeful sampling was used for this qualitative study. Berg (2007) identifies purposive sampling as a method of selecting participants who signify the phenomenon being reviewed. In the first step of selecting participants, the researcher contacted several universities and social service agencies in Pennsylvania, New York, Illinois and Virginia using employee and university listservs, the Counselor Education and Supervision Network-Listserv and social media platforms that included Facebook and LinkedIn. Informed consent was reviewed and signed and questions were addressed (Glesne, 2006).

Snowball sampling. Snowball sampling was used for the qualitative study as well. Snowball sampling is used when the researcher recruits prospective participants by receiving contact information provided by the initial participants (Noy, 2008). Snowball sampling is one of the most often used sampling methods in qualitative research (Noy, 2008). Those who had agreed to participate were asked for referrals to other clinical supervisors who they believed experienced the same phenomena being studied. Those individuals were contacted using email to see if they would be willing to participate in the study.
*Informed consent*

An informed consent is an explanation to prospective participants regarding the purpose and specifics of the study (Glesne, 2006) and will be provided to each participant. The informed consent included: the researcher’s identity, the purpose of the study, what to expect, what will happen with the results, selection of participants, risks and benefits to participants, confidentiality, frequency and duration of interviews, and requests for Zoom recordings for the interviews (Glesne, 2006). The informed consent provided an opportunity for participants to ask questions and receive answers (APA, 2015).

*Selection*

With permission from the universities and agencies, clinical supervisors were recruited through a recruitment email describing the following:

1. the researcher, which identified the researcher as a doctoral candidate at Duquesne University in the Counselor Education and Supervision program and include contact information
2. purpose of the study, which included the title of this qualitative study, the sample to which the researcher plans to speak with (self-identified clinical supervisors)
3. copies of the informed consent, which include: identifying the researcher, the purpose of the study, what to expect, what will happen with the results, selection of participants, risks and benefits to participants, confidentiality, frequency and duration of interviews, and requests for recording of Zoom interviews.
4. In order to participate in this study, participants will have to meet the following criteria: be at least 18 years of age, have received a master’s degree in one of the
behavioral health fields, self-identify as a clinical supervisor, and have at least one year of clinical supervisor experience.

**Data Collection**

Data for the study were collected through semi-structured individual interviews using the Zoom application and the researcher’s journal notes. Zoom protects data at the application level using an advanced encryption system (Zoom, 2020). The Zoom platform was HIPAA compliant for covered entities (Zoom, 2020). In the use of Zoom, privacy features remained in the control of the meeting host and approved participants at the discretion of the host. These features include entrance to the meeting, screen sharing, and recording abilities. Each meeting link was generated only for the purposes of each specific interview and the waiting room was enabled to allow for the meeting host to verify participants prior to entry. Following participant’s entrance to the meeting, the host locked the room to prevent any further entry.

Data collection began by conducting recording semi-structured, Zoom interviews with the willing participants. The sample of participants included 10 individuals who identified themselves as clinical supervisors. The interviews took approximately one hour, but more time was given if needed. Once the interviews were completed, Otter.ai, an artificial intelligence transcription service, was used to transcribe the interviews verbatim. Each transcript was given back to the participants to ensure accuracy. The researcher explicated the data by examining the transcripts and identifying themes among the participants responses. The researcher used Hycner’s (1985) guidelines for the phenomenological analysis of interview data to give meaning to the participants experiences and Bronfenbrenner’s (2005) bioecological model for human development to describe how the participants were persuaded by their environment.
Semi-Structured Interviews

A semi-structured interview layout was used to obtain information from participants in the study. Semi-structured interviews are a suitable way to investigate the views and opinions of participants regarding certain intricate and delicate topics and offer the ability to request for more information or to seek clarification of responses (Barriball & While, 1994). The aim of this method was to homogenize the stimulus by keeping the questions the same, but then adding explanations and using probing questions as differences among the participants (Barriball & While, 1994).

Alternatively, structured analysis assumes that all participants use common vocabulary and hope that each participants’ words carry the same meaning, which can create a major limitation for the study (Barriball & While, 1994). Semi-structured interviews allow the interviewer to alter the wording but not the meaning; additionally, it respects individuals’ differences in vocabulary and understanding of the questions (Barriball & While, 1994). Reliability and validity are contingent on the researcher’s ability to keep the central meaning of the questions consistent, rather than the repetition of words used to describe these questions (Barriball & While, 1994). Semi-structured interviews also offer the researcher the ability to use probing questions. Probing questions in semi-structured interview format can assist in safeguarding reliability, due to their ability to clarify and prompt in the exploration of new topics, thereby getting more information than the question originally sought (Barriball & While, 1994). Interview lengths were scheduled for up to an hour and were conducted using Zoom. All interviews were recorded in a confidential and safe environment, so the participants felt comfortable disclosing their experiences. The researcher kept a reflection journal describing participants’ nonverbal communications, initial themes, and reactions to the content shared.
Transcription

For this procedure, Otter.ai, an artificial intelligence transcription service, was used to transcribe the interviews verbatim. To begin the process, the researcher listened to the recorded interviews, taking in the narratives while paying close attention to the wording and inflection of the participants’ responses. The next step of the process required the researcher to listen to the recordings a second time, only this time typing verbatim the questions and probes spoken by the researcher as well as the responses given by the participant. During the facilitation of these interviews, the researcher kept a reflection journal to document observations or clarifications, which were later combined into the typed transcriptions margins as suggested by Hycner (1985). The transcripts provided each participant with feedback to determine their accuracy. All participants confirmed the accuracy of the transcripts. The transcriptions were only reviewed by the primary researcher. Identifying information was removed from the transcripts and kept in a file on the researcher’s password-protected computer.

Interview Questions

In order to conduct a semi-structured interview, some initial structure had to be set before the interviewer could proceed with the interview. The interview questions were formatted in wording that was less clinical than the research question. The format was intended to provide necessary detail and background to the questions, while highlighting the intended content in the research question. The structured questions that were used as a starting point for the interview were as follows:

1. What was the focus or goal of your superior in their supervision with you?
2. Do you think that your supervision was effective? What was missing?
3. Were there times when the lack of clinical training of your supervisor impacted your work with your supervisees?
4. How transparent were you with your supervisor about your frustration?

5. Were you impacted vicariously by your work?

6. Did your lack of clinically focused supervision help you or hinder you with managing your own vicarious experiences with the work?

7. What did you do when you had clinically focused issues that you needed to deal with that you felt your supervisor did not have the skill set to help you?

8. How did your supervision impacted other areas of your life?

9. What did you like about your supervision?

10. What trainings might you recommend for your superior?

11. How long do you think a clinician needs to receive supervision? Why?

12. How did you hear about the study?

13. Do you know other clinicians who might be a fit the criteria?

Instrumentation

In addition to the interview questions, observations and interactions with the participants, the researcher was the primary instrument in the qualitative study. (Glesne, 2006). An important factor in a qualitative study is for the researcher to evaluate and discuss their qualifications (Krathwohl & Smith 2005). The researcher provided a description of her professional career experiences and personal interest in the qualitative study in the following paragraphs.

Researcher as Instrument

As a clinician, I have worked in the mental health field since I completed my Marriage and Family Therapy program in 2010. During my first clinical experience, as a Crisis Phone Clinician, I effectively managed critical situations. I employed professional techniques such motivational interviewing and demonstrated advanced skills and sound judgment when screening for emergencies. I coordinated within a team of multidisciplinary professionals and community
resources during crisis intervention, including but not limited to, local hospitals, law enforcement and local agencies.

After six years of crisis work, I chose to further my education and was accepted into Duquesne University’s Counselor Education and Supervision doctoral program. During my third year of the program, I was hired as the Clinical Supervisor for Family Links Family Treatment Center where I directly supervised the clinical professional staff in drug and alcohol treatment and case management areas. I evaluated their performance and training needs by monitoring case activity, documentation, and treatment planning, while I carried a small caseload and provided individual, group, and family services.

Since then, I have continued my work in various supervisory roles including Crisis Clinician Supervisor, Mobile Residential Support Team Supervisor and Program Coordinator. As I transitioned through those roles my desire to be a supervisor began to dwindle. After numerous conversations with professional resources, I realized that being supervised by non-clinically trained managers resulted in many challenges, including but not limited to, questioning my self-efficacy as a supervisor. I sought the supervisor literature for support and quickly observed a gap, there was no literature discussing supervisors’ experiences when receiving supervision. The literature discussed the need for counselors to receive effective supervision, but nothing was mentioned about supervisors receiving supervision. Due to my passion for clinical supervision and curiosity of other supervisors’ experience, it seemed only fitting that I explore and assess clinical supervisors’ perceptions of the supervision they receive.

I consulted with my committee for insight to ensure that I avoided allowing my personal experiences and assumptions to interrupt the participants narrative. In order to reduce the bias, I kept a reflection journal throughout the duration of the study to process areas where my bias may
have surfaced. The objective when taking this approach was to reduce the implications of bias in my work with this topic and population.

**Researcher Journaling and Note Taking**

During each Zoom interview, the researcher documented nonverbal communications, initial themes, and reactions to the content shared. The researcher took those notes and included the question and client number so that later it could be matched up in the typed transcription. Patton (2002) stated that journaling is a good method of assisting the researcher in the explication process. After each interview, the researcher wrote in her reflection journal documenting her initial thoughts and reactions to avoid her own potential biases. The researcher reviewed the journals before working on the explication process. Some of the journals were discussed and processed with her chair to ensure success in avoiding the influences of biased thinking in the explication process (Hycner, 1985).

