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Effective Clinical Supervision in Substance Use Disorder Treatment Programs and Counselor Job Performance

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Abstract

When mental health counselors have limited and/or inadequate training in substance use disorders (SUDs), effective clinical supervision (ECS) may advance their professional development. The purpose of the current study was to investigate whether ECS is related to the job performance of SUD counselors. Data were obtained in person via paper-and-pencil surveys from 392 matched SUD counselor-clinical supervisor dyads working in 27 SUD treatment organizations across the United States. ECS was rated by counselors and measured with five multi-item scales (i.e., sponsoring counselors' careers, providing challenging assignments, role modeling, accepting/confirming counselors' competence, overall supervisor task proficiency). Clinical supervisors rated counselors' job performance, which was measured with two multi-item scales (i.e., task performance, performance within supervisory relationship). Using mixed-effects models, we found that most aspects of ECS are related to SUD counselor job performance. Thus, ECS may indeed enhance counselors' task performance and performance within the supervisory relationship, and, as a consequence, offset limited formal SUD training.

Keywords

effective clinical supervision; counselor job performance; substance use disorder professionals; clinical supervisor-counselor dyad; counselor professional development

Mental health counselors help individuals, families, and groups with numerous mental health issues such as substance use disorders (SUDs), depression, anxiety, trauma, stress management, and family- and aging-related changes (U.S. Department of Labor, 2010). Licensure and certification requirements generally mandate that mental health counselors have a master's degree in a counseling-related field of study and work under the direct supervision of a senior clinical practitioner for a specified period of time (Council for

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Accreditation of Counseling and Related Educational Programs [CACREP], 2009; U.S. Department of Labor, 2010). SUD treatment is one of the few mental health care settings where counselors without at least a master's degree, licensure, or certification can have direct contact with and engage in client care (Eby, McCleese, Baranik, & Owen, 2007; Knudsen, Boyd, & Studts, 2010; Powell & Brodsky, 2004; Rothrauff, Abraham, Bride, & Roman, 2011; Substance Abuse and Mental Health Administration [SAMHSA], 2009). As a result, there is great variability in counselor professional training in SUDs (Culbreth & Borders, 1998; Powell & Brodsky, 2004; SAMHSA, 2009) and subsequently some concern that SUD counselors may not be adequately prepared when entering the field.

One way to help prepare mental health counselors for working with SUD clients may be through effective clinical supervision (ECS) (Powell & Brodsky, 2004; SAMHSA, 2008, 2009). It is commonly believed that there are benefits to ECS in terms of increased skill development for counselors (SAMHSA, 2008; 2009). However, there are no studies published within the SUD field that examine the relationship between ECS and counselor job performance. At the same time, there is limited empirical evidence in other fields regarding the strength of the relationship between ECS and counselor performance on the job (for reviews see Jones, 2006; Wheeler & Richards, 2007). Thus, the purpose of the current study is to investigate the relationship between ECS in SUD treatment programs and counselors' job performance.

Effective Clinical Supervision (ECS) and Counselor Job Performance

The Center for Substance Abuse Treatment (CSAT, 2007) defined effective clinical supervisors as skilled and experienced senior clinicians who are well informed about SUDs and evidence-based assessment, intervention, treatment, and recovery practices. In other words, one important aspect of ECS is task proficiency. However, ECS requires more than technical competence on the part of a clinical supervisor (Powell & Brodsky, 2004). ECS is commonly described as a working alliance between counselor and clinical supervisor (Efstation, Patton, & Kardash, 1990). Through the working alliance the supervisor uses social influence, confirmation, and acceptance to help the counselor perform better on the job and develop professionally. According to counselors, the most important aspects of ECS are receiving professional support, obtaining social support to reduce burnout, learning how to work with particular types of clients, learning specific counseling skills, and developing greater self-awareness (Culbreth, 1999; Usher & Borders, 1993). This is consistent with Powell and Brodsky's contention that another important aspect of ECS involves the clinical supervisor acting as a mentor for the counselor. As such, in the present study we conceptualize ECS in terms of both clinical supervisory task proficiency and the provision of mentoring support.

It is widely acknowledged that there are two different types of mentoring support: career-related support and psychosocial support (Kram, 1985; Ragins & McFarlin, 1990). As such, both types of mentoring support are conceptualized as part of ECS. In terms of career-related support, we focus on sponsorship and challenging assignments. According to Kram, sponsorship can be active (e.g., nominating a counselor for a desirable lateral move or promotion) or passive (e.g., affiliation with a highly regarded clinical supervisor elevates a

counselor's own reputation among others and can lead to career opportunities). Mentors can also offer challenging assignments, which provide opportunities for counselors to develop new skills and receive on-going performance-related feedback (Kram, 1985). In terms of psychosocial support, we focus on role modeling and acceptance-and-confirmation. Through the process of role modeling, a clinical supervisor demonstrates the attitudes, values, and behaviors that a counselor desires to emulate (Kram, 1985). This helps solidify the counselor's professional identity and can strengthen commitment to the profession. Acceptance-and-confirmation involves the provision of positive regard, support, and encouragement, which motivates the counselor to try new things on the job (Kram, 1985).

