Clinical Supervisor Self-Perceived Addiction Competencies in Response to the Opioid Epidemic

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CLINICAL SUPERVISOR SELF-PERCEIVED ADDICTION COMPETENCIES
IN RESPONSE TO THE OPIOID EPIDEMIC

A DISSERTATION

Submitted to the Faculty of
Montclair State University in partial fulfillment
of the requirements for
the degree of Doctor of Philosophy

by

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May 2020

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CLINICAL SUPERVISOR SELF-PERCEIVED ADDICTION COMPETENCIES
IN RESPONSE TO THE OPIOID EPIDEMIC

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Abstract

CLINICAL SUPERVISOR SELF-PERCEIVED ADDICTION COMPETENCIES
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by Elizabeth A. Conte

As the United States is facing an unprecedented national opioid epidemic it is essential that clinical supervisors who oversee the practice of Licensed Professional Counselors demonstrate understanding, knowledge, and application of addiction competencies. The purpose of this study was twofold: to identify the self-perceived addiction competencies of Approved Clinical Supervisors (ACS), and to examine the predictive value of addiction education (graduate and training courses), direct substance use counseling, and generalist counseling experience in relation to supervisors' self-perceived addiction competency. The results of multiple linear regression analyses indicated that substance use counseling experience had a significant relationship with self-perceived addiction competency. Additionally, when combining all three predictor variables in the model, a positive relationship with ACSs’ self-perceived addiction competencies exists. This dissertation includes an overview of the study, a review of the literature, a description of the study’s methodology, and analysis of the results. Finally, a discussion of the study findings in relation to enhancing addiction training and experience requirements to assist clinical supervisors in providing effective supervision to counselors providing services to individuals with substance use disorders is discussed.

Keywords: clinical supervision, addiction, addiction competencies
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DEDICATION

I dedicate this dissertation to those whose indelible spirit remind me each day of the importance of kindness, generosity, support, laughter, and love: John Thomas Sr. and Ida Conte, Anthony and Filomena Ventello, John Thomas Conte Jr., John Thomas Conte III, Jeanne Conte, and Joseph Guerra.
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CHAPTER ONE: INTRODUCTION

Clinical Supervisor Self-Perceived Addiction Competencies in Response to the Opioid Epidemic

For the first time in United States history, drug poisoning was the leading cause of accidental death, surpassing the number of motor vehicle crashes, firearm deaths, suicide, and homicide (Drug Enforcement Agency [DEA] 2017). Opioid addiction is driving this unprecedented epidemic as a record number of 70,237 Americans died from opioid-related overdoses in 2017 (Center for Disease Control [CDC], 2018d; National Institute on Drug Abuse [NIDA] 2018c). Since 1999, the rate of overdose deaths involving opioids, including prescription pain relievers and heroin, has nearly quadrupled (CDC, 2017b; DEA, 2017). In fact, opioids caused the greatest loss of life from fatal drug overdoses worldwide (United Nations Office on Drugs and Crime [UNODC], 2017). Furthermore, in just one year, nearly 1.3 million Americans needed hospital care for opioid-related issues (Agency for Healthcare Research and Quality, 2017).

On average, 130 people across the United States die every day from an opioid overdose, with more than 46 dying each day from overdoses involving prescription opioids (CDC, 2018a; U.S. Department of Health and Human Services [HHS], 2018). This growing crisis is causing devastating societal effects, placing burdens on workplaces, the health care system, families, states, and communities (Berry, Sullivan, Kmiec, & Douaihy, 2013). NIDA (2018a) estimated that the total cost of substance misuse due to crime, lost work productivity, and health care is more than $740 billion annually. The surge in opioid deaths is attributable to a dramatic increase in pain reliever prescriptions (e.g., oxycodone, Vicodin), drug accessibility, low cost, and the use of highly toxic heroin adulterants such as fentanyl (CDC, 2017a; Cicero, Ellis, & Suratt, 2015; Kerensky & Walley, 2017; NIDA, 2018c). Although certain risk factors affect the likelihood of
developing an addiction (e.g., family history, co-occurring disorder, prescription pain reliever use, peer pressure, history of substance use, gender), there is no evidence to suggest that any racial, ethnic, religious, or socioeconomic group can claim to remain untouched by addiction (Center on Addiction, 2017).

Addiction continues to be one of the most prevalent public health issues in the United States (HHS, 2016; Volkow, Poznyak, Saxena, Gerra, & UNODC-WHO, Informal International Scientific Network, 2017). In fact, one in seven Americans will experience a problem with alcohol or misuse other drugs in their lifetimes (HHS, 2016). Additionally, many of those with a substance use diagnosis will also meet the criteria for another mental health condition. For example, in 2014, about 21.5 million Americans age 12 and older (8.1%) were classified with a substance use disorder (SUD), and approximately 7.9 million adults had co-occurring disorders (Substance Abuse and Mental Health Services Administration [SAMHSA], 2018a).