**Ethical Considerations**

After completion of the dissertation proposal defense, this dissertation proposal was submitted, reviewed, and accepted by Duquesne University’s Institutional Review Board (IRB). To prepare for that process, the researcher constructed the informed consents and refined measures taken to ensure the following: confidentiality; the ethical treatment of participants; compliance with the time limits related to data gained from the study; and how to adequately report findings. After receiving approval from the IRB, data collection began. Ethical considerations were reviewed with the dissertation chair and committee prior to data collection and were considered throughout the entirety of the study.
Informed Consents

The process of informed consent will consist of reviewing with participants their rights, roles, and responsibilities as participants in this research project. The American Psychological Association (APA) (2015) Ethical Principles of Psychologist and Code of Conduct, Standard 8, Research and Publication, requires the following when obtaining the informed consent:

1. the purpose of the research, expected duration and procedures
2. their right to decline to participate and to withdraw from the research once participation has begun
3. the foreseeable consequences of declining or withdrawing
4. reasonably foreseeable factors that may be expected to influence their willingness to participate such as potential risks, discomfort or adverse effects
5. any prospective research benefits
6. limits of confidentiality
7. incentives for participation
8. whom to contact for questions about the research and research participants rights’

This procedure took place on two levels, verbally and in writing. Informed consent began at the stage of recruitment discussed in previous sections by letting individuals know the purpose of the study from the start. Next, when individuals reached out by email and expressed interest in participating, the researcher expressed her gratitude and requested that they complete a brief demographic questionnaire. This brief demographic questionnaire assessed their identity and how well they were aligned with the features of the targeted population, which was clinical supervisors with at least one year of supervisory experience.
Those individuals who did not align with the study were thanked for their interest and were informed they did not fit within the study’s parameters. Those individuals were interested and fit the parameters for participation were informed of the time and length of the study; intent and purpose of participation; confidentiality policies; and methodology. The researcher verified that they wanted to proceed with the study and reminded them that they could withdraw their participation at any time. After obtaining verbal consents from the participants, the researcher scheduled a meeting time and sent them a secure Zoom link.

A written version of the informed consent document was also distributed to each participant prior to the start of the interview. It included procedures of the study, confirmation that their participation is voluntary and can be revoked at any moment, a review of the risks and benefits of participants, and confidentiality efforts. These consents were reviewed with the participants and signed before the researcher conducted the semi-structured interviews. Copies of results and transcriptions were offered to participants to ensure transparency in the process. This was explained to the participants and was free of charge.

**Treatment of participants**

In addition to the informed consent, Glesne (2006) identifies five principles to consider in appropriate treatment of participants: (1) participants must have sufficient information about the study for participants to be able to choose whether to participate, (2) participants may leave the study at any time, (3) all known risks to participants must be eliminated, (4) benefits must outweigh all possible risks, and (5) the study must be implemented by qualified researchers. These principles were also considered prior to data collection and throughout the study.

In order for participants to decide if they wanted to participate, the researcher provided ample information to all participants with a review of the informed consent. Participants were
informed that their participation in this study was voluntary and that they could leave the interview at any time. Participants were informed that they would not receive personal gains from this study but were informed that their participation could help researchers gain a better understanding of clinical supervisors’ experiences.

Confidentiality

Participants were informed of confidentiality and that any identifying knowledge would only be known to the researcher. None of the participants were identified in the data transcriptions. All transcribed data was disguised using numbers as participant identifiers. All recordings and printed copies of transcriptions were kept under password protection to ensure that the researcher and committee members would only have access to their interviews.

Data Storage and Retention

Participants were informed that the Zoom interviews were recorded and later transcribed. Participants were given the option to interview with or without the camera. Any notes or documentation would be kept locked away and only the primary researcher would have access to those documents and files. All electronic media was password protected. Zoom recordings were destroyed upon the completion of the study. Documents related to the study were stored until the completion of the study and then were destroyed.

Report Findings

Prior to data collection, all participants were informed that their identities were protected. Once data was transcribed, all participants were given the transcripts to review for accuracy, revisions to the transcriptions were made if participants noted inaccuracy. In addition, the findings of this study were also provided to participants if they wished to obtain a copy for their review and alterations were made if any inaccurate findings were noted by the participants.
Data Analysis

The approach to gathering and explicating the data was phenomenological in nature. This study used Hycner’s (1985) eight steps for phenomenological analysis of interview data for explication.

Bracketing and Phenomenological Reduction

Hycner (1985) encourages an approach to reviewing recordings and transcribed interviews with a neutral mindset for meanings to surface. In order for meanings to develop, the researcher will “bracket” the meanings and interpretations of data to enter the “world” of the participant (Hycner, 1985). The researcher will follow Hycner’s (1985) recommendation of repeated listening of interview recordings to gain familiarity with interviewees’ data.

Listening to the interview for a sense of the whole

Listening for the whole of the interview is the process which requires the researcher to listen and read the interviews multiple times (Hycner, 1985). It is important that during these reviews the researcher listens for the “non-verbal and para-linguistic levels of communication, that is, the intonations, the emphases, the pauses, etc.” (Hycner, 1985, p 281). Journaling on these topics is mentioned by Hycner to be helpful to enter the experience of the interviewee and start to gain a better understanding of the context of what will be spoken in the interview.

Delineating units of general meaning

This step in the process will involve the researcher giving meaning to what will be expressed in each interview (Hycner, 1985). This will be a unique part of the process and these themes will surface on their own (Hycner, 1985). The goal of this step is to gain units of general meaning which express “unique and coherent meaning (irrespective of the research questions)” (Hycner, 1985, p 282). It will be crucial in this process to consider these themes from the data in
the interviews, the process of reading the transcripts repeatedly will avoid filling in the gaps from a place of bias, as well as consulting with the dissertation committee on potential areas of bias.

**Delineating units of meaning relevant to the research questions**

By this stage, the units of meaning will be applied back to the research question (Hycner, 1985). Themes that emerged that were not relevant to the original research question will not be included for further analysis. Units of meaning that will be considered “ambiguous or uncertain” will be included to avoid missing any meanings.

**Clustering units of relevant meaning**

Clustering in the process of qualitative analysis will require the researcher to search through the interviews for significant units of meaning (Hycner, 1985). The researcher will review the interviews numerous times until common themes and similar meanings naturally emerge (Hycner, 1985).

**Determining themes from clusters of meaning**

This part of the process will require the researcher to broaden the lens once more and analyze “all the clusters of meaning” to establish whether there will be crucial themes which speak to the essence of those clusters (Hycner, 1985). This is an independent call, and just as with all the other steps, the researcher will have to guard against bias when formulating conclusions. To avoid this, the researcher will meet with the chair and committee to confirm that these themes are appropriate and rooted in the interviews as opposed to the researcher’s biases or presumptions.

**Summary Review and Modify Themes**

As previously mentioned, results, and transcripts were presented to participants as a way to safeguard accuracy (Hycner, 1985). Another option for feedback was given to participants as
well as an opportunity to review the themes and what they might think of them. This review process attested better accuracy in reporting results of the interviews and offered another form of analysis that stayed true to the experiences of the participant being portrayed (Hycner, 1985).

**Dependability of the Data and Credibility**

The transcripts were provided to each participant for feedback to determine its accuracy as suggested by Hycner (1985). The transcriptions were done by Otter.ai, an artificial intelligence transcription service, to achieve another level of reliability to the text, and the recordings were transcribed verbatim to ensure open availability for analysis and assessment. The use of continuous discussion with the committee also confirmed that the researcher was guarding her biases and limiting the effect on data interpretation. The researcher used Hycner’s (1985) guidelines to phenomenological analysis of interview data to highlight the experiences of clinical supervisors in a manner that would be free from bias.

**Chapter Summary**

The purpose of this study was to further understand clinical supervisors experiences when receiving solely administrative supervision. Since the phenomenon of supervisors receiving supervision from non-licensed/non-clinically trained superiors has not yet been explored, a qualitative approach was appropriate to gather the lived experiences of the participants being studied. To further guide this phenomenological qualitative approach, Urie Bronfenbrenner’s (2005) bioecological model of human development was used to discuss the development of all five systems: microsystem, mesosystem, exosystem, macrosystem, and chronosystem. Data was collected through individual interviews with ten willing participants. Participants were chosen through purposeful sampling and snowball sampling methods. In addition to individual interviews, field notes, and analytic notes were also used for data collection. Data was explicated
using Hycner’s (1985) eight step process: (1) Bracketing and Phenomenological Reduction, (2) Listening to the interview for a sense of the whole, (3) Delineating units of general meaning, (4) Delineating units of meaning relevant to the research questions, (5) Clustering units of relevant meaning, (6) Determining themes from clusters of meaning, (7) Summary Review and Modify Themes and (8) Dependability of the Data and Credibility.
CHAPTER IV: RESEARCH FINDINGS

The findings of this study illuminate the lived experiences of those who self-identified as clinical supervisors who currently or previously received administrative supervision from non-licensed/non-clinically trained superiors. The study was informed by the theoretical lens of Urie Bronfenbrenner’s (2005) bioecological model of human development. This approach allowed the researcher to take an in-depth look at the complex interactions between the five systems: microsystem, mesosystem, exosystem, macrosystem and the chronosystem, each contained within the next. Hycner’s (1985) guidelines to phenomenological research were used to explicate the interview data. The data obtained from these interviews provided a rich description of the participants’ experience when receiving solely administrative supervision. This chapter provides a case-by-case narrative for each of the 10 individual interviews that were conducted for this study. In addition to the supporting statements pulled from each transcription, the categories derived from the data were organized into tables. The Chapter concludes with a cross-case analysis and summary, providing the reader with a detailed understanding of clinical supervisors’ experiences when receiving solely administrative supervision from a non-licensed/non-clinically trained superior. All of this material acts as an introduction to an in-depth analysis of the central themes in Chapter Five.

Demographic Information

There were 32 individuals who responded to recruitment emails. Of those 32 inquiries, 10 participants met the study criteria and were willing to engage in the requirements of the study. To protect participant confidentiality, participants were assigned a number by which they were referred to throughout the discussion of the research findings. Six of the 10 participants identified as White, two identified as Black, one identified as Multiracial and one participant
selected the “preferred not to answer” option. There were eight females and two males, ranging in age from 33 to 55. All participants self-identified as clinical supervisors with at least one year of experience. Of the 10 participants, six lived in Pennsylvania, two lived in New York, one lived in Illinois, and one lived in Virginia. All 10 participants had earned a Master’s degree. One of the ten participants identified as Licensed Clinical Social Worker – R (The “R” privilege requires insurance carriers to provide reimbursement for psychotherapy services whenever a health insurance contract includes reimbursement.), three identified as Licensed Clinical Social Workers, one identified as a Licensed Master Social Worker, one identified as a Licensed Clinical Professional Counselor, three identified as Licensed Professional Counselors and one identified as a Licensed Marriage and Family Therapist. Table 1 provides a summary of the demographic information of participants.