The Need for Competent SUD Counselors

Estimates have indicated that the SUD counselor workforce in the U.S. will grow at a much faster rate than the average rate for all other occupations (U.S. Department of Labor, 2010). In particular, the counselor workforce in SUD treatment and behavioral health is expected to grow 21% between 2008 and 2018. Among staff working in SUD treatment, counselors are the frontline professionals working with clients on a daily basis, more so than other professionals in this type of environment (e.g., physicians, nurses). SUD counselors are responsible for providing a wide range of services including individual and group counseling, crisis intervention, family support, and outreach. SUD counselors also teach daily living skills and help arrange supportive services for clients who complete treatment and are transitioning back to the community (U.S. Department of Labor, 2010).

In addition to general counseling skills, counselors need to be aware of issues that are unique to SUD clients (National Institute on Drug Abuse [NIDA], 2009). The NIDA considers SUD a chronic medical disease that frequently requires long-term behavioral, medical, and pharmaceutical treatment and routinely entails relapse and repeated treatments. Clients may go through withdrawal, need medically-assisted detoxification, and experience intense episodes of cravings and compulsions that counselors have to help address. Thus, counselors have to be trained in a variety of treatment modalities such as behavioral interventions and cognitive therapies. Further, SUD counselors need to be familiar with evidence-based treatment options (Martino, 2010) to provide optimal client care. This also applies to evidence-based practices that are outside of the realm of counselor practices such as the prescription of pharmacology, which is generally restricted to physicians.

SUDs also often occur in combination with co-occurring, co-morbid, and other mental health disorders (SAMHSA, 2008). SUD clients are also at greater risk for infectious diseases such as HIV/AIDS, hepatitis, and tuberculosis that necessitate counselors to assess, educate, and counsel at-risk clients (NIDA, 2009). SUDs affect not only brain function and behavior but also all aspects of an individual's life including family, work, and society. As a result, treatment is complex and typically involves a team of practitioners. The gamut of possible client needs requires well-trained professionals to effectively assist clients in SUD treatment.

Need for ECS to Promote SUD Counselor Competence

Programs accredited by CACREP prepare future professionals to work with clients from diverse backgrounds and with a wide range of mental health disorders, including SUDs. However, the inclusion of training in SUDs is a rather recent addition to the CACREP requirements. The 2001 standards did not include SUD specific domains and only mentioned “substance abuse” four times without further explanation or discussion (CACREP, 2001). In contrast, the 2009 standards specifically provide a section on “addiction counseling” and require students to show proficiency in SUD foundations, counseling/prevention/intervention, diversity/advocacy, assessment, research/evaluation, diagnosis, and skills/practices (CACREP, 2009).

An examination of research findings based on the 2001 CACRAP standards showed that few programs accredited by CACREP required students to take SUD-related course work (Salyers, Ritchie, Luellen, & Roseman, 2005; Whittinghill, Carroll, & Morgan, 2004). Whittinghill et al. found that although 82% of CACREP accredited programs included in their study offered SUD courses, only 30% of them required students to complete at least one SUD course. Similarly, Salyers et al. showed that although 84.5% of the CACREP accredited programs surveyed offered SUD-related courses, only 27% required students to complete SUD-related course work. They further noted that more than 50% of clients encountered by students during practicum suffered from SUDs, and 11% to 50% of student internships occurred in SUD treatment centers. Students, not surprisingly, listed their practicum and internship as the main sources for learning about SUD issues. Thus, in the absence of adequate SUD coursework preparation, ECS seems to be an important aspect of SUD counselors’ professional development.

Additionally, ECS helps counselors, particularly those who lack formal graduate education in counseling, to recognize and deal with counseling-related concerns such as dual relationships and boundary issues, and transference and countertransference within the counselor-client relationship as well as within the counselor-supervisor relationship (SAMHSA, 2007). Dual relationships and boundary issues occur when interactions within the dyad go beyond the professional relationship (e.g., supervisor also becomes the counselor's therapist, counselor also becomes the client's Alcoholics Anonymous sponsor, consensual sexual relationship between counselor-patient or counselor-supervisor). Transference takes place when someone projects an important person onto someone else and expects that person to behave a certain way. For instance, counselors who are themselves in recovery may see themselves in their clients and expect the clients to behave in a very specific way during the recovery process. Countertransference, in contrast, takes place when unresolved personal issues are projected onto another person (e.g., a counselor feeling anger toward a client for no apparent reason, a supervisor seeking approval from a counselor). It is the clinical supervisor's duty to help the counselor identify and overcome counseling-related issues to assure optimal client outcomes. However, because any of these counseling-related issues can occur both within the counselor-client relationship and within the counselor-supervisor relationship, ECS may need to be examined by a third party when dyad issues arise between the counselor and the clinical supervisor.