As the United States is facing an unprecedented national opioid epidemic and health insurance becomes more accessible for mental health and SUD treatment, licensed counselors with or without experience or education in addiction-specific counseling will be called on to treat this population. Seemingly, counselors do possess the skills that can be used to address many of the issues that arise for people when initiating substance use treatment and recovery. Counselors deliver professional counseling services appropriate to their education and experience, and most states consider it within a counselor’s scope of practice to provide services to individuals with SUD. However, not all counselors have had experience working with individuals with SUD or have had addiction specific coursework. Subsequently, to ensure quality care, clinical supervision is essential to guide, evaluate, and monitor counselor practice in serving this
Clinical supervision has many definitions; most agree that it is a collaborative, on-going relationship between a supervisor and supervisee that has the simultaneous purposes of promoting and monitoring clinical proficiency and professional growth (Bernard & Goodyear, 2018; Borders, 2006; Loganbill, Hardy, & Delworth, 1982; Milne & Watkins, 2014). It is an intervention provided by a more senior member of a profession to a junior colleague or colleagues (Bernard & Goodyear, 2018). Supervision encompasses elements of teaching, counseling, and consulting to improve the supervisee’s skills and professional development (Bernard & Goodyear, 2018; Borders, 2014; Milne & Watkins, 2014). Furthermore, clinical supervisors serve as gatekeepers of the profession to monitor the quality of professional services to ensure client growth and safety (Bernard & Goodyear, 2018).

Effective clinical supervisors are skilled, experienced clinicians. A proficient addiction counselor supervisor is one that is not only skilled in supervision but is also knowledgeable about SUD and generally accepted research-based assessments, interventions, treatment, and recovery strategies (CSAT, 2009b; Martino, 2010). They understand the addiction profession and acknowledge and advocate for education and training to strengthen the breadth of addiction treatment competencies (Morgen, 2017; Powell & Brodsky, 2004). For example, supervisors must be willing to provide education about the etiology and course of addiction, the multidimensional nature of addiction, the variety of treatment approaches available, the complexity of treatment pertinent to a substance (i.e., opioids), best practices, and strategies in addiction counseling (Culbreth & Cooper, 2008). Furthermore, all supervisees, including those not specifically working in the addiction field or with co-occurring conditions, would benefit

population (Bernard & Goodyear, 2018; Center for Substance Abuse Treatment [CSAT], 2009a).
from discussions about the biological and psychological vulnerabilities for addiction, potential for doctor shopping, comorbidity with other psychiatric disorders, and various relationships that exist between the multiple influences and consequences of addiction (Madson & Green, 2012). In addition, supervisors educate supervisees about the importance of providing ancillary services for clients and their families, which can extend the supervisee’s original conceptualization of treatment (e.g., co-occurring disorders, HIV positive status, psychosocial services such as housing, financial assistance, and navigation through the criminal justice system (Powell & Brodsky, 2004; SAMHSA, 2011). Finally, clarifying supervisee attitudes and bias toward addiction is critical for the supervisory process for both counselors lacking addiction experiences and for those in recovery who might make assumptions that they understand clients with similar experiences or who may need support for their own recovery (Culbreth & Borders, 1999; Jordan, Miller, & Napolitano, 2008; Madson & Green, 2012).

Given the increase in substance-related counseling presentations, it seems likely that supervisors with or without addiction-specific supervision will be overseeing the work of counselors with and without addiction-specific education. Unfortunately, the prevalence of addiction counseling coursework in master’s degree counseling programs is minimal. For example, out of 859 accredited counseling programs in the United States, only 10 are accredited specifically in addiction counseling (Council for Accreditation of Counseling and Related Programs [CACREP], 2020). Most clinical supervisor training consists of a master’s degree in counseling supplemented with a credential as an Approved Clinical Supervisor (ACS; Center Credentialing & Education [CCE], 2020). The ACS credential allows qualified supervisors to demonstrate their training and experience with the theory and practice of supervision. There are
some clinical supervisors, however, who similar to counselors with dual licensure as a professional counselor and as an addiction specialist, have taken addiction specific coursework or have had addiction-related counseling experience.

**Statement of the Problem**

As the prevalence of substance use and co-occurring disorders, particularly opioid use disorders, continues to increase to epidemic proportions in the United States and around the world, it is inevitable that professional counselors will encounter this problem and subsequently work with individuals with SUD. Although counselors are proficient in providing general counseling services and it is within their scope of practice to treat individuals with addiction, not all counselors have the knowledge and skills to provide quality SUD services. Subsequently, clinical supervision is necessary and is the primary source of support and resources in aiding counselors’ professional development to ensure that they provide ethical and effective addiction treatment services to their clients (CSAT, 2009a; Kavanagh et al., 2003; Kilminster & Jolly, 2000; Mor Barak, Travis, Pyun, & Xian, 2009; Powell & Brodsky, 2004; Wheeler & Richards, 2007). To meet supervisees’ needs in addressing multiple and complex problems in many aspects of substance use and recovery, it is necessary for the supervisor to be proficient in addiction competencies. However, the increase in counseling services provided by counselors with minimal addiction-specific education leads to supervisors overseeing work for which they may not have been specifically trained themselves.

Effective clinical supervision is the primary means through which counselors develop the skills, knowledge, and competence required for effective and ethical addiction practice (DaRamsey et al., 2017; Sias & Lambie, 2006). Supervisors are expected to be knowledgeable in
all clinical areas in which they are supervising as well as remain up-to-date with emerging advances in the field to provide effective supervision (American Counseling Association [ACA] Code of Ethics, 2014; Association for Counselor Education and Supervision [ACES], 2011; Falender & Shafranske, 2017). As clinical supervision has a considerable influence on a clinician’s training, professional development, deployment of knowledge, skills, and competencies, as well as promoting clinical efficacy (Cashwell & Dooley, 2001), identifying supervisors’ self-perceived addiction competencies to advance counselor effectiveness in treating individuals with SUD and co-occurring disorders is needed. To date, however, there are no studies that have measured counselor supervisors’ specialized addiction competencies.