Table 1
Demographic Information

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<th>PARTICIPANTS</th>
<th>RACE</th>
<th>GENDER</th>
<th>AGE</th>
<th>STATE</th>
<th>HIGHEST DEGREE</th>
<th>LICENSE TYPE</th>
<th>MH EXPERIENCE</th>
<th>CURRENT POSITION</th>
<th>SUPERVISOR EXPERIENCE</th>
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</table>
Individual Interviews

All interviews were semi-structured in format and were conducted online and recorded using Zoom, a video platform, to assist in making the transcription process precise. Throughout the semi-structured interviews, field notes were taken to record the non-verbal behaviors of the participant’s and the researcher’s personal thoughts that surfaced during the interview. Personal reflections were shared with the participants and thoughts of significance were recorded after the completion of the interviews. All interviews were conducted in a private location, such as an office or private residence. The interviews ranged in duration from 20 to 75 minutes.

Analysis of Individual Interviews

After the completion of the individual interviews Otter.ai, an artificial intelligence transcription service, was used to transcribe the interviews verbatim. The researcher immersed herself in the data, which helped identify themes, patterns, and individual differences among the participants. While reviewing the video recordings and transcriptions multiple times, the researcher took additional notes and placed them along the margins of the transcriptions. These techniques provided an opportunity for the researcher to begin explicating the data.

Once the transcription process was complete, the Zoom interviews and transcriptions were reviewed multiple times, the data were explicated using Hycner’s (1985) guidelines for the phenomenological analysis of interview data. The eight-step data explication process assisted the researcher in identifying participants meaning, themes, and individual differences: (1) Bracketing and Phenomenological Reduction, (2) Listening to the interview for a sense of the whole, (3) Delineating units of general meaning, (4) Delineating units of meaning relevant to the research questions, (5) Clustering units of relevant meaning, (6) Determining themes from clusters of
meaning, (7) Summary Review and Modify Themes and (8) Dependability of the Data and Credibility.

Hycner’s (1985) data explication process provided an opportunity to manage the large amount of data obtained. First, bracketing and reduction, allowed the researcher to reduce the amount of data collected. The transcriptions of the ten participants included hundreds of pages of data and reduction allowed for better management of that data. Next, the researcher delineated the data by removing units of meaning that were not related to the phenomenon being studied. This provided an opportunity to begin to identify themes in each individual interview. Third, the researcher began to cluster the units of meaning to identify emerging themes. Fourth, the researcher summarized the interviews with the identified themes to prepare for data explication. Finally, the researcher extracted themes among participant interviews including common and individual differences identified by participants, while being mindful not bundle themes together that had significant differences. The significant themes were organized into nine major categories:

1. Health
2. Professional Development
3. Staff Needs
4. Additional resources
5. Personal Development
6. Career
7. Program Management
8. Professional Relationships
9. Emotional Supports
Case-by-Case Analysis

This section provides a detailed description of the 10 interviews conducted in the order that they occurred. Each description includes a case-by-case analysis of the participants’ experiences with the phenomenon being studied. These narratives illustrate the nine categories discussed above.

Participant #1

The first interview was conducted with a 33-year-old, White male, and Licensed Clinical Social Worker from Pennsylvania. He was a director that worked in the mental health field for 10 years with six years of supervisor experience. He received supervision “mostly on the spot” and the goals were focused on “higher level decision making” which included how to “deal with stakeholders” and the “next steps of the program.” When asked how he felt about the supervision he received he replied, “How do I feel about it is a good question, I think it’s an interesting style of supervision. I don’t think it provides the professional support I’m used to getting as a clinician.” Clinical supervision was something that was afforded to him throughout his professional career, but as a director it was his first time working under the leadership of someone that was not clinically trained. He noticed several things were missing within his supervision such as a “lack of an emotional connection” and a decrease in space to process the “day-to-day challenges” that he encountered with his staff. When asked if his work impacted other areas of his life he responded,

“Oh absolutely, I think there’s some significant impacts! Working in a nonprofit, in my opinion, should always be mission driven, but just receiving administrative supervision makes it feel more distanced from the mission and more like a business. I think it’s tough to find a blend because nonprofits are businesses and they still need to operate, but the
morale piece, the psychological impact is just not addressed. It’s more so, let’s talk about getting up the census and addressing the areas of noncompliance. There’s no space to talk about the human side of things, which then impacts downstream. What is my emotional availability to my staff because I’m dealing with my own stuff? How effective is my decision making or problem-solving skills with such high levels of stress? At some point it starts to bleed out.”

He acknowledged there were times when he lost sleep because he was thinking about “work issues.” He shared, “Yeah, there’s a mental burnout that probably could be better addressed with better supervision but I have a really good support system. I’m surrounded by people that I can communicate what I’m experiencing.” He later shared how the lack of clinical training of his supervisor impacted the hiring process. “When hiring somebody, they did not value the clinical license or experience, which led to them hiring people who were not qualified for the positions. When that happened, it created difficulty for the program because it was mis-staffed which resulted in people getting pulled from other programs. It was spreading people thin.” When asked what he did with clinically focused issues that his supervisor was not equipped to deal with he responded by saying,

“So, that is something that I was really struggling with. I just internalized it and just dealt with it for basically the first six to seven months of the supervision arrangement because I had to be very cautious to maintain appropriate boundaries with my own supervisees. As time passed, I started to reach out to a peer, someone who was clinically trained and on the same administrative level, which essentially created an additional line of support. I still find that person’s perspective is kind of muddied, it’s almost like they don’t have the time because they have their own layers of responsibility.”

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He shared a few things that he liked about his supervision. “I have blind spots coming from the human services field, as a social worker we don’t receive a lot of education around fiscal and compliance issues. My supervisor has been in the field for 20 years and brings a lot of that knowledge to the table.” When asked what trainings he would recommend for his supervisor he replied, “I went through an actual post-graduate certification in clinical supervision, which opened my eyes to the differences between group, peer and individual supervision. I’m also very focused on professional development, so I want clinical supervision to be a vehicle not just for you to do your job effectively but to help you develop as a professional clinician.” When asked how long a professional should receive clinical supervision he stated, “I haven’t really thought about it before because I’ve always assumed that I would be receiving it. I think it will always have value but there’s probably an endpoint, just in terms of moving up through the administrative roles.”

**Participant #2**

The second interview was conducted with a 47-year-old, White female, and Licensed Clinical Professional Counselor from Illinois. She was a director and worked in the mental health field for 16 years with 13 years of supervisor experience. She received supervision from the Chief Financial Officer of her company and the goals were focused on “productivity, performance, financial concerns, things of that nature.” When asked if her supervision was effective she replied, “No, I don’t necessarily think so. I think that I would like to have a supervisor that has some interest in my professional development. I’m in a doctoral program which I shared with my supervisor. We had one conversation when I started two years ago, and it’s never come up again. There’s a big disconnect and I have some frustration about unrealized
goals and objectives.” She added that she would like to discuss with her supervisor what it takes to get to the next level in the company.

“I don’t know entirely that I want to be a CEO but I feel like that’s the natural progression. I talk to my staff all the time about. Where are you going? Where do you want to be? What are your goals for the future? What does that look like? How do I help you get there? I believe in investing in staff and developing them and helping them to realize their goals, even if it means that they advance or move out of the organization. And yet, it sort of stops at my level. So to not have that as a part of my own supervision, I doesn’t necessarily feel as though there is a huge investment.”

When asked what else was missing from her supervision she quickly stated, “Frequency. It’s as needed. It was a little bit more frequent when my supervisor first started supervising me but as they got more comfortable it just dropped off.” She shared that she could be “transparent to a point” with her frustrations and “sort of reflect back that frustration of not understanding how it all works, but the lack of knowledge and unwillingness to learn is incredibly frustrating and disrespectful.” She added, “I’ve learned my supervisor. I know what is going to be potentially effective and what might actually turn that person off or frustrate them.” She later reflected, “I provide this sort of emotional support to my supervisor on a regular basis that things are going to be okay. It would be nice if just once I received that in return.” When asked what she did with clinically focused issues that her supervisor was not equipped to deal with she responded,

“So the manager who is over our outpatient services is also very experienced and knowledgeable and we work in tandem frequently. I utilize her as a checks and balance to discuss the things maybe I haven’t considered. I often reflect on what the literature says
or consider what a previous clinical supervisor might say. With agency work I don’t feel that I have the ability necessarily to go out and seek a mentor outside of the organization so that can be hindering at times.”

When asked if her work impacted other areas of her life she responded, “Well, I mean the spillover impacts home. If there is stress and I’m trying to manage it, the fallout often happens with my family. If I’m upset or struggling and I need emotional support I go to my husband or mother. I really, really, really, really, really try hard to separate work stress from home stress because I don’t want my kids to see me come home upset or grumpy.” She shared a few things that she liked about her supervision. “I like success, I like achieving things. Supervision is very task oriented. I like that it is very efficient, if something needs to be discussed we work through an agenda. I get what I need and then I’m done. There’s not a lot of investment in what I’m doing or where I want to go but there is awareness that I have kids and a family, and I like that.”

When asked what trainings she would recommend for her supervisor she replied, “So, in Illinois, our Counseling Association offers an array of supervisory trainings, and they’re really good. They are very informative topics: ethical supervision, multicultural supervision and boundaries. I had a social worker take those trainings because I believe she could benefit from them.” When asked how long a professional should receive clinical supervision she stated, “Forever. I think there is value in having someone else’s perspective. There’s also a validation piece, it can start to get a little overwhelming in some regard even when you’re really experienced.”