Current Study and Hypotheses

The purpose of the present investigation was to examine the relationship between ECS in SUD treatment programs and counselor job performance using matched data from counselor-clinical supervisor dyads. Consistent with previous research (Borman & Motowidlo, 1993, 1997; Duarte, Goodson, & Klich, 1994), counselor job performance was conceptualized in terms of task performance (i.e., performance of core job duties) and performance within the supervisory relationship (i.e., willingness to learn, responsiveness to job-related feedback). Further, consistent with discussion of ECS in the literature, we examined counselor reported career-related (i.e., sponsorship, challenging assignments) and psychosocial (i.e., role modeling, acceptance-and-confirmation) mentoring support provided by their clinical supervisor and task proficiency of the clinical supervisor as indicators of ECS (Kram, 1985; Powell & Brodsky, 2004; Ragins & McFarlin, 1990).

The following hypotheses are proposed:

1. ECS (providing sponsorship for counselors' careers, providing challenging assignments, acting as a role model, accepting-and-confirming counselors' competence, supervisor task proficiency) is positively related to counselor task performance.
2. ECS (providing sponsorship for counselors' careers, providing challenging assignments, acting as a role model, accepting-and-confirming counselors' competence, supervisor task proficiency) is positively related to counselor performance within the supervisory relationship.

Method

Design and Setting

Data were obtained from SUD professionals who participated in the 2007 Managing Effective Relationships in Treatment Services (MERITS I) project. MERITS I is a national longitudinal project funded by the National Institute on Drug Abuse (NIDA) and is carried out by researchers affiliated with the University of Georgia. Briefly, MERITS I utilizes the NIDA Clinical Trials Network (CTN) as a platform to examine the work experiences of SUD professionals in the United States. The purpose of the CTN is to investigate the efficacy of evidence-based practices in the field with the ultimate goal to narrow the research-to-practice gap (Hansen, Leshner, & Tai, 2002). The response rate was greater than 80% for both counselors and clinical supervisors.

Treatment organizations were recruited in May 2004 during formal presentations at the CTN's External Affairs Subcommittee Meeting and during the Community Treatment Program Caucus. Some additional community treatment program directors who were recognized leaders within the CTN were also introduced to the study and asked to facilitate recruitment of treatment organizations. A total of 26 CTN-affiliated treatment organizations and 1 non-CTN-affiliated treatment organization agreed to participate in the study. Treatment organizations are defined as relatively autonomous, free-standing operational units that are located in the community (Veteran's Health Administration organizations,

prison-based organizations, and driving-under-the-influence schools were excluded.). The majority of treatment organizations were non-profit entities (89%), free-standing units not located on a hospital campus (81%), and accredited (70%). All major regions of the U.S. were represented with 26% of treatment organizations located in the Eastern U.S., 11% in the Midwest, 26% in the South, and 37% in the West.

Participants

Trained research assistants traveled to treatment organizations to administer paper-and-pencil surveys to all counselors and clinical supervisors who were identified by administrators shortly before the researchers' arrival. Due to high turnover among SUD staff, counselors and supervisors not included on this list were eligible to complete a survey as long as counselors had direct contact with clients in a therapeutic relationship (i.e., individual or group counseling sessions, or both) and clinical supervisors engaged in written and/or face-to-face supervision with their counselors. Almost all of the supervisors (99%) interacted with their counselors face-to-face, which included reviewing case notes or audio/video tapes, observing counseling sessions, or listening to clinical case presentations. Counselors and supervisors who were unable to participate on the day of data collection had the option to complete and mail back the surveys.

Data were obtained from 162 clinical supervisors and 392 counselors who were under their supervision. This yields a sample size of 392 matched counselor-clinical supervisor dyads. On average, clinical supervisors completed performance appraisals on 2.42 counselors (range 1-9 counselors). All procedures were approved by the Institutional Review Board at the University of Georgia. We note here that SUD professionals working in CTN-affiliated organizations have been found to be similar to non-CTN-affiliated SUD professionals (Knudsen, Ducharme, & Roman, 2007). Clinical supervisor and counselor background characteristics are displayed in Table 1 and discussed in the results section.

Dependent Variables

Consistent with existing research (Cascio & Aguinis, 2005; Gatewood & Field, 1994) and to avoid concerns with self-report bias in job performance ratings (Viswesvaran, 2001), clinical supervisors provided ratings of counselors' job performance. The use of multi-source performance feedback is used in many organizational settings (Church & Bracken, 1997; Hoffman & Woehr, 2009). Counselor job performance was measured with two Likert-type scales ranging from 1 = *strongly disagree* to 5 = *strongly agree*.