Research Questions

The purpose of the study was to identify clinical supervisors’ addiction competencies and to determine how contextual factors inform their supervisory practice of overseeing the work of counselors who work with individuals with SUD.

The primary questions that guided my study are:

RQ1: What are the self-perceived addiction competencies of Approved Clinical Supervisors?

RQ2: How do years of generalist counseling experience, addiction education, recovery status, and direct substance use counseling experience contribute to supervisors' self-perceived addiction competency level?

Significance of Study

With the influx of individuals requiring addiction treatment considering the opioid crisis, the prominence of co-occurring disorders, and the availability of new funding opportunities,
counselors with and without addiction specific experience and coursework will inevitably treat
clients with addiction and mental health conditions. These counselors require guidance from
clinical supervisors charged with overseeing their work to ensure they provide effective and
ethical services (CSAT, 2009a; Kavanagh et al., 2003; Kilminster & Jolly, 2000; Laschober, de
Tormes Eby, & Sauer, 2013; Mor Barak et al., 2009; Powell & Brodsky, 2004; Wheeler &
Richards, 2007). Effective clinical supervisors may indeed enhance counselors’ performance
and offset limited formal SUD training (Laschober et al., 2013). However, there is little
empirical evidence about clinical supervision in addiction treatment to substantiate these
assertions (Laschober, de Tormes Eby, & Sauer, 2012).

This study contributes to the existing knowledge base and the field of counselor
education and supervision by expanding the research on clinical supervisor addiction
competencies and strategies, the professional development of counselors-in-training, and client
care (Culbreth & Cooper, 2008; Schmidt, 2012). The study results demonstrated the
identification and assessment of ACSs’ self-perceived addiction counseling skills and
knowledge. This data can form the basis for a competency-based model of clinical supervision
that focuses specifically on the specialization and learning outcomes for SUD practice (Falender
& Shafranske, 2007). By developing and implementing competency-based models specific to
addiction counseling supervision, SUD treatment providers and counselor educators can develop
and promulgate strategies that can customize and enhance curriculum and training programs.
These strategies are needed to enhance training, research, and practice to ensure a systematic and
intentional approach to clinical supervision (Falender, 2018; Fouad et al., 2009). The result is enhanced clinical supervision practice that can foster talent development, support collaborative efforts to develop and promote career pathways, ensure fidelity to evidence-based practice, and bridge the gap between behavioral health programs and educational program providers to ensure a supply of workers with the appropriate skills (Alagoz, Hartje, & Fitzgerald, 2017; Baer et al., 2007; Hoge, Morris, Laraia, Pomerantz, & Farley, 2014; Knudsen, Roman, & Abraham, 2013).

**Theoretical Lens**

I used transformative learning theory to provide a lens for identifying how supervisors translate knowledge of addiction into competent counseling practice. Transformative learning theory is grounded in the work of Mezirow (1975) and is a process resulting in a transition of an individual’s understanding of their values, beliefs, assumptions, and worldviews. The result is opportunities to try out new strategies, views, and approaches (Cranton, 1994; Mezirow, 2012). The theory brings to bear a structure of how clinical supervisors may experience, learn, transform, and adapt knowledge, skills, and competencies surrounding the opioid epidemic and treatment of individuals with SUD. Transformative learning theory corresponded fittingly with my study goal to measure the self-perceived addiction competencies of clinical supervisors. Through this study, I identified participants’ knowledge and experiences that guide their supervisory practice to oversee the work of counselors who work with individuals with SUD. I identified clinical supervisors’ self-perceived addiction competencies and categorized the contextual factors that influence their level of addiction competencies. In conclusion, it is important to note that the focus of the study was 1) supervisors’ perceived knowledge as opposed to their development, and 2) supervisors’ perceived knowledge of addiction competencies and not on the actual practice of addiction counseling.
Chapter Summary

Considering the country’s opioid crisis, the increasing number of individuals diagnosed with co-occurring disorders, and new federal, state, and insurance funding opportunities, counselors with and without addiction specific experience and coursework will be called upon to work with individuals with SUD and co-occurring disorders. Some counselors and supervisors may have addiction competencies, and some may not. Regardless, it is incumbent upon the clinical supervisor to ensure that counselors provide effective and ethical services. The study contributes to the gap in the literature regarding clinical supervisor self-perceived addiction competencies via a quantitative study utilizing a survey instrument and data analysis. The study provides the fields of counseling, counselor education, addiction treatment, prevention, government, and public health valuable data to inform future practice and learning.

Organization of the Dissertation

The dissertation is presented in five chapters. In Chapter One, I introduced the topic for this study, presenting the nature of the problem, the significance of the study, and the research design. Chapter Two is a review of the literature. In Chapter Three, I discuss the methodology of the study. In Chapter Four, I present the results of the study, and in Chapter 5, I discuss the study implications and identify the results of the analyses in relation to the project’s research questions, study limitations, and recommendations for future research.

Definition of Terms

The following definitions are provided to ensure understanding and consistency of terms throughout the proposal.
**Addiction.** “A chronic disease characterized by drug seeking and use that is compulsive or difficult to control, despite harmful consequences” (NIDA, 2018e). The terms “addiction” and “substance use disorders” are used interchangeably throughout the proposal.

**Co-occurring disorder.** A term for when someone experiences both a mental health and a substance use disorder (SAMHSA, 2019).