**Participant #3**

The third interview was conducted with a 34-year-old, Multiracial female, and Licensed Clinical Social Worker – R from New York. She was a supervisor and worked in the mental health field for 11 years with four years of supervisor experience. The goal of her supervision
“was more about tasks.” When asked if her supervision was effective, she replied, “Was it effective for task supervision? Sure.” She later added,

“I think that our goals, at the end of the day were pretty similar. So, it was kind of up to me to present the material in a way that was going to be engaging, and to connect with the clients. I think I was able to do that.”

When asked what was missing from her supervision she responded,

“I mean, definitely the clinical aspect. I think where it becomes a little difficult is, if the program is truly based on 100%, non-clinical interventions, I think just receiving administrative supervision is fantastic. However, there's an intersection in roles, right? So there needs to be some sort of higher up staff person that has clinical training that is able to supervise anyone that's doing any type of clinical work, whether they’re licensed, in the process of licensure, or whatever. Otherwise, you run into what I ran into, where you’re expected to do clinical work but not have the appropriate guidance. Legally, I could practice the way that I wanted to but is it really in best practice? Is it as ethical as I'd like it to be? No.”

She shared that she was “somewhat transparent” with her frustrations. “If I did bring up ideas on how to handle clinical things she would listen to them and allow me to address them the way I felt best. Occasionally, she would praise my ideas. Other times, she couldn't see past the wall and would get stuck on ‘that’s not how we do things here.’ As the Women’s Coordinator, I was trying to bring in this trauma lens and I felt like I couldn’t do that, because people weren't necessarily on the same clinical level.” When asked if her work impacted other areas of her life she responded, “I mean, I think I would feel frustrated sometimes and it would transfer over. I had my own therapist that I used to process things. But as much as I tried to compartmentalize it,
it led to frustration in my personal life. I was short with other people even though it wasn’t about them. There was definitely a transference of energy that happened.” She shared a few things that she liked about her supervision. “She had a lot more experience with the administrative role from a macro level, in terms of how to set up a successful group. Even though I've initiated groups before it was not with a brand new program. So that was that was very helpful.” When asked what trainings she would recommend for her supervisor she replied, “So this probably sounds harsh, because that would kind of involve returning to school. It seems harsh in a sense that it might not be feasible but would be ideal. If that is unable to be the case then maybe agencies can, at least for a period of time, hire an outside clinical supervisor to get direct knowledge or bounce ideas off of. Outside consultation might be helpful.” When asked how long a professional should receive clinical supervision she stated, “Forever. I'm a true believer, I don't think that people should stop because they don’t know everything. When we use a certain skill set, modality, theoretical framework, we get so stuck in it and don't realize that actually might not be beneficial to our clients. Clinical supervision is always going to be important.”

**Participant #4**

The fourth interview was conducted with a 48-year-old, White female, and Licensed Clinical Social Worker from Pennsylvania. She was a program director and worked in the mental health field for 22 years with 25 years of supervisor experience. She received supervision “as requested or needed.” When asked if her supervision was effective, she replied, “I mean, I think so. If I were somebody who needed more attention, it would be challenging like if I had a question on how to deal with a client issue. I’m pretty independent, I don’t need a lot of that anymore. I feel like most of the time, I do know what to do. If I don't I usually have enough people on our team to have peer supervision with. I find the person to help answer the question.”
When asked what was missing from her supervision she responded, “At my level I’m not surrounded by people that have a whole lot of experience. When I first started in the field years ago, there were more people that had a knowledge base. We had to learn as we were coming up. Organizations are missing that training piece.” When asked if her work impacted other areas of her life she responded, “When our business was owned by somebody else previously, she took a very hands-on approach to supervision. She had high expectations and was more of an aggressive supervisor. To shift to not having that at all was a very strange transition. She was super hyper-focused which then made me hyper-focused only to shift to a company that isn't like. Everybody was looking at me like I’m crazy. They couldn’t understand why I was worried about so many things.” She later added, “I think it was a trauma response.” She shared a few things that she liked about her supervision. “I am very autonomous and independent. I prefer to be left alone and not told what to do. So, it worked for me. Structure is important and if I couldn't do that for myself, it would be bad.” When asked what trainings she would recommend for her supervisor she replied, “My supervisor is a doctor, so I think he's where he needs to be. I think the issues is with how our company is arranged.” When asked how long a professional should receive clinical supervision she stated, “I don’t think there’s a time limit on that, I think you'd need to do that as long as you're working."

*Participant #5*

The fifth interview was conducted with a 41-year-old, White female, and Licensed Professional Counselor from Pennsylvania. She is currently in private practice but has worked in the mental health field for 17 years with 10 years of supervisor experience. The focus of her supervision prior to private practice was, “So it's like going way back to like, community mental health for me. It was basically just billing, notes, audits and all of that.” She shared, “I wanted to
do good work with the patients, but I needed clinical supervision to help me with that. Instead, all I had time to focus on was getting all of my paperwork entered into the system.” When asked if her supervision was effective, she replied, “No. I felt like I knew a lot more coming right out of school than the people that were above me. A lot of them had never worked in the mental health field. My supervisor had a master’s degree in public relations. I do not understand how they could supervise therapists with no official mental health training.” When asked what was missing from her supervision she responded, “Everything especially ethical things. They were not familiar with the duty to warn and things like that, like we had a situation come up with major safety concerns and they did not handle it the appropriate way. It was terrible, terrible! When I brought up clinical concerns, my supervisor was like a deer in headlights. That's when I came across your study and I realized I needed to talk about my experience.” She shared that she felt comfortable being “pretty transparent but not as much” as she would have liked to have been. She reported an internal conflict, “I kept questioning myself. Everything they taught me in school did not align with the jobs I worked. I always knew what school taught me was right, but I kept going back and forth in my head asking myself if I was wrong. How could I be productive if I wasn’t doing well myself? It’s terrible the way it affects you.” When asked if her work impacted other areas of her life she responded, “I wouldn't say it impacted my family but more so I questioned my professional abilities. I wasn’t sure if I should continue being a therapist, I wasn’t sure if it was the field for me.” She shared that she did not like anything about her supervision, “I think it was just one of those mandatory things I had to just deal with. I would have preferred to be meeting with the families or looking for resources.” When asked what trainings she would recommend for her supervisor she quickly replied, “Ethics!” When asked how long a professional should receive clinical supervision she stated, “I don’t think it should be
mandated but you don't know it all just because you have your license. I think a good clinical supervisor would want to continue to receive supervision.”

**Participant #6**

The sixth interview was conducted with a 34-year-old, White female, and Licensed Professional Counselor from Pennsylvania. She was a clinical supervisor and worked in the mental health field for 10 years with four years of supervisor experience. The focus of her supervision was, “Mostly just to make sure my team was staying aligned with everything that they needed to do and completing tasks on time.” When asked if her supervision was effective, she replied, “Generally, yes, like 85% of the time. Maybe 90% of the time. It was supportive in the way that my supervisor helps me brainstorm ideas. He's pretty hands off, so I come up with an idea and he’ll let me go on it and see what happens. But it's not clinical in the sense where I could necessarily come to him and say, hey, I'm dealing with countertransference issues with myself or with somebody I'm supervising, what do I do here?” When asked what was missing from her supervision she responded, “Being able to connect with somebody who is a counselor and understands or has been there before. There are people that I reach out to when it's gotten to the point that my supervisor can’t help. He can’t really help me with my personal development or growth in this position.” She shared that she is vocal enough when she sees something potentially happening. “I’m actually really lucky with that I can be completely transparent. I can talk to him and say no, I think we should be doing things this way. He's really open and receptive to all of it.” She added, “I think he is doing a great job with what he has, the only frustrating part is that he doesn’t quite understand what’s happening. I believe he has a bachelor’s in psychology but has never taken a counseling course.” When asked what she did with clinically focused issues that her supervisor was not equipped to deal with she responded by saying, “Sought
outside supervision, or bounced ideas off my staff.” When asked if her work impacted other areas of her life she responded, “That's a good question. I guess it's impacted me in a positive way. This role has slowly grown underneath me, I started to recognize how much I really loved the process teaching through supervision. It’s changed my career pathway, and my understanding of what I want to do with my future. It’s helped me kind of formulate a new pathway that I didn't ever think was an option.” She shared what she liked about her supervision, “How real, honest, and transparent it can be. I like the availability.” When asked what trainings she would recommend for her supervisor she replied, “I would put him through a master's level clinical counseling program.” When asked how long a professional should receive clinical supervision she stated, “Forever, as long as they're in the field.”

**Participant #7**

The seventh interview was conducted with a 35-year-old, White female, and Licensed Professional Counselor from Pennsylvania. She was a director and worked in the mental health field for 14 years with five and a half years of supervisor experience. The focus of her supervision was, “Helping me grow into a better leader.” When asked if her supervision was effective, she replied, “I would think that my supervision was effective in certain regards. I think there's always room for growth. But I think I have definitely grown a lot as a leader, so I would say that was effective.” When asked what was missing from her supervision she responded, “Clinical growth, I think that was important for me to have. I was taught motivational interviewing and how to facilitate that but I went brief crisis intervention to seeing patients over longer periods of time. The focus shifted and I needed guidance on developing treatment plans and other clinical aspects.” She added, “We needed help grounding ourselves in the different theories to develop interventions and provide adequate treatment.” She shared that she was only
able to be moderately transparent. “Those needs didn’t always get met though.” She later shared that she was unable to give her staff what they needed to be successful in their roles, “I felt inadequate because I didn’t have a strong enough clinical expertise.” When asked what she did with clinically-focused issues that her supervisor was not equipped to deal with she responded by saying, “Obtained my own supervision, read a lot, reached out to people that were in similar roles and bounced ideas off of them.” When asked if her work impacted other areas of her life she responded, “Ultimately, there was a lot of good that came of it. It made me realize I was good at leadership and I liked that. I felt more stressed in the clinical areas. When I got home I felt like I had to keep working to try and figure things out, which definitely affected my relationship with my partner. He did not always understand why I could not disconnect.” When asked what trainings she would recommend for her supervisor she replied, “To get trained better in more clinical models that were used for outpatient therapy.” When asked how long a professional should receive clinical supervision she stated, “Forever, I don’t think we should ever stop receiving supervision. It feels really good to have someone to talk to about the work you're doing.”