Counselor task performance—Counselor task performance was measured with a 20-item scale developed for this study following guidelines for the development of performance rating instruments (see Gatewood & Field, 1994; Uniform Guidelines on Employee Selection, 1978). Items included in the counselor performance scale are based on a thorough review of their job tasks using the Department of Labor's O*Net system (<http://online.onetcenter.org/>) and empirical research on counselor job requirements and competencies (e.g., Ellis, 1991; Overholser & Ricciardi, 1992; Powell & Brodsky, 2004; United States Department of Health and Human Services, 1998). Finally, an advisory board panel of nine experts in the field of SUD treatment with varying educational degrees (e.g.,

MSW, PhD, MD) and positions (e.g., executive director of addiction research and treatment services, senior vice president for clinical services, SUD program director) reviewed the instrument and provided feedback on the appropriateness and comprehensiveness of counselor job tasks.

We examined the factor structure of the counselor task performance measure using exploratory factor analysis with maximum likelihood extraction and oblimin rotation. We adopted Kaiser's eigenvalues greater than 1.0 rule, Cattell's scree test, and Horn's parallel analysis as criteria for determining the number of factors to retain. Each of these criteria supported the unidimensionality of the scale. The one-factor solution accounted for a substantial percentage of the variance of the initial solution (98.18%) and factor loadings ranged from .63 to .75. The coefficient alpha for the current study was .95. Sample items from this measure include "Counselor effectively facilitates group interaction to bring about recovery," and "Counselor develops client treatment plans based on evidence-based practices."

Counselor performance within the supervisory relationship—Counselor performance within the supervisory relationship was measured using a seven-item scale developed by Eby, Durley, Evans, and Ragins (2008). The coefficient alpha for this study was .92. Previous research finds that this measure has acceptable reliability (coefficient alpha > .70), as well as construct-related and criterion-related validity (Eby et al., 2008). Two sample items from this measure include, "This counselor is reluctant to change his/her behavior in response to feedback" (reverse scored), and "This counselor's performance does not meet my expectations" (reverse scored).

Independent Variables

Counselors provided ratings of the effectiveness of their clinical supervisors. Clinical supervisors' career-related mentoring behavior was measured with two 3-item scales from Ragins and McFarlin (1990)—*sponsorship* (e.g., "My clinical supervisor helps me reach my career goals.") and *challenging assignments* (e.g., "My clinical supervisor assigns me tasks that push me into developing new skills."). Clinical supervisors' psychosocial mentoring behavior was also measured with two scales from Ragins and McFarlin—*role modeling* (e.g., "My clinical supervisor represents who I want to be.") and *acceptance-and-confirmation* (e.g., "My clinical supervisor sees me as being competent."). Responses for these measures were recorded on a Likert-type scale ranging from 1 = *strongly disagree* to 5 = *strongly agree*. Coefficient alphas for the current study ranged from .90 to .92.

Also consistent with existing research (Cascio & Aguinis, 2004; Gatewood & Field, 1994) and the use of upward performance ratings (Church & Bracken, 1997; Hoffman & Woehr, 2009), counselors provided ratings of effective clinical supervision. Clinical supervisor *task proficiency* was measured using a 14-item scale developed for this study similarly to the counselor task performance measure. Guidelines for the development of performance rating instruments were followed (see Gatewood & Field, 1994; Uniform Guidelines on Employee Selection, 1978). Items included in the clinical supervisor task proficiency scale are based on a thorough review of their job tasks using the Department of Labor's O*Net system

(<http://online.onetcenter.org/>) and empirical research on supervisor job requirements and competencies (e.g., Ellis, 1991; Overholser & Ricciardi, 1992; Powell & Brodsky, 2004; United States Department of Health and Human Services, 1998). The same advisory board experts in the field of SUD treatment reviewed the instrument and provided feedback on the appropriateness and comprehensiveness of clinical supervisor job tasks.

We examined the factor structure of the supervisor task proficiency measure using exploratory factor analysis with maximum likelihood extraction and oblimin rotation. We adopted Kaiser's eigenvalues greater than 1.0 rule, Cattell's scree test, and Horn's parallel analysis as criteria for determining the number of factors to retain. Each of these criteria supported the unidimensionality of the scale. The one-factor solution accounted for a substantial percentage of the variance of the initial solution (69.96%) and factor loadings ranged from .80 to .86. The coefficient alpha for the current study was .98. Sample items include "My supervisor helps me improve my skills as a counselor," and "My supervisor assists me with approaching unique problems that I encounter with clients." Responses were recorded on a Likert-type scale and ranged from 1 = *very ineffective* to 4 = *very effective*.

Control Variables

Control variables included supervisor reports on the number of years they have been supervising each counselor, their perceived relationship quality with each counselor, and counselor reports of counselors' tenure as SUD professionals (in years). Perceived relationship quality was assessed with Allen's and Eby's (2003) four-item scale (e.g., "The relationship between this counselor and I is very effective."). Responses were recorded on a Likert-type scale and ranged from 1 = *strongly disagree* to 5 = *strongly agree*. These variables were included as controls because counselor job performance is likely to be influenced by how long counselors have been working with their clinical supervisors, the quality of that relationship, and the counselors' experience working as SUD professionals (Culbreth & Borders, 1998; Duarte et al., 1994; Powell & Brodsky, 2004).