**Credentialing.** An individual process, usually in written form, which provides a basis of confidence and indicates evidence of authority in each field. Credentials are the documents that constitute evidence of training, licensure, experience, and expertise of a practitioner.

**Drug misuse.** “The use of prescription drugs without a prescription or in a manner other than as directed by the prescriber” (CDC, 2017a, Opioid Overdose, Commonly Use Terms section).

**Drug poisoning.** Preferred language of drug overdose; a life-threatening incident that requires immediate emergency attention (Recovery Research Institute, 2018). Drug poisoning may occur intentionally or accidentally when a person misuses a prescription opioid or an illicit drug such as heroin (NCADD, 2018).

**Generalist counseling practice.** Generalist counseling practice refers to the conventional practice of mental health counseling to work with individuals, families, and groups in treating mental, behavioral, and emotional problems and disorders (ACA, 2011). Licensed Professional Counselors (LPCs) who engage in generalist counseling practice are master's-degree practitioners who may develop an area of expertise to work with special populations or issues, requiring advanced knowledge that is documented by coursework, national certification, or a state credential.
Evidence-based practice. “Evidence-based practices are interventions for which there is consistent scientific evidence demonstrating that the desired outcomes are obtained. Rigorous assessments, such as multiple and randomized clinical trials, consensus reviews of available science, or expert opinion based on clinical observation are conducted to identify such practices” (Central Addiction Technology Transfer Center, 2009, p. 3).

Fentanyl. “A synthetic opioid pain reliever many times more powerful than other opioids and is approved for treating severe pain, typically advanced cancer pain” (CDCb, 2018, Opioid Overdose: Fentanyl section, para.1).

Heroin. “Heroin is a semi-synthetic, highly addictive opioid that is made from morphine, a substance taken from opium poppy plants, and can produce intense feelings of euphoria” (CDCc, 2018, Opioid Overdose, Heroin section).

Licensure. “A process by which a governmental authority grants permission to an individual practitioner or health care organization to operate or to engage in an occupation or profession” (World Health Organization, 2019, Health Systems Strengthening Glossary section, para. 6).

Opioids. Opioids are a class of drugs used to reduce pain. They include prescription drugs, such as oxycodone (OxyContin), hydrocodone (Vicodin), and morphine, as well as the illegal drug heroin. These drugs are effective painkillers that slow breathing and produce feelings of relaxation and euphoria. People can become both psychologically and physically dependent on these powerful substances (ACA, 2017; American Psychiatric Association, 2017).

Opioid-related overdose. Overdose via heroin or prescription drugs.
**Opioid use disorder.** A problematic pattern of opioid use that causes significant impairment or distress. Also referred to as “opioid abuse” or “opioid addiction” (CDC, 2017a, Opioid Overdose, Commonly Used Terms section).

**Overdose.** Injury to the body that happens when a drug is taken in excessive amount. An overdose can be fatal or nonfatal (CDC, 2017a, Commonly Used Terms section).

**Oxycodone.** A pain reliever available legally by prescription.

**Recovery.** “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (SAMHSA, 2012, Working Definition of Recovery, p. 3).

**Substance misuse.** The use of any substance in a manner, situation, amount, or frequency that can cause harm to the user and/or to those around them. Prolonged, repeated misuse of a substance can lead to a SUD, a medical illness that impairs health and function. Severe and chronic SUD are commonly referred to as addictions (HHS, 2016).

**Substance use disorder.** A substance use disorder is a medical illness characterized by clinically significant impairments in health, social function, and voluntary control over substance use. Clinically and functionally impairment caused by substance use, including health problems, disability, and failure to meet major responsibilities at work, school, or home. Substance use disorders are measured on a continuum from mild, moderate, to severe based on a person’s number of symptoms (HHS, 2016). The terms “substance use disorders” and “addiction” are used interchangeably throughout the proposal.

**Substance use disorder treatment.** A service or set of services that may include medication, counseling, and other supportive services designed to enable an individual to reduce
or eliminate alcohol and/or other drug use, address associated physical or mental health problems, and restore the patient to maximum functional ability (HHS, 2016).

Vicodin. Vicodin is a brand name prescription opioid pain reliever medication consisting of hydrocodone and acetaminophen. Even when taken correctly, Vicodin can result in opioid addiction and misuse (Drugs.com, 2018).
CHAPTER TWO: REVIEW OF THE LITERATURE

As the United States is currently facing an unprecedented opioid epidemic, increasing numbers of clinical supervisors are needed to ensure professional counselors provide effective addiction counseling services. In Chapter Two, I detail literature identifying the required addiction competencies of professionals working with clients with substance use and co-occurring disorders. I begin the chapter by addressing the rationale for clinical supervisors to have knowledge and experience of addiction competencies and provide a brief history of clinical supervisor education and credentialing requirements. I describe areas of specialization that are fundamental in the delivery of competent supervision and will detail clinical supervisor competencies related to the addiction field. I additionally cite research and draw upon past studies that support the purpose of the study. This review has provided an opportunity to uncover gaps and shortcomings in the literature as well as an opportunity to integrate new findings with previous sources.