**Participant #8**

The eighth interview was conducted with a 39-year-old, Black male, and Licensed Master Social Worker from Pennsylvania. He was a director and worked in the mental health field for 15 years with eight years of supervisor experience. The focus of his supervision was, “Business aspects rather than understanding that the business is affected by the capacity of clinical staff to carry out interventions as well as to feel safe in an environment where that is not always guaranteed. When asked if his supervision was effective, he replied, “Not at all.” When asked what was missing from his supervision he responded, “The ability or capacity for my supervisor
to show interest in developing their skills to be able to pour into the stuff under them. No leader, no manager, and no supervisor is perfect that's not my point, but are they pushing to enhance their skillset? He added that the lack of clinical training impacted his staff, “I think I had grown in my managerial position to understand that you have to pay the bills, that was an obvious thing. I think where the disconnect happened was when staff feeling disoriented but being expected to continue work as usual. They encountered everything, it ranged from a child having a temper tantrum to the onset of schizophrenia. He shared, “Not addressing the staff’s needs in an effective way was extremely debilitating, people quit which later led to my supervisor requesting assistance with recruitment efforts, which was really frustrating. There was a huge disconnect. I think a lot of the issues revolved around the staff caring for the clients.” He identified himself as a “blunt person” but later stated, “I also had to temper it knowing that I was one of two Black males, on a managerial level within that agency. So, I was honest, but not, like, brutally honest.” He shared that the lack of clinically-focused supervision often hindered him, “I think the areas that I needed to grow in were hard to manage when I was left addressing crises 24/7. I didn’t have a chance to breathe, eventually I developed a tension in my right shoulder. I didn't notice it until I left the environment. That’s when I realized, oh my gosh, I've literally been holding all of that tension right here! And, so, to answer your question, I wasn't able to make the connection quick enough to help myself recover and therefore how could I help staff to be more attuned?” Reflecting back, he stated, “It actually started to cause my personality to change. My responses were short with less empathy.” When asked what he did with clinically-focused issues that his supervisor was not equipped to deal with, he responded by saying, “Kept it to myself… I did not want to divulge the information only to get a lackluster or negligent response. That was more harmful to me at that time.” When asked if his work impacted other areas of his life he
responded, “Hmm, really good question. I'm very attuned to my family, my kids but I became detached, my capacity was just severely diminished. My kids would ask, ‘Daddy, can we do this?’ I would say, ‘I know we used to, but no.’ It was a tired beyond tired. It was just straight up burnout and vicarious trauma and I couldn't shake it.” He later added, “I'm a semi-ambitious person. I don't want to take over the world, I just kind of want to take over my block. But some of that ambition went right out the window. Momentarily part of me died. Honestly, that’s the best way to put it. I had to preserve every ounce of energy just to survive.” When asked what he liked about his supervision he stated, “The chance to exercise what I believe leadership is which is not position, but influence. Even if I don't want to be here, how do I present information and create an interaction, whether it makes me uncomfortable or not, that I can change not just this person, but because this person is a part of a larger system, change the system? I liked that it was an opportunity to potentially change an ineffective system.” When asked what trainings he would recommend for his supervisor, he replied, “Honestly, group work. Almost like a group support process but for leaders. Something that emphasizes communication amongst leaders.”

**Participant #9**

The ninth interview was conducted with a 55-year-old, female (who preferred not to identify her race), and Licensed Clinical Social Worker from Virginia. She was a clinical supervisor and worked in the mental health field for 25 years with 20 years of supervisor experience. When asked what the focus of her supervision was, she stated, “I just can't say that I ever received supervision from a non-clinical person in the way that I would think of receiving supervision. Receiving supervision means you meet with somebody who is focused on helping you to develop as a clinician or professional. Someone that you're meeting with, right? No, we talked about medication and stuff.” When asked if her supervision was effective, she replied,
“No.” When asked what was missing from her supervision, she responded, “The clinical piece.” When asked about transparency, she shared, “I was too transparent which is one of the reasons I left.” She added, “The lack of clinically-focused supervision made things worse.” When asked what she did with clinically-focused issues that her supervisor was not equipped to deal with she responded by saying, “I went to the regional person.” When asked if her work impacted other areas of her life she responded, “I think all of those experiences have been very valuable because I’ve learned so much.” She shared what she liked about her supervision, “She was very familiar with the industry. She understood the company culture and how to maneuver situations.” When asked what trainings she would recommend for her supervisor she replied, “Leadership training because we have the most backwards management structure.” When asked how long a professional should receive clinical supervision, she stated, “I don’t think everyone should work in a vacuum, you need to have consultation available to you and readily make use of it and not work in isolation. There are people who are licensed that I would not feel comfortable with them seeing clients without regular supervision and it has nothing to do with how long they've been in the field.”

**Participant #10**

The tenth interview was conducted with a 35-year-old, Black female, and Licensed Marriage and Family Therapist from Pennsylvania. She was a director and worked in the mental health field for 12 years with nine years of supervisor experience. The focus of her supervision was, “Am I checking the notes and making sure their case loads are full?” When asked if her supervision was effective, she replied, “I felt like it was sort of a perfunctory kind of thing and was not a great use of my time. It was not supportive to me in any way. But I did it because I had to do it. My supervisor felt inept. I had more experience than them, where their experience did
not seem applicable.” When asked what was missing from her supervision she responded, “Expertise, you know, someone who's really got solid clinical foundation that they can stand on. Sometimes what was being asked of them did not allow them to make it a supportive space. They were being asked to follow up on numbers and keep track of data rather than provide a clinical space. And I could feel that pull from them in the room.” She shared later, “I’m sure the lack of clinically-focused supervision impacted the work I did with my supervisees. I tried very hard to say, well, that's my problem. I tried to provide an exceptional experience, but it must have not been right because I wasn't able to have that that modeled for me, and I wasn't able to have a parallel space for my own support. So I think it probably wasn't as rich as it could have been.” She shared that she not able to be very transparent. “I didn't feel like I had the ability to say, this is my experience, that it would be heard, or that something good would come of it. Instead, it felt like nothing good would come of me telling someone else about this or even talking to my supervisor about it directly.” When asked what she did with clinically-focused issues that her supervisor was not equipped to deal with she responded by saying, “I stopped bringing up those issues. I just started to realize it was useless. I think if you had asked me when I was going through it, I would have said, no, it doesn't hinder me. I figured it out by doing my own research and talked to my peers. If I felt really stuck, I might have sought out a journal article or book.” When asked if her work impacted other areas of her life she responded, “Well, it was definitely frustration that I brought home. I would tell my partner, oh, my goodness, I cannot believe I have to deal with this.” When asked what trainings she would recommend for her supervisor she replied, “As a MFT, I had to take supervisor fundamentals. I think they should take that because it would have been so helpful. Walking through that process of writing down your theory of supervision and how it works, I think that's a valuable process.” When asked how long a
professional should receive clinical supervision she stated, “Career long. I don't think weekly supervision is necessary as we get more seasoned, but some space, whether it's a peer space, or once a month, I think it’s valuable.”

**Cross-Case Analysis**

The 10 participants in the individual interviews verbalized many similarities as they described the experiences of receiving administrative supervision from a non-clinically trained superior. However, not all of the analytical categories were represented in each individual interview. Table 2 provides a cross-case analysis of the supporting themes from each analytical category between all of the individual interviews.

**Table 2**

**Nine Emerging Themes**

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<tr>
<th>Health</th>
<th>Professional Development</th>
<th>Staff Needs</th>
<th>Additional Resources</th>
<th>Personal Development</th>
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<td>Trainings:</td>
<td>Supervision Frequency</td>
<td>TED Talks</td>
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<td>• Clinical Knowledge</td>
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<td>• Clinical Self-Awareness</td>
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<th>Career</th>
<th>Program Management</th>
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<td>Productivity</td>
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The above table shows the nine emerging themes found among the individual interviews, which are further discussed in the following chapter. All of the interviews explored the supervisor’s personal experiences when receiving administrative supervision from a non-licensed/non-clinically trained superior. Included are narratives of each interview among which participants described (1) the goals of the administrative supervision, (2) how effective/ineffective administrative supervision was, (3) how transparent they could be with their superiors, (4) where they found answers to clinically focused issues that their superiors were not equipped to deal with, (5) what they liked about the supervision they received, (6) trainings that might be beneficial for their superiors and (7) how long they believed a professional should receive clinical supervision. What was of interest to the researcher were the various approaches the participants took to address clinically focused issues that their superiors were not equipped to address. The supporting statements in the cross-case analysis have been used to develop central themes that are further discussed in the following chapter.

**Summary**

This chapter provides an overview of the data explicated from all 10 individual interviews. Narrative descriptions of each individual interview provide supporting statements from participants that relate to the theoretical frameworks and identified themes. Tables are used to organize the supporting themes that correspond to the analytical categories when applicable. The chapter concludes with a cross-case analysis of the supporting statements within the analytical categories. This data was used to construct the main themes that are elaborated in the following chapter. A further explication of the main themes is presented in Chapter Five.
CHAPTER V: DISCUSSION

The preceding chapters constitute an inquiry into clinical supervisors’ experiences when receiving exclusively administrative supervision from non-licensed/non-clinically trained superiors. A review of the problem, background, and rationale was provided in earlier chapters to enhance the reader’s understanding of the history, purpose, and benefits of clinical supervision. First, the research question and literature review were presented, then a description of the methodology was provided, and finally, the data were collected and explicated accordingly. The researcher sought to further explore the themes that emerged during this qualitative study.