Data Analysis

Descriptive statistics including frequencies, means, and standard deviations were calculated for all clinical supervisor and counselor variables using SAS 9.2 (see Table 1 for background characteristics). Correlation analyses were conducted to determine the associations among all study variables (see Table 2). The hypotheses were tested with mixed-effects models that take into account the clustering or multi-level structure of the data with counselors being clustered within supervisors (see Table 3).

With clustered data, the assumption is that measurements on units within clusters (counselors with the same supervisor) are more similar than measurements on units in different clusters. We tested this assumption by calculating the intraclass correlation coefficients (ICCs) which showed that 28% of the variance for task performance and 16% of the variance for performance within the supervisory relationship was explained by supervisor clustering. These ICCs suggest a fair amount of clustering within supervisors, requiring the use of statistical techniques that account for the clustering such as mixed-effects models rather than standard ordinary least square regression models. Failure to

account for the clustering can result in misleading inferences. For more detailed information on multi-level data analysis we refer the interested reader to Raudenbush and Bryk (2001). Although an examination of statistical tests did not indicate multicollinearity (variance inflation factors were lower than 3.0), independent variables were centered at the mean to avoid potential issues.

Results

Counselor and Clinical Supervisor Characteristics

Counselors—Results in the left column of Table 1 labeled *Counselors* indicate that the counselors' average tenure in the current SUD treatment center was 4.65 years and the counselors' average job tenure was 3.44 years. Counselors, on average, were 43.62 years old, worked 44.05 hours per week, earned \$33,730 per year, had a caseload of 26.19 clients, and had 56.30% of clients diagnosed with co-occurring psychiatric disorders. The majority of counselors were certified or licensed SUD professionals (55.06%), were females (61.48%), held a master's degree or higher (52.07%), and considered themselves Caucasian (62.50%). Many of the counselors were themselves in recovery (39.36%). Counselors also varied in the extent of educational training they had in SUD (11.82% had none, 46.79% had some, and 41.39% had a great extent) and mental health counseling (7.67% had none, 34.02% had some, and 58.31% had a great extent).

Clinical supervisors—The right column of Table 1 labeled *Supervisors* also shows that the average supervisor treatment center tenure was 8.91 years, the average supervisor job tenure was 5.53 years, and the average supervisor tenure as a clinical supervisor was 7.60 years. In addition, they supervised an average of 6.97 counselors, had a caseload of 11.75 clients, and had 60.21% of clients diagnosed with co-occurring psychiatric disorders. Supervisors, on average, were 47.48 years old, worked 46.90 hours per week, and earned \$51,180 per year. The majority of supervisors were certified or licensed SUD professionals (74.05%), were females (62.73%), held a master's degree or higher (75.16%), and considered themselves Caucasian (76.73%). Many of the supervisors were themselves in recovery (28.85%). They further varied in the extent of educational training they had in SUD (15% had none, 50% had some, and 35% had a great extent), mental health counseling (5.62% had none, 31.25% had some, and 63.13% had a great extent), and clinical supervision (37.50% had none, 56.88% had some, and 5.62% had a great extent).

Descriptive Statistics of and Correlations among Study Variables

The left column in Table 2 shows the means and standard deviations for all variables included in the analyses of the mixed-effects models. According to supervisor reports, counselors' average task performance was 3.26 and performance within the supervisory relationship was 4.04 on a 1 (*strongly disagree*) to 5 (*strongly agree*) scale. In terms of clinical supervisor mentoring behaviors, the averages as reported by counselors were 3.44 for sponsorship, 3.66 for challenging assignments, 3.35 for role modeling, and 3.97 for acceptance-and-confirmation on a 1 (*strongly disagree*) to 5 (*strongly agree*) scale. The average clinical supervisor task proficiency according to counselor reports was 3.07 on a 1 (*very ineffective*) to 4 (*very effective*) scale. Supervisors noted that they supervised their

counselors an average of 1.93 years and rated their relationship quality an average of 3.92 on a 1 (*strongly disagree*) to 5 (*strongly agree*) scale. Finally, counselors reported an average of 7.10 years of experience as SUD professionals.

The right side of Table 2 displays the correlations among all variables. As expected, counselor task performance and performance within the supervisory relationship were both significantly positively related to clinical supervisor task proficiency, sponsorship, challenging assignments, role modeling, and acceptance-and-confirmation. In addition, supervisor reports of relationship quality were significantly positively related to both counselor job performance measures. Counselors' tenure as SUD professionals was also significantly negatively related to their performance within the supervisory relationship. Moreover, there were significant correlations among all independent variables. The control variable relationship quality was significantly positively related with all independent variables with the exception of challenging assignments. Finally, counselors' tenure as SUD professionals was significantly negatively correlated with challenging assignments and significantly positively related with years supervising the counselor.