Substance use disorders (SUD) are becoming increasingly multifaceted as drug use patterns are changing and co-occurring disorders occur more often. Complex treatment issues, workforce shortages, stigma, and geographical maldistribution of behavioral health providers can create treatment barriers that are associated with premature mortality, productivity loss, high rates of disability, and increased risk of chronic disease (Alegría, Nakash, & NeMoyer, 2018; HHS, 2016). Professional counselors can meet the demand for treatment services, close existing treatment gaps, and promote improved patient outcomes. Accordingly, clinical supervision is essential to prepare and sustain the addiction treatment field with qualified counseling professionals that will contribute to stronger interventions to prevent and reduce addiction, resulting in improved ethical client care (Laschober et al., 2013).
Addiction Counseling

Addiction counseling is a process of helping individuals identify behaviors and problems related to their addiction with the goal of reducing or eliminating their substance use. By establishing a collaborative relationship, clinicians work to engage clients, listen to their stories, and evaluate their mental, physical and addictive behaviors (U.S. Department of Labor, Bureau of Labor Statistics [BLS], 2018). Addiction counselors identify issues, concentrate on what causes clients to engage in addictive behaviors, create goals and treatment plans, and teach individuals how to modify and establish health behaviors (BLS, 2017; SAMHSA, 2018b, Whittinghill, 2005). Additionally, addiction counselors seek to address issues in social, emotional, and occupational functioning. For example, addiction counselors assist clients in finding housing, reestablishing their careers, providing updates and progress reports to courts, referring clients to support groups, setting up aftercare plans, meeting with family members, and providing guidance and support. Additionally, counselors help their clients seek medical help and peer support through groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) and assist their clients in navigating public aid systems (SAMHSA, 2018b; Whittinghill, 2005).

Counselors provide addiction counseling work in a variety of environments including hospitals, residential and outpatient treatment facilities, schools, governmental facilities such as prisons, juvenile detention centers, probation offices, and private practice offices. Addiction counseling is provided on an individual or group level. Individual therapy consists of creating an environment where lifestyle changes can begin. Counseling often focuses on reducing or stopping substance use, skill building, adherence to a recovery plan, and social, family, and
professional/educational outcomes. Group counseling provides social reinforcement for the pursuit of recovery and typically includes psychoeducation using specific protocols, manuals, and worksheets (SAMHSA, 2018b; Stevens & Smith, 2018).

Furthermore, substance use counselors help individuals with both crisis and long-term management issues that range from finding immediate medical help to preventing a return to addiction on an ongoing basis. Counselors employ interventions such as cognitive behavioral therapy, motivational enhancement therapy, and solution-focused therapy (McHugh, Hearon, & Otto, 2010; NIDA, 2018b). Behavioral therapies recommended by SAMHSA (2017a, 2018b) help individuals modify their attitudes and behaviors related to substance use, increase healthy life skills, and participate in alternative forms of treatment including medication.

Addiction counselors assess an individual’s openness to change, enhance client motivation, honor a client’s pathway to recovery, and possess a style and theoretical orientation that best meets the needs of the client (CSAT, 2013; Miller & Rollnick, 2013). Counselors are trained to assist in developing personalized recovery programs that identify clients’ strengths, help to establish healthy behaviors, and provide coping strategies (Miller, 2014). In this regard, the counselor’s role goes far beyond simply listening, teaching, and offering advice, as effective treatment addresses all of the client’s needs, not just their substance use (Miller 2014; NIDA, 2018c). Furthermore, treatment is most successful when tailored to the needs of the individual seeking help and includes family and community support (Van Wormer & Davis, 2018). During the recovery process, counselors will typically offer encouragement and guidance to help clients repair existing relationships if necessary (Connors, DiClemente, Velasquez, & Donovan, 2013;
NIDA, 2018d). Additionally, counselors assist with establishing a support network consisting of caring individuals that will help the individual work toward recovery. Quality treatment is also dependent upon the counselor or facility treatment philosophy, the qualifications of the clinical staff, program dynamics, and the use of best practices as well as the counselor’s ability to address specific demographic needs (Glasner-Edwards & Rawson, 2010; NIDA, 2018d).

Regardless of professional identity or discipline, each treatment provider must have a basic understanding of addiction that includes knowledge of current models and theories, appreciation of the multiple contexts within which substance use occurs, and awareness of the effects of psychoactive drug use (CACREP, 2016; CSAT, 2017; Morgen, 2017).

**Origins of Addiction Counseling**

Historically, addiction counseling consisted of broken attempts to detox individuals in jails and psychiatric institutions. This view of addiction was based on a morality perspective with treatment involving punishment to correct maladaptive and negative behavior (Chasek, Dinsmore, Tillman, & Hof, 2015). This perspective led to the stigmatization of those with addiction disorders and toward the addiction counseling field in general (Miller, Scarborough, Clark, Leonard, & Keziah, 2010). With the advent of the American Society of Addiction Medicine’s (ASAM, 1990) designation of alcoholism as a disease in 1956, societal attitudes about the nature of addiction began to change, and insurance companies began to reimburse for addiction treatment (White, 1998). Consequently, individuals, who for years believed that addiction was a predicament of their own moral demise, were now able to seek treatment with less self-shame.

The origins of addiction counseling began in the 1970s as individuals who were in
recovery from alcohol use realized a need to provide specialized care. These individuals began to deliver counseling services based on their personal knowledge of recovery and treatment. Traditionally, if an individual presented with both a mental health issue and SUD, their treatment was siloed between two systems of care as generalist counselors and other healthcare workers had limited knowledge of addiction (Pedersen & Sayette, 2020; SAMHSA, 2017a). For many years, the system of care remained separated until federal monies required states to provide evidence-based treatment. As a result, states required addiction counselors to become certified or licensed as addiction professionals, and addiction competencies were formulated based on job task analysis and research conducted in the field.