The focus of this study was to explore the experiences of clinical supervisors who previously or currently received solely administrative supervision from their non-licensed/non-clinically trained superiors. Clinical supervisors who participated in this study identified unique experiences when receiving administrative supervision. Although participants provided various descriptions of administrative supervision, their stories revealed both positive and negative experiences. Some of the positive experiences expressed by participants included the ability to be autonomous, the ability to have precise and achievable goals, the ability to develop professional relationships that later formed into friendships, and the ability to gain knowledge regarding finances, compliance, regulations, and productivity. Other participants described negative experiences such as insufficient emotional support, shortage in professional development opportunities, a lack of consistency and/or frequency of supervision, the inability to be fully transparent about their needs, concerns or challenges, physical and/or mental health problems, and the questioning of their own self-efficacy and/or career choice.

Chapter Five provides a review of the 10 narratives and nine themes that emerged from the data using Hycner’s (1985) guidelines to phenomenological research to explicate the data and
Bronfenbrenner’s Ecological Systems Theory as the theoretical approach. The 10 narratives illustrated a variety of perspectives of participants’ experiences during administrative supervision while the nine themes emerged from the explication of these narratives. Each theme illuminated the clinical supervisors’ experiences related to the research question. The following question guided the researcher’s study: How do clinical supervisors who are providing clinically-focused supervision experience the supervision they receive from their non-licensed/non-clinically trained superior? The chapter concludes with a review of the limitations of the study, questions that were generated from the study, and suggestions for future research that may provide additional clarity in this area of exploration.

Research Question and Identified Themes

In this section, the researcher discusses the relationship between the research question and the identified themes. The researcher created categories for some of the themes because they were similar to each other. For example, productivity and regulations were two similar themes, so the researcher grouped them together and called them “program management.” In the end, the researcher had a total of nine themes. Four themes were associated with the microsystem, one theme was associated with the mesosystem, one theme was associated with the exosystem, one theme was associated with the macrosystem, and two themes were associated with the chronosystem.

Discussion of the Findings

The researcher’s findings suggest that multiple factors contributed to the participants’ experiences when receiving administrative supervision. These factors are discussed here in the context of Bronfenbrenner’s (2005) bioecological system’s theory which contains five
environmental systems: microsystem, mesosystem, exosystem, macrosystem, and chronosystem.

The researcher will discuss the five systems and nine themes in the following paragraphs.

Table 3
Clinical Supervisors’ Environmental Systems
**Microsystem**

All five systems are interrelated, as shown above in Table 3, which means the influence of one system on the clinical supervisor’s development depends on its relationship with the others. The sphere closest to the supervisor is called the microsystem and contains the supervisor’s innermost environment (Kumpf, 2014). Relationships in a microsystem are bi-directional, meaning the clinical supervisor can be influenced by other people in their environment and is also capable of changing the beliefs and actions of other people too. Furthermore, the reactions of the clinical supervisor to individuals in their microsystem can influence how they treat them in return. The interactions within microsystems are often very personal and are crucial for promoting and nurturing the clinical supervisor’s development. If the clinical supervisor has an open and strong relationship with their superior, this will have a positive effect on them, whereas an inadequate relationship with the superior will have a negative effect on the clinical supervisor’s development and ability to successfully fulfill their responsibilities. Participants’ microsystems were organized into four themes – health, emotional supports, personal development, and additional resources.

**Health.** The participants reported their mental and/or physical health was often impacted by their experiences. Participant #2 reported, “I was looking for emotional support.” Participant #5 shared, “It was probably one of the most destructive mental health periods of my life.” Participant #8 reflected, “I would say momentarily part of me died.” Participant #9 shared, “I went to work with a stomachache for six years straight.” Given the intensity of the participants responses, it is evident that their mental and physical health were impacted. If the supervisors were not at full capacity, how were the counselors influenced, and how were the clients impacted?
**Emotional Supports.** Participants were directly and vicariously impacted by their work which often impacted relationships with their family, friends, and significant others. Participant #1 stated, “Well, the spillover impacts home, the fallout often happens with family because I’m looking for emotional support.” Participant #7 shared, “I feel like I had to keep working to try and figure things out, which definitely affected my relationship with my partner. He did not understand why I could not disconnect.” Participant #8 reported, “I became detached from my family and children because my capacity was just severely diminished.” Given the participants’ responses, it seems the supervisors did not receive satisfactory supervision and their unmet needs impacted their personal relationships outside of work. Similar to counselors who are affected directly and vicariously by their work, supervisors are impacted as well and may benefit from a balanced approach that includes both administrative and clinical guidance.

**Personal Development.** Several participants used their personal therapist to address issues of self-efficacy and other concerns that surfaced during work. Participant #3 stated, “I talked to my personal therapist but it wasn’t anything formal.” Participant #5 responded, “I started questioning myself and if I was in the right field.” Participant #7 reported, “My therapist helped with more of the personal stuff.” Participant #8 reported, “The lack of ability to look through a deeper clinical lens was incapacitating.” Participant #9 shared, “I got therapy for myself when I needed it.” Given the participants’ responses, it appears the lack of clinical support impacted their mental state, self-efficacy, and professional abilities which resulted in them consulting with their personal therapists. Despite the years of experience, all clinicians can benefit significantly from, and in some cases, need to consult with another clinical professional.

**Additional Resources.** Participants used additional resources to address the clinical concerns they did not believe their superiors had the skillsets to address. Participant #2 stated, “I
go to the literature and use self-reflection.” Participant #5 shared, “Coworkers, I was so fortunate to have a strong team.” Participant #7 reported, “I obtained and paid for my own supervision and lots of reading. I also reached out to people that I knew were in similar roles.” Participant #1 stated, “I internalized it.” Participant #9 reported, “I kept it to myself.” Participant #10 shared, “I stopped bringing up those issues; honestly, after a while, you just start to realize this is useless.”

Most participants embraced peer supervision or sought outside clinical supervision, while a few participants felt as though they had no other option but to accept or suppress it. Given the variety of responses, it appears the participants value and need clinical guidance whether it is from a supervisor, peer, or clinical resource. It is possible the supervisors who did not have access to resources may have missed out on opportunities to learn and grow which could have potentially impacted the counselors and/or the clients.

**Implications.** The microsystem represents the interpersonal interactions experienced by the developing supervisor (Lau & Ng, 2014) in a given framework of face-to-face relationships, such as work, home, and family (Viola et al., 2021). The microsystem has the most impact on the supervisor’s development (Kumpf, 2014); therefore, if supervision is lacking or ineffective, this can have an impact on the development of the supervisor and counselor’s level of functioning (Kuhn, 2009). The results of this study reveal that participants’ professional development and personal relationships were negatively influenced by the inadequate supervision they received. This leaves the researcher wonder, how are the clients being impacted if the clinical supervisors are being influenced negatively?

**Mesosystem**

The next system, moving away from the clinical supervisor, is the mesosystem. The mesosystem encompasses the interactions between the clinical supervisor’s microsystems, such
as the interactions between the supervisor and their coworkers or between their coworkers and their families. The mesosystem is where the supervisor’s individual microsystems do not function independently but are interconnected and assert influence upon each another. For instance, if the clinical supervisor’s family communicates with the supervisor’s superior, this interaction may influence the supervisor’s development. Essentially, a mesosystem is a system of microsystems. According to the bioecological systems theory, if the family and supervisor’s superior and coworkers get along and have a good relationship, this should have positive effects on the supervisor’s development, compared to negative effects on development if the family does not get along with the supervisor’s superior or coworkers. Participants’ mesosystems were organized into one theme called professional relationships.

**Professional Relationships.** Participants used colleagues for peer supervision to gain a different perspective, to process transference or countertransference, and to explore other clinical challenges that surfaced. Participant #2 shared, “I use the manager who is over our outpatient therapy services as a support. Participant #4 stated, “Peer supervision, but I would have to go somewhere else if I had a legitimate question.” Participant #6 reported, “Seek outside supervision or consult with a few people that I technically supervised.” Participant #8 shared, “I obtained my own supervision. I also reached out to people that I knew that were in similar roles.” Participant #9 stated, “I had my clinical supervisor that I hired.” Given the participants responses, there is a prevalent need for clinical guidance when clinical services are being provided. The participants turned to professionals who had an understanding of common clinical problems that take place in therapy. If counselors are expected to have a basic clinical awareness and understanding of such concepts, the supervisors’ superiors should be held to the same expectations.
Implications. The mesosystem is a set of interrelations between two or more settings in which the developing supervisor becomes an active participant (Lau & Ng, 2014). These are the interactions between contexts in which the person actively participates (Viola et al., 2021), such as coworkers, agencies, friends, and extended family members (Kuhn, 2009). The results of this study reveal that the professional relationships participants’ have built and maintained with their peers is what is making up for the clinical support they do not receive in their supervision, which leaves the researcher to wonder if it is appropriate to seek guidance outside of the agency structure. What potential liability issues does that generate?

Exosystem

The exosystem refers to processes that take place between two or more settings in which the supervisor may not be immediately contained in but can still influence their development in important ways (Fair, 2017). The exosystem incorporates other formal and informal social structures, which do not contain the clinical supervisor but indirectly influences them as they affect one of the microsystems. Examples of exosystems include the regulations and legislation within the mental health field. These are environments in which the supervisor is not involved and are external to their experience but nonetheless affects them anyway. An instance of exosystems affecting the supervisor’s development happen when regulations change within the mental health field. The supervisor’s responsibilities may be impacted as a result of the changes, resulting in a positive or negative effect on the supervisor’s development. Participants’ exosystems were organized into one theme called program management.

Program Management. Participants administrative supervision focused on program management. Participant #1 reported, “Higher-level decisions, what are the next steps of our program, how to deal with stakeholders and program areas, fiscal and compliance issues.”
Participant #2 stated, “Productivity, performance, financial concerns, how things are running, program or staff needs.” Participant #6 shared, “Billable hours, notes, and audits.” Participant #9 reported, “The logistics of the job, what needs to be done, the regulations, good patient care.” Participant #10 shared, “Sometimes, it was more of checking the notes and making sure that their caseloads were full.” Given the overwhelming responses, it seems that participants need administrative supervision to address the business aspect but still desire a balanced approach that includes clinical supervision.