ECS and Counselor Job Performance

As shown in Table 3, the first hypothesis was partly supported. Consistent with expectation, counselors who received more sponsorship and greater acceptance-and-confirmation by their supervisors had significantly higher task performance ($\beta = .08, p = .003$ and $\beta = .08, p = .003$, respectively). Although the zero order correlations were significant, neither challenging assignments nor supervisor task proficiency were significant predictors of counselor task performance when the other aspects of ECS were simultaneously considered (see Table 3). Also counter to our hypothesis, counselors who received more role modeling by their clinical supervisor were rated significantly lower on task performance ($\beta = -.08, p < .001$). Regarding the control variables, the number of years that the supervisor supervised the counselor was significantly negatively related to task performance ($\beta = -.02, p = .043$) and relationship quality was significantly positively correlated with task performance ($\beta = .33, p < .001$). Counselors' tenure as SUD professional was not significantly related to task performance ($p > .05$).

As shown in Table 3, the second hypothesis was also partially supported. As expected, counselors who received more sponsorship and acceptance-and-confirmation were rated significantly higher on performance within the supervisory relationship by their supervisors ($\beta = .15, p = .003$ and $\beta = .17, p = .002$, respectively). Although the zero order correlations were significant, neither role modeling nor supervisor task proficiency was predictive of counselor performance within the supervisory relationship. Moreover, counter to our prediction counselors who reported receiving more challenging assignments received significantly lower performance within the supervisory relationship ratings from their clinical supervisors ($\beta = -.13, p = .004$). For the control variables, relationship quality was significantly positively related to performance within the supervisory relationship ($\beta = .75, p < .001$), and counselors' tenure as SUD professionals was significantly negatively correlated to performance within the supervisory relationship ($\beta = -.01, p = .004$). No significant

relationship was found between years of supervising a counselor and performance within the supervisory relationship ($p > .05$).

Discussion

The purpose of the current study was to assess whether there is a positive relationship between counselors' ratings of ECS (providing sponsorship for counselors' careers, providing challenging assignments, acting as a role model, accepting-and-confirming counselors' competence, supervisor task proficiency) and clinical supervisors' ratings of counselors' task performance and performance within the supervisory relationship. We find that some aspects of ECS are significantly positively related to both types of counselors' job performance. Consequently, ECS appears to be potentially important for promoting SUD counselors' job performance.

The Role of ECS in Understanding Counselor Job Performance

Interestingly, we found that clinical supervisor mentoring behaviors but not supervisor task proficiency are unique predictors of counselor job performance. The provision of career-related mentoring (sponsorship) and psychosocial mentoring (acceptance-and-confirmation) is consistently positively related to both counselor task and performance within the supervisory relationship. Sponsorship is the most frequently observed type of career-related mentoring support and is aimed at helping with career advancement (Kram, 1985). It involves providing public support and actively nominating someone for developmental lateral moves and promotional opportunities within the organization. In the absence of sponsorship, individuals are often overlooked for important assignments and opportunities (Kram, 1985). Sponsorship may also have a motivational effect on counselors that enhances willingness to learn and makes counselors more responsive to feedback on how to improve on the job. A clinical supervisor who mentors a counselor may provide the type of informal learning that is critical for enhancing job performance.

The provision of acceptance-and-confirmation is also consistently positively associated with counselor task and performance within the supervisory relationship. This type of psychosocial mentoring support involves the clinical supervisor providing support, encouragement, and positive regard (Kram, 1985). This may empower counselors to experiment with new behaviors without risk of negative reprisal (Kram, 1985), which enhances learning and may lead to higher job performance. Efstation's and colleagues' (1990) concept of the working alliance between counselor and clinical supervisor supports our finding that acceptance-and-confirmation predicts counselor performance. The authors discussed how the clinical supervisor uses social influence, acceptance, and rapport building to help counselors acquire skills and motivate them to display these skills on the job. Our findings provide some of the first empirical evidence to support the importance of the working alliance in understanding counselor job performance.

Furthermore, we note three unexpected outcomes. Even though the zero order correlations were positive and significant, clinical supervisor task proficiency was not a unique predictor of counselor job performance. This is surprising considering that counselors have opportunities to learn from higher performing clinical supervisors, which may translate into

greater job performance. However, it is important to note that those clinical supervisors who are more proficient on the job also tend to provide more mentoring support (see Table 2). So, although task proficiency did not demonstrate unique predictive effects on counselor job performance, additional research is needed to gain an understanding of the conditions and types of supervisor task proficiencies that may lead to counselor job performance, help promote counselors' competence, and foster a knowledgeable SUD treatment workforce.