**Addiction Counseling Prevalence**

One of the major challenges facing addiction counselors is the growing gap between the number of clients requiring specialized treatment and those who receive it. In 2017, an estimated 21 million people aged 12 or older needed substance use treatment in the United States (SAMHSA, 2018a). This translates to about 1 in 13 people needing treatment. Among young adults aged 18 to 25, however, about one in seven people needed treatment. Only about one in ten people aged 12 or older who needed substance use treatment received treatment at a mental health or substance use facility in the past year (SAMHSA, 2018a).

Based on these statistics, there is a growing need for behavioral healthcare providers in the United States. In fact, employment of substance use and mental health counselors is projected to grow 20% from 2016 to 2026, much faster than the average rate for all occupations (BLS, 2017). Furthermore, the need for specialized addiction treatment far exceeds therapeutic resources that currently exist (Das & Roberts, 2016; HHS, 2016; White, 2013). Additionally,
with the passage of the Affordable Care Act, Medicaid reimbursement for SUD, and state and federal funding to advance treatment in response to the opioid epidemic, it seems plausible that the need for counselors will continue to soar (Alagoz et al., 2017; HHS, 2018).

Ideally, addiction treatment should be available in all systems of healthcare, not just specialized substance use treatment centers (Van Wormer & Davis, 2018). It seems inevitable, therefore, that all counselors will encounter clients who demonstrate signs of addiction, even if addiction is not the presenting issue (Chandler, Balkin, & Perepiczka, 2011; Miller, 2014; Miller, Forcehimes, & Zweben, 2011; Salyers, Ritchie, Cochrane, & Roseman, 2006; Van Wormer & Davis, 2018). Furthermore, as the opioid crisis deepens in America, counseling professionals, regardless of their area of expertise, are needed more than ever to help address this crisis. As addiction treatment incorporates a wide range of therapeutic processes aimed at meeting the specific needs of the client, including the biological, psychological, and social aspects of addiction, it makes sense that the need for competent counseling practice that encompasses addiction competencies is necessary (Davies, Elison, Ward, & Laudet, 2015; CSAT, 2009b).

Integrated Care

Integrated care is critical to meet the specified needs of the approximately 7.9 million adults in the United States who have co-occurring disorders (HHS, 2016; Mueser & Gingerich, 2013; NIDA, 2018d; Priester et al., 2016; SAMHSA, 2017b). Integrated treatment is a means of coordinating addiction and mental health interventions, rather than treating each disorder separately and without consideration for the other. According to the National Survey of Substance Abuse Treatment Services (N-SSATS, 2018), about 45% of Americans seeking SUD treatment have been diagnosed as having a co-occurring mental health disorder and SUD.
Additionally, multiple national population surveys have found that about half of individuals who experience a mental illness during their lives will also experience a SUD and vice versa (Kelly & Daley, 2013). Furthermore, SUDs co-occur at high prevalence with mental disorders, such as depression, anxiety, post-traumatic stress disorder, and bipolar disorder (HHS, 2016).

Well-supported scientific evidence shows that the traditional separation of SUD treatment and mental health services from mainstream health care has created obstacles to successful care coordination (Hepner, Hunter, Paddock, Zhou, & Watkins, 2011; HHS, 2016; Kessler et al., 2006). That is, one clinician treats the mental health disorder, and another treats the SUD. Services that integrate screening, assessments, interventions, use of medications, and care coordination between general health systems and specialty SUD treatment programs or services promote better care. Integrated treatment brings SUD treatment and health care systems, including behavioral health, into alignment so that they can address a person's overall health, rather than a substance misuse or a physical and mental health condition alone or in isolation. When evidence-based practices such as integrated care are utilized, positive outcomes increase (Kelly & Daley, 2013; Mueser & Gingerich, 2013; Torrens, Rossi, Martinez-Riera, Martinez-Sanvisens, & Bulbena, 2012). However, research demonstrates that the current SUD workforce cannot meet the existing need for integrated healthcare (Haley & Golden, 2015; HHS, 2016).

Professional counselors are in a unique position to provide integrated care and treat co-occurring disorders (Kerwin, Walker-Smith, & Kirby, 2006). Through their comprehensive education, experiences, and skills, professional counselors can provide treatment services that encompass a wide variety of client needs. However, not all professional counselors have had addiction education, internship, or work experiences even though most states consider addiction
treatment within the professional scope of counselor practice (Tabor, Camisa, Yu, & Doncheski, 2011). Many master’s counseling programs do offer an addiction track or advanced addiction course electives and the possibility of students completing a practicum or internship at a SUD treatment facility (Morgen, Miller, & Stretch, 2012). Nevertheless, not all counselors are adequately prepared to provide SUD services as not all counselor education programs require knowledge or skill development in this area (CACREP, 2016). Therefore, to deliver substance use counseling services in an integrated, specialized, and ethical manner, counselors and the clinical supervisors who oversee their practice require knowledge of addiction competencies (ACA Code of Ethics, 2014; Sales, 1999).

Credentials

Addiction counseling is performed by substance use counselors with a specialized license or certification or by individuals, who through their scope of practice can treat people with addictive disorders. This category includes licensed professional counselors, social workers, physicians, nurses, and other behavioral and health care practitioners. There is much debate in the field of behavioral health whether addiction counseling warrants individuals to possess a certification or license as an addiction counselor (Morgen, 2017). However, others in the field maintain that addiction counseling is a specialized field and should only be performed by counselors with specialized training, experience, and competencies (Van Wormer & Davis, 2018).