**Implications.** Elements within the exosystem that are relevant to supervision might include managed care entities, government legislation, and county/state licensing agencies (Kuhn, 2009). Supervisors are often required to provide appropriate support and/or guidance to supervisees with regard to navigating the exosystem (Kumpf, 2014). The results of this study reveal that participants’ supervision was focused on addressing the administrative responsibilities that would maintain a successful program and business. This leaves the researcher curious, how can a business maintain its success while meeting the staff and clients’ needs?

**Macrosystem**

The macrosystem occurs on a global scale and focuses on how cultural elements affect the clinical supervisor’s development, such as socioeconomic status, wealth, poverty, and ethnicity. Thus, the culture that individuals are immersed within may influence their beliefs and perceptions about events that transpire in life. The macrosystem differs from the previous ecosystems as it does not refer to the specific environments of one supervisor, but the already established society and culture which the supervisor is developing in. This can also include the socioeconomic status, ethnicity, geographic location and ideologies of the culture. For example, a clinical supervisor working under a licensed and clinically trained superior would experience a
difference in clinical support than a clinical supervisor working under a non-licensed/non-clinically trained superior. Participants’ macrosystems were organized into one theme called professional development.

**Professional Development.** Participants recommended training topics they believed their non-licensed/non-clinically trained superiors skillsets could benefit from. Participant #1 responded, “Your clinical supervisor shapes your approach and interventions, so I think trainings that validate that and that keep professionals informed.” Participant #2 reported, “Our counseling association offers an array of supervisory trainings that include ethical supervision, multicultural supervision and boundaries.” Participant #4 stated, “They need to be clinically trained, which might involve being fired or going back to school.” Participant #5 reported, “Ethics.” Participant #7 responded, “A master’s clinical counseling program.” Participant #9, “Leadership training because we have the most backwards management and structure.” Given the variety of the participants’ responses, it appears the participants were able to fill a deficit in the support they received. A common theme was the supervisors’ superiors needed more training in leadership and ideally for the superiors to return to school to obtain a clinical degree.

**Implications.** The macrosystem accounts for all dominant societal and cultural beliefs (Fair, 2017), traditions, values, ideologies (Viola et al., 2021), professional, and legal influences shaping the learning environment (Bronfenbrenner, 1979). Mental health stigma and stereotypes can be found within this system (Kumpf, 2014). The results of this study reveal that participants believed their non-licensed/non-clinically trained superiors needed specific trainings to shape their learning environment. This leave the researcher asking, is it appropriate for superiors to supervise clinical supervisors without proper knowledge and adequate training?
**Chronosystem**

Bronfenbrenner identified the chronosystem as an addendum to the bioecological systems theory (Bronfenbrenner, 1992) because it illustrated his belief that individuals’ learning and their environments change through time as they develop (Lau & Ng, 2014). The chronosystem system consists of all of the environmental changes that occur over the lifetime which influence development, including major life transitions and historical events. These can include normal life transitions such as being promoted to a new position but can also include non-normative life transitions such as leaving a job because of insufficient resources and support. Participants’ chronosystems were organized into two themes: career and staff needs.

**Career.** Other participants adjusted their career track. Participant #6 reported, “I recognized how much I loved the teaching process which has sort of changed my career and my understanding of what I want to do.” Participant #7 stated, “Ultimately, I developed into a good leader.” One participant whose position was created strictly address the clinical aspect of the program considered returning to school to obtain a doctoral degree in order to fulfill her newfound passion of teaching.

**Staff Needs.** Participants identified things they would like to receive from their superiors. Participant #1 reported, “A holistic approach that includes clinical, administrative, and emotional support.” Participant #2 stated, “It would be nice to talk about my career trajectory.” Participant #8 reflected, “Knowledge to enhance the clinical skills of my three managers I supervise.” Given the participants responses, it appears a variety of their needs were unmet and some resentment may have possibly formed. Supervisors who are heard, adequately supported, overwhelmed and so forth, are less likely to self-disclose, which leads to bigger issues.
Implications. The chronosystem positions the other systems within a time frame subjectively experienced by the supervisor throughout their life (Kumpf, 2014). Systems are not stagnant, political, educational, and community factors are constantly changing (Chan et al., 2019). The results of this study reveal that participants’ professional and academic needs can and will continue to change as time passes which will require the superiors to remain aware, knowledgeable, and flexible. This leaves the researcher wondering, what else can be done to better support clinical supervisors’ needs over time, in a non-clinical environment?

Implications of the Study for the Field

According to the literature, the quality of the supervisory relationship is essential to effective clinical supervision (Cheon et al., 2009), satisfaction with supervision (Wilcox et al., 2021), self-efficacy (Park et al., 2019), and supervisee self-disclosure of personal and professional experiences (Spence et al., 2014). Quality supervision protects against burnout and emotional exhaustion and can serve as a potential buffer against a variety of negative job experiences (Knudsen et al., 2008), while insufficient, minimal, or no clinical supervision can lead to a decrease in job performance (Cashwell & Dooley, 2001), and possible burnout which can cause harm to the clients (Thompson et al., 2011). A poor supervisory experience can harm a counselor personally as well as professionally (Shaffer & Friedlander, 2015).

The function of the supervisor is to assist the counselor in minimizing the effects of such exposure, to help prevent impairment (Newell & MacNeil, 2010), and to encourage continued professional development that ensures high quality care and services for the clients (Snowdon et al., 2019). However, clinical supervisors must have the necessary training and competence in order to provide effective support (Kilminster et al., 2007). The supervisory relationship has been
found to be an essential factor of the actual counseling process and the outcome, which means clinical supervision at all levels of experience deserves attention (Park et al., 2019).

This study was the first empirical study to investigate clinical supervisors who provide clinical supervision and receive specially administrative supervision from non-licensed/non-clinically trained superiors. The findings of this study suggest that clinical supervisors experience the same exposure to vicarious trauma, burnout, compassion fatigue, secondary traumatic stress similar to the counselors they supervise. This is because clinical supervisors are not receiving the proper support and clinical guidance in comparison to what they are providing to the counselors they supervise.

Counselors are not required to continue supervision after licensure because there are no state-wide requirements for ongoing supervision post licensure. In order for the field to improve in these areas, and for client welfare to become a serious priority, continuing education credits are no longer enough. Similar to social workers, clinical supervisors should only be supervised by a licensed and clinically-trained professional who has completed a clinical graduate degree in the mental health field and has a minimum of five years of experience in the field. Five years allows the superior the opportunity to learn how to properly manage significant errors and sincerely reflect on such events so they substantially improve their practice as a supervising manager (Grant et al., 2012). Administrative and clinical supervision should be a requirement in all agencies, while clinical supervision should be a requirement for all clinicians post licensure and throughout their clinical practice. These expectations should be reflected in state-wide requirements, mental health legislation, and all programs that provide clinical services.
Limitations of the Study

This qualitative study used 10 participants who self-identified as clinical supervisors. The participants in this study were selected based upon them receiving exclusively administrative supervision from non-licensed/non-clinically trained superiors. Although the researcher was looking for a specific criteria, she received an overwhelming response within a matter of two weeks from professionals who had a visceral reaction to the study. Over 37 people responded and celebrated the research topic and stated it was an issue that needed to be addressed in the clinical supervision literature and documented. The clinical supervisors that were selected to participate in the study were largely distressed with their superiors’ lack of clinical training and the quality of supervision their superiors provided, which in turn may have skewed the data towards the negative perspective.

The demographic questionnaire indicated minimal diversity among the participants’ age, gender, race and geographical location. Participants ranged from 33 to 55 years old. This may have impacted the study because of the years of experience in the field. Majority of the participants were in their 30’s with about 10 years of experience. Clinical supervisor with greater than 10 years of experience may have responded differently to the interview questions. All of the clinical supervisors identified as female, except two participants who identified as males. This may have impacted the study because the data was skewed towards the female experience. Women and men communicate, and may approach conflict, differently. All of the clinical supervisors identified as White, except two participants who identified as Black, one individual that identified as Multiracial and one individual who did not respond to this question on the demographic questionnaire. This may have impacted the study because it did not reflect a difference in cultural-professional perspectives. The participants were recruited from
Pennsylvania, New York, Illinois, and Virginia. This may have impacted the study because these states are closer to the East Coast. The Midwest and the West Coast may have differed in responses, needs and approaches to getting those needs met. The study may not accurately reflect the experiences of self-identified clinical supervisors from other age groups, genders, races, and geographical locations.

The duration of experience among the participants is another limitation to this study. The researcher selected participants who had a minimum of one year of experience to increase the likelihood of finding clinical supervisors who received exclusively administrative supervision; however, this may have eliminated participants who had less than one year of experience, but only received administrative supervision. It would have been interesting to hear about the experiences described by self-identified clinical supervisors who were new to the field.

The researcher herself may have been a limitation in this study through her own biases and presuppositions when conducting interviews and explicating the data. The researcher experienced receiving just administrative supervision from a non-licensed/non-clinically trained managing superior while providing clinical supervision. These experiences and their effects may have influenced the data collection process and interpretation of the data. Although it is not possible to completely avoid personal biases and presuppositions, the researcher attempted to eliminate them through the analytical notes she took following interviews and through consultation with her committee members. It could also be that some individuals may have felt pressured to answer in a way they believed the researcher expected them to. Despite a thorough review of confidentiality with each participant and explanation that all identifying information would be removed, some may have been concerned that the information they provided would be
revealed through this study. Finally, some participants may not have been able to accurately recall past experiences with administrative supervision.

**Considerations for Future Research**

Clinical supervisors receiving solely administrative supervision from non-licensed/non-clinically trained superiors is not a topic that has received a lot of attention in the research literature. In this study, the researcher interviewed 10 self-identified clinical supervisors who received solely administrative supervision from a non-licensed/non-clinically trained superior while providing clinical supervision to their supervisees. Other researchers can expand the study to look at how the lack of proper training and/or credentials influence the legal, medical, and business industries. Other researchers can build on this study by exploring clinical supervisors who receive both administrative and clinical supervision. For example, future research can address clinical supervisors’ quality and/or satisfaction when receiving both administrative and clinical supervision. Future research on this topic can add to supervision literature as a whole and could potentially shed light on the similarities and/or differences to the supervisors’ experience when receiving administrative supervision.