Additionally, role modeling was negatively related to task performance, and providing challenging assignments to the counselor was negatively related to performance within the supervisory relationship. Both of these findings are counterintuitive. However, in contrast to the mixed-effects models, the zero order correlations in Table 2 show a positive relationship between role modeling and task performance and between providing challenging assignments and performance within the supervisory relationship. The reversal in signs could suggest a possible suppression effect, which occurs when the direct and indirect effects of an independent variable on the dependent variable show opposing signs (Cohen & Cohen, 1983). Thus, these results need to be replicated before firm conclusions can be reached.

Practical Implications

Counselors working in SUD treatment programs are helping clients with a myriad of issues. Ongoing professional development is vital for understanding and treating the complexities associated with SUDs to ensure the best client outcomes. However, SUD counselors often lack adequate professional training in working with clients. Only about half of the counselors in our study were licensed or certified SUD professionals, less than half of the counselors noted that they had a *great extent* of SUD coursework in formal training, and slightly more than half of the counselors mentioned that they had a *great extent* of formal training in mental health counseling. In order to promote counselors' SUD training, they should be supported and encouraged to seek out various learning opportunities that could include professional conference attendance, subscription to professional journals focusing on counseling and SUD treatment, seminars or lecture series offered within their treatment organization and their community, or webinars sponsored by professional organizations.

Further, considering the important role that clinical supervisors play in promoting counselors' professional development and job performance, it is important to foster the counselor-clinical supervisor relationship. Based on our findings, clinical supervisors should be encouraged to become mentors to their counselors through providing sponsorship, offering challenging assignments, being a good role model, and being accepting-and-confirming of their counselors. Sponsoring counselors' career development, for example, can be achieved by offering public support of a counselor within the treatment program or nominating an outstanding counselor for a lateral career move and for promotions. Clinical supervisors can provide assignments that are challenging to counselors, which help them to develop new skills. Acting as a role model to counselors is not only related to better performance within the supervisory relationship but also increases a counselor's identity with the SUD profession. Moreover, acceptance-and-confirmation can be conveyed through positive regard, encouragement, and support.

Finally, in addition to provide on-going training for counselors, it is important for clinical supervisors to receive appropriate training. We found that more than half of our clinical supervisors stated that they only received *some extent* of training in clinical supervision in formal educational training. Treatment programs should capitalize on the significantly positive relationship between ECS and counselor job performance. Clinical directors, for instance, could require practitioners to obtain appropriate professional training in clinical supervision prior to promoting counselors to supervisors. In addition, all clinical supervisors could be required to be licensed or certified mental health professionals for counselors to gain the greatest benefits from the counselor-clinical supervisor working alliance.

Limitations and Conclusion

One limitation of this study is the use of a cross-sectional non-experimental design, which only allows us to identify relationships between ECS and counselor job performance. As a consequence we cannot make definitive causal statements regarding the effects of ECS on counselor job performance. Reverse causality is possible for some proposed relationships. For example, as counselor job performance increases, clinical supervisors may provide more career-related and psychosocial mentoring. Future studies using multiple waves of data collection or employing experimental designs are needed to draw firmer cause-and-effect conclusions.

Another limitation is the use of survey data rather than researcher-observed data to assess ECS and counselor job performance. However, there are several limitations associated with observational data including criterion deficiency (incomplete observations of performance due to the practical limitations of extended observation) and criterion contamination (using observers can disrupt the customary work activities being observed; Smith, 1976). Observational data are also less useful for professions where much of the behaviors that comprise effective job performance are not easily quantifiable using observational methods and there is considerable discretion in how to perform job tasks (Smith, 1976). Moreover, other-rated performance data are routinely used in research on job performance, and research supports the validity of such measures (Hoffman & Woehr, 2009). We also included a measure of relationship quality and length of the supervisory relationship in the mixed-effects models pertaining to counselor job performance in an effort to rule out several plausible alternative explanations for our findings: namely that a supervisor rates a counselor higher on job performance if the relationship is higher quality or if the supervisor has been working with the counselor for a longer period of time (Culbreth & Borders, 1998; Duarte et al., 1994; Powell & Brodsky, 2004).

In conclusion, considering the increasing need for qualified and knowledgeable SUD counselors amidst often limited prior training in SUD treatment, it is important to investigate whether ECS can improve SUD counselors' professional development. Examination of our findings shows a link between ECS and better counselor job performance. Thus, it appears that mental health counselors may benefit from ECS in SUD settings such as mentorship and a strong working alliance with their supervisors to help them improve their job performance. Future research in this area should aim to increase our understanding of the link between

ECS, factors that promote counselor professional development in SUD treatment, and the effects on organizational and client outcomes.