Regardless of the discipline or credential, the direct impact of SUD is experienced by clinicians in all types of settings. Clinicians need to have some familiarity with the various psychoactive substances, the dynamics of addiction, and the assessment and treatment needs of
those who experience problems with them (Miller, 2014; Straussner, 2013). This includes an understanding of the knowledge, skills, and addiction competencies needed to provide effective and ethical counseling services to clients with SUD (CSAT, 2017; Pederson & Sayette, 2020).

Today, all 50 states require the licensure or certification of addiction counselors; however, each state has different requirements and prerequisites regarding the experience, education, and examination requirements of addiction counselors. These requirements may range from alcohol and drug counselors who possess a high school diploma to a master’s degree. However, most counselors providing addiction counseling adhere to credentialing bodies’ scopes of practice for addiction counselors formulated from SAMHSA’s *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes TAP 21* (CSAT, 2017), which identifies the addiction practice proficiencies determined to be essential to effective counseling for SUD.

Although formulated exclusively for the addiction counseling field, the SAMHSA competencies have become the standard for which all professionals should approach addiction counseling (CSAT, 2017). Prior to the development of these practice competencies, and due to the differing routes of addiction counseling training and certification options, a fragmented approach to addiction counseling training emerged with insufficient literature to guide addiction counseling curriculum standards (Miller et al., 2010; Mustaine, West, & Wyrick, 2003).

**Addiction Competencies**

In addition to general counseling principles of empathic, collaborative planning, addiction counseling has specialized tasks, strategies, and standards that promote wellness and recovery. Hence, to ensure that the treatment needs of individuals are effectively executed, it makes sense that specific competencies guide the skills and knowledge needed for professionals
to facilitate an expanding array of addictions and complex interventions (Duryea & Calleja, 2013; Miller et al., 2011). The goal of developing and implementing core competencies in behavioral health is to advance an understanding of the skill sets and competencies essential to educate and train the workforce. For example, addiction counselors must understand the context in which addictive behaviors and treatment occur as well as knowledge of the community and cultural systems that are embedded within this system (Myers & Salt, 2018). Furthermore, addiction counselors must have familiarity with psychosocial, physiological, and pharmacological knowledge of the nature of addiction and treatment (Graves & Goodwin, 2008; Myers & Salt, 2018), co-occurring disorders, cultural issues, recovery management, and family dynamics (Astramovich & Hoskins, 2013).

In 1974, the first of a series of studies on the credentialing of counselors working in alcohol and drug treatment programs began the movement toward the certification and licensure of addiction counselors (White, 1998). As recognition of addiction and co-occurring disorders continued to expand, so has an ongoing examination about the training, credentialing, and competencies necessary to provide ethical and effective treatment (Duryea & Calleja, 2013). Toward this end, addiction counseling gatekeeping organizations, such as SAMHSA, CSAT, and the National Board for Certified Counselors [NBCC], formed the National Steering Committee on Addiction Counseling Standards and developed a national set of comprehensive knowledge, skill, attitude, and self-awareness competencies to guide addiction counselor practice, development, and curriculum planning (CSAT, 2017). By systematically conducting focus groups and by conducting a role delineation study, the committee collected, evaluated, and developed existing and new addiction educational and professional development curricula. As a
result, in 2006 SAMHSA published the *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes TAP 21* (CSAT, 2017) which identified the addiction practice proficiencies determined to be essential to effective counseling for SUD. This document, authored by the Addiction Technology Transfer Center National Curriculum Committee in 1998 and updated nine times (CSAT, 2017), details eight practice dimensions of addiction counseling, which include 100 discrete competencies. Although there are no consistent national credentialing guidelines for addiction counselors, most states, alcohol and drug associations, and academic institutions adhere to *TAP 21* to guide and promote the ethical practice and best interests of the public, the client, the addiction counselor, and the addiction counseling profession (Lassiter & Culbreth, 2017).

**TAP 21 Practice Dimensions**

*TAP 21* is comprised of three sections of addiction competencies: knowledge, skills, and attitudes. The knowledge competencies focus on counselors’ understanding of the theories, etiology, and treatment of addiction; the skill competencies address aptitude in the provision of treatment services; and the attitude and self-awareness competencies examine counselors’ self-awareness of personal beliefs and biases regarding addictions. This includes openness and flexibility to alternative approaches to traditional biopsychosocial models of treatment and 12-step adherence to recovery (Chasek et al., 2015). The competencies also encompass diversity and counselor willingness to examine beliefs about addictions as important aspects of effective and ethical counseling practice (ACA *Code of Ethics*, 2014; Broadus, Hartje, Roget, Cahoon, & Clinkinbeard, 2010; CSAT, 2017).
More specifically, the practice dimensions are delineated as:

1. Clinical evaluation, which includes screening and assessment, knowledge of diagnostic criteria, assessment instruments, and treatment options;

2. Treatment planning, in collaboration with the client, based on assessment, short and long-term specific and measurable objectives;

3. Referrals based on knowledge of professional and community resources;

4. Service coordination which includes implementing the treatment plan, consulting with other professionals, case management, and continued assessment and treatment;

5. Counseling individuals, groups, families, and significant others;

6. Education, addiction education to the client, family, and community;

7. Documentation, including management of records, preparation of reports, plans, discharge planning, and summaries; and

8. Professional, legal, and ethical responsibilities, including the confidentiality of all health records (CSAT; 2017; Myers & Salt, 2018).