**Questions Generated by This Study**

Generating questions for further research is expected in qualitative studies. The questions that were generated by this study follow:

1. Where should clinical supervisors who receive administrative supervision go to address clinically focused concerns their superiors are unable to address?

2. How long does an experienced clinical supervisor need to receive supervision?

3. How is the client’s welfare impacted by the non-licensed/non-clinically trained superior’s management?
Conclusion

The guiding question of this study asked, “How do clinical supervisors who are providing clinically focused supervision experience the administrative supervision they receive from their non-licensed/non-clinically trained superiors?” Chapter Five offered an overview of the study and a discussion on the findings and the research question. The themes were developed through the lens of Bronfenbrenner’s (2005) bioecological systems theory. The researcher’s findings reflect the participants’ experiences and were discussed under the following systems: microsystem, mesosystem, exosystem, macro system and chronosystem. Nine themes emerged as a result of this study. Four themes were associated with the microsystem, one theme was associated with the mesosystem, one theme was associated with the exosystem, one theme was associated with the macro system, and two themes were associated with the chronosystem.
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Appendix A: Recruitment Email
Email to Program Directors Requesting to Recruit Participants for the Study

Subject: Experience is the Best Teacher: Exploring Clinical Supervisors’ Experiences Who Receive Exclusively Administrative Supervision From Non-Licensed/Non-Clinically Trained Superiors

Dear [Program Director’s Name],

My name is Monica Pattillo, and I am a doctoral candidate at Duquesne University. I am contacting you to request permission to recruit clinical supervisors for participation in a research study. I am conducting this study as part of the requirements for my doctoral degree in Counselor Education and Supervision. I am interested in exploring clinical supervisors experiences who have or are currently receive solely administrative supervision from non-licensed/non-clinically trained superiors. I am contacting you because you are listed as the [position] for [insert program name]. If you could, please forward the paragraph below (along with the attached informed consent document) describing the study, its intent, and requirements for participation. I thank you in advance for your assistance. This study has been approved by Duquesne’s Institutional Review Board for the Protection of Human Subjects.

E-mail to Participant
You are being asked to participate in a research project that seeks to investigate the experiences of clinical supervisors who receive solely administrative supervision from their non-licensed/non-clinically trained superiors. This is a research project being conducted by a doctoral candidate for her dissertation work in her Counselor Education and Supervision program at Duquesne University. You are being asked to participate in an interview that will last approximately 1 hour. Attached to this e-mail you will find the informed consent document for the study that explains, in detail, the purpose of the study and other important details. If you are interested in participating, please follow the link below to complete a brief demographic questionnaire. If you fit the sample characteristics regarding clinical supervisors receiving administrative supervision from non-licensed/non-clinically trained superiors, you will be contacted by the researcher to schedule your interview. This study has been approved by Duquesne University Institutional Review Board. Simply click on the link below, or cut and paste the entire URL into your browser to access the questionnaire:

[Insert survey link here]

Thank you for your time and consideration,

Monica Pattillo, LMFT
pattillom@duq.edu
Counseling Education Doctoral Candidate
Duquesne University
Appendix B: Informed Consent
CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: Experience is the Best Teacher: Exploring Clinical Supervisors’ Experiences Who Receive Exclusively Administrative Supervision from Non-Licensed/Non-Clinically Trained Superiors

INVESTIGATOR: Monica Pattillo, M.A., LMFT, Doctoral Candidate
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ADVISOR: Dr. Debra Hyatt-Burkhart, Ph.D., LPC, ACS
Department Chair, Associate Professor
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(412) 396-5711

SOURCE OF SUPPORT: This study is being performed as a partial fulfillment of the requirements for the doctoral degree in The School of Education; Department of Counseling, Psychology, and Special Education at Duquesne University.

STUDY OVERVIEW: This is a research project being conducted by a doctoral candidate in the Counselor Education and Supervision Program at Duquesne University. The purpose of this study is to investigate the lived experiences of clinical supervisors who receive administrative supervision from non-licensed/non-clinically trained superiors. You are being asked to participate in an interview that will last approximately 1 hour. Participation in this study will require some level of comfort talking about your personal experiences when receiving administrative supervision. Risks associated with participation are minimal and no greater than would be encountered in day-to-day conversations.
PURPOSE: The purpose of this study is to investigate the lived experiences of clinical supervisors who receive solely administrative supervision from non-licensed/non-clinically trained superiors.

In order to qualify for participation, you must:

- Possess a master’s degree in one of the behavioral health fields
- Self-identify as a clinical supervisor
- Have at least one year of clinical supervisor experience
- Have received or are currently receiving solely administrative supervision from a non-licensed/non-clinically trained superior

PARTICIPANT PROCEDURES: If you provide your consent to participate, you will be asked to participate in an individual interview using the Zoom application. The interviews will be recorded and later transcribed. Interviews will take approximately 1 hour to complete. During the interview, you will be asked questions about your personal experiences as a clinical supervisor receiving solely administrative supervision from a non-licensed/non-clinically trained superior. Following the transcription of the interviews and data analysis, I will provide a summary of the themes from your interview to you through email. You will be given the opportunity to provide feedback to me about whether your interview data has been interpreted accurately. These are the only requests that will be made of you.

RISKS AND BENEFITS: There are minimal risks associated with participating in this study, but no greater than those encountered in everyday life. There are no direct benefits to participating in this study, however you may experience positive psychological effects from having your experience validated by others and knowing that you assisted in the research study. You may also develop personal insight of your own experiences that may impact your supervisory work in positive ways.

COMPENSATION: There will be no compensation in exchange for participating in this study. However, participation in this study will not cost you anything.
CONFIDENTIALITY: Your participation in this study, and any identifiable personal information you provide, will be kept confidential to every extent possible, and all data will be destroyed at the completion of the study. All written and electronic forms of data and study materials will be kept secure. Electronic data (electronic transcriptions, researcher journals) will be stored in a password protected folder on a password protected computer. Recordings will be stored in a password protected folder on a password protected computer and will be destroyed at the completion of the study. Transcriptions will be de-identified using participant numbers. All results will be reported in aggregate. All direct quotes from participants will be presented using participant numbers. All written and electronic documentation will be destroyed at the completion of the study. Additionally, any publications or presentations concerning this research will only use data that is combined with all subjects; therefore, no one will be able to determine how you responded. All direct quotes from participants will be presented using participant numbers.

The Zoom platform is HIPAA compliant for covered entities (Zoom, 2021). In the use of Zoom, privacy features remain in the control of the meeting host and approved participants at the discretion of the host. These features include entrance to the meeting, screen sharing, and recording abilities. Each meeting link is generated only for the purposes of each specific interview and the waiting room is enabled to allow for the meeting host to verify participants prior to entry. Following participant entrance to the meeting, the host can lock the room to prevent any further entry. Zoom protects data at the application level using an advanced encryption system (Zoom, 2021). For more information visit https://zoom.us/docs/doc/Zoom-hipaa.pdf.

RIGHT TO WITHDRAW: You are under no obligation to start or continue your participation in this study. You may withdraw at any time without penalty or consequence by emailing your desire to cease participation to the principal investigator. Previously collected data will be immediately destroyed and will not be included in the data analysis, final report, or any subsequent publications.

SUMMARY OF RESULTS: At the completion of the study, a summary of the study’s
results will be provided to you at no cost. You may request this summary by contacting the researchers. The information provided to you will not be your individual responses. Rather, the information will summarize the total findings of the research project.

**FUTURE USE OF DATA:** Any information collected that can identify you will not be used for future research studies, nor will it be provided to other researchers.

**COVID-19 CONSIDERATIONS:**
I understand that the researcher(s) running this study have put in place the following guidelines to address concerns related to COVID-19:

- Participant interviews are all being conducted virtually via zoom.

**VOLUNTARY CONSENT:** I have read this informed consent form and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw at any time, for any reason without any consequences. Based on this information, I certify I am willing to participate in this research project.

I understand that if I have any questions about my participation in this study, I may contact Monica Pattillo at pattillom@duq.edu or (347) 871-1729 or Dr. Debra Hyatt-Burkhart at hyattburkhartd@duq.edu or (412) 396-5711. If I have any questions regarding my rights and protections as a subject in this study, I can contact Dr. David Delmonico, Chair of the Duquesne University Institutional Review Board for the Protection of Human Subjects at (412) 396-1886 or at irb@duq.edu

___________________________________  __________________
Participant’s Signature  Date

___________________________________  __________________
Researcher’s Signature  Date
Appendix C: Brief Demographic Questionnaire
Brief Demographic Questionnaire

1. Age: ______________
2. Gender: ______________
3. Race/Ethnicity: ______________
4. University you received your master’s degree from: ____________________________
5. Title of your master’s program: ____________________________
6. Professional discipline/Title of licensure: ______________
7. Total number of years accumulated as a practicing clinician: ______________
8. Title of your current position: ______________
9. Number of years spent in your current position: ______________
10. Is it a supervisory role: ______________
11. How many years of experience do you have as a supervisor: ______________
12. Do you receive supervision (Administrative, Clinical, Peer): ______________
13. How often do you receive supervision: ______________
Appendix D: Interview Questions
Interview Questions

1. What was the focus or goal of your superior in their supervision with you?

2. Do you think that your supervision was effective? What was missing?

3. Were there times when the lack of clinical training of your supervisor impacted your work with your supervisees?

4. How transparent were you with your supervisor about your frustration?

5. Were you impacted vicariously by your work?

6. Did your lack of clinically focused supervision help you or hinder you with managing your own vicarious experiences with the work?

7. What did you do when you had clinically focused issues that you needed to deal with that you felt your supervisor did not have the skill set to help you?

8. How did your supervision impacted other areas of your life?

9. What did you like about your supervision?

10. What trainings might you recommend for your superior?

11. How long do you think a clinician needs to receive supervision? Why?

12. How did you hear about the study?

13. Do you know other clinicians who might be a fit the criteria?