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Table 1**Counselor and Clinical Supervisor Characteristics**

	Counselors (n= 392)	Supervisors (n = 162)
Tenure in this treatment program/years (<i>M, SD</i>)	4.65 (5.10)	8.91 (7.50)
Tenure in current job/years (<i>M, SD</i>)	3.44 (4.01)	5.53 (6.42)
Tenure as clinical supervisor/years (<i>M, SD</i>)	N/A	7.60 (6.96)
Total number of counselors under supervision (<i>M, SD</i>)	N/A	6.97 (4.99)
Age/years (<i>M, SD</i>)	43.62 (11.97)	47.48 (10.65)
Work hours/week (<i>M, SD</i>)	44.05 (7.87)	46.90 (8.10)
Annual salary/1,000 (<i>M, SD</i>)	33.73 (9.55)	51.18 (14.24)
Current caseload (<i>M, SD</i>) ¹	26.19 (25.19)	11.75 (10.78)
% clients with co-occurring psychiatric disorder	56.30 (32.22)	60.21 (31.36)
Certified or licensed SUD professional (<i>n, %</i>)	212 (55.06)	117 (74.05)
...as independent counselor	62 (29.25)	35 (29.91)
...as social worker	24 (11.32)	20 (17.09)
...as psychologist	2 (0.94)	1 (.86)
...as "other"	50 (23.58)	28 (23.93)
... no response	74 (34.91)	33 (28.21)
Extent of SUD coursework in formal educational training (<i>n, %</i>)		
None	46 (11.82)	24 (15.00)
Some	182 (46.79)	80 (50.00)
Great	161 (41.39)	56 (35.00)
Extent of mental health counseling in formal educational training (<i>n, %</i>)		
None	30 (7.67)	9 (5.62)
Some	133 (34.02)	50 (31.25)
Great	228 (58.31)	101 (63.13)
Extent of training in clinical supervision in formal educational training (<i>n, %</i>)		
None	N/A	60 (37.50)
Some	N/A	91 (56.88)
Great	N/A	9 (5.62)
Female (<i>n, %</i>)	241 (61.48)	101 (62.73)
Personally in recovery (<i>n, %</i>)	148 (39.36)	45 (28.85)
Master's degree or higher (<i>n, %</i>)	201 (52.07)	121 (75.16)
Race/Ethnicity (<i>n, %</i>)		
Caucasian	240 (62.50)	122 (76.73)
African American	72 (18.75)	14 (8.80)
Hispanic	52 (13.54)	11 (6.92)
Asian	3 (0.78)	1 (0.63)
Multi-racial/Other	17 (4.43)	11 (6.92)

Note.

¹ n = 78 clinical supervisors who carry a caseload

Table 2

Descriptive Statistics and Correlations among Study Variables

	<i>M</i>	<i>SD</i>	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.
Dependent Variables (Counselor Job Performance)												
1. Task Performance	3.26	.43	1.00	.68***	.23**	.12*	.18***	.29***	.23***	.01	.60***	-.03
2. Performance within Supervisor Relationship	4.04	.87	1.00	.27***	.12*	.27***	.33***	.27***	.03	.65***	-.15**	
Independent Variables (Effective Clinical Supervision)												
3. Sponsorship	3.44	1.00	1.00	.59***	1.00	.72***	.57***	.56***	.08	.18**	-.05	
4. Challenging Assignments	3.66	.87	1.00	.49***	1.00	.48***	.50***	.50***	.00	.08	-.15**	
5. Role Modeling	3.35	1.12	1.00	.61***	1.00	.61***	.59***	.59***	.07	.24***	-.07	
6. Acceptance-and-confirmation	3.97	.84	1.00	.54***	1.00	.54***	.54***	.54***	.08	.27***	-.07	
7. Supervisor Task Proficiency	3.07	.69	1.00	.10	1.00	.10	.10	.10	.20***	-.08		
Control Variables												
8. Years Supervising Counselor	1.93	.230	1.00	.14**	1.00	.14**	.14**	.14**	.37***			
9. Relationship Quality	3.92	.73	1.00		1.00					1.00		
10. Counselor Tenure as SUD Professional	7.10	6.88	1.00								1.00	

* $p < .05$

** $p < .01$

*** $p < .001$.

Table 3
 Mixed-Effects Models Results: Counselor Task and Performance within the Supervisory Relationship and Effective Clinical Supervision

	Task Performance			Performance within Supervisory Relationship		
	β	SE	t	β	SE	t
Independent Variables (Effective Clinical Supervision)						
Sponsorship	.08	.03	3.01**	.15	.05	2.92**
Challenging assignments	-.03	.02	-1.32	-.13	.05	-2.87**
Role modeling	-.08	.02	-3.57***	-.07	.04	-1.65
Acceptance-and-confirmation	.08	.03	3.00**	.17	.05	3.11**
Supervisor task proficiency	.06	.03	1.88	.09	.06	1.51
Control Variables						
Supervise counselor/years	-.02	.01	-2.03*	-.02	.02	-1.50
Relationship quality	.33	.0	13.39***	.75	.05	15.86***
Counselor tenure as SUD professional/years	.00	.00	1.09	-.01	.01	-2.85**
<i>n</i>	379			379		
<i>Log Likelihood</i>	269.9			742.2		

* $p < .05$

** $p < .01$

*** $p < .001$