In addition to the practice dimensions, the National Steering Committee on Addiction Counseling formulated Transdisciplinary Foundations comprised of understanding addiction, treatment knowledge, performance readiness, and application to practice (CSAT, 2017). The Transdisciplinary Foundations provide the addiction counselor with a wide knowledge base that includes familiarity with the categories, range and effect of legal and illegal psychoactive substances, risk and resiliency factors in the development of SUD, models and theories of addiction treatment, cultural competency in working with a wide variety of client populations, standards of conduct in the helping relationships, diagnostic criteria, insurance and health
maintenance options, and the roles of the family, social network, and community in recovery (CSAT, 2017; Myers & Salt, 2018).

The TAP 21 addiction competencies have been improving addiction counseling and addiction counselor education across the country in many ways and have become a benchmark by which curricula are developed, and educational programs and professional standards are measured for the field of substance use treatment in the United States. The most common reported application of the competencies has been in curriculum/course evaluation and design for higher education; personal professional development; student advising, supervision, and assessment of competent practices; design of professional development and continuing education programs; and certification standards and exams (Morgen, 2017; Myers & Salt, 2018). Although the TAP 21 addiction counselor competencies describe what fully proficient counselors can do in clinical practice, fundamentally, it is the clinical supervisor’s responsibility to mentor counselor development and facilitate the building of new knowledge and skills, not only during counselors’ early years but also throughout their careers. As such, clinical supervisors overseeing the professional services of counselors treating individuals with SUD require aptitude and proficiency in addiction competencies.

Clinical Supervision

Clinical supervision, a process used to enhance counselor development and protect client welfare, is a fundamental building block for counselor practice and professional growth. The overarching goal of an effective supervisor is to facilitate the independent and competent clinical practice of the supervisee (Bernard & Goodyear, 2018; Falender, 2014). Clinical supervisors assist supervisees in forming a strong therapeutic alliance with their clients, facilitate their
understanding of the therapeutic process and promote the delivery of effective services (Bernard & Goodyear, 2018; Falender & Shafranske, 2017; Wheeler & Richards, 2007). Clinical supervision in all behavioral health fields, including counseling, focuses on teaching and mentoring professionals, monitoring, evaluating, and promoting clinical competencies, and safeguarding the welfare of clients while endorsing effective practice and professional development of the supervisee (Bernard & Goodyear, 2018; Dollarhide & Miller, 2006; Falender & Shafranske, 2017).

Bernard and Goodyear (2018) offered a definition of clinical supervision that is widely accepted in the counseling field that identifies the participants in the relationship, the quality of the relationship, and its purposes. They described clinical supervision as an intervention provided by a more senior member of a profession to a junior colleague or colleagues (Bernard & Goodyear, 2018). The relationship encompasses elements of teaching, counseling, and consulting, which improves the supervisee’s skills and professional development (Bernard & Goodyear, 2018; Borders, 2014). Accordingly, clinical supervisors ensure that counselors adhere to the fidelity of evidence-based practices that increase treatment efficacy and cost-effectiveness (Todd & O’Connor, 2005). Additionally, supervisors offer support and feedback, provide training to strengthen supervisees’ clinical skills, and act as consultants to guide clinical decision-making (Bernard & Goodyear, 2018; Bradley, Kottler, & Lehrman-Waterman, 2001).

Clinical supervisors influence the transfer of knowledge, the development of clinical competencies in trainees, and the quality of services provided to clients (Bernard & Goodyear, 2018; Falender & Shafranske, 2017; Kaslow, 2004; Wheeler & Richards, 2007). Although clinical supervision shares many of the interventions used in counseling, consultation, and
teaching, due to its evaluative and hierarchical nature, the process of supervision differs (Bernard & Goodyear, 2018). For this reason, supervisors not only provide supervisees with ongoing informal and formal evaluations but also serve as gatekeepers of the profession. At minimum, this can be supported through clinical supervisors ensuring their own competency as supervisors (ACA Code of Ethics, 2014; ACES Best Practices, 2011).

Clinical Supervision Competencies

Clinical supervision is a vital component to the counseling field and is recognized as a specialized role, requiring additional training and competence (Getz, 1999; Gray & Erickson, 2013; McMahon & Simons, 2004; Sterner, 2009). Competence is generally understood to mean one is qualified and capable of performing a specific function in a professional manner (Kaslow, 2004). Competencies, on the other hand, are the necessary knowledge, skills, values, and behaviors that guide the interventions a supervisor employs during interactions with supervisees. Each clinical profession has competencies tailored to their respective profession. For example, physicians, nurses, social workers, counselors, and teachers all adhere to competencies within their profession that guide the work that they perform. Many of the competencies surrounding medical, educational, and behavioral health care are similar; however, within each profession, there are general competencies as well as best practices that define a discipline.

Counselor clinical supervision requirements and best practices have been delineated by several organizations including ACA (2014), ACES (2011), CACREP (2016), and the CCE (2020). These organizations have identified the specific skills, knowledge, and experiences for which clinical supervisors must demonstrate competence when performing clinical supervision. Bernard and Goodyear (2018) suggested supervision competency training consist of models of
supervision, counselor development, supervision methods and techniques, the supervisory relationship, evaluation, ethical and professional issues, multicultural competencies, and familiarity with relevant research on supervision. Accordingly, much of the research in the past ten years has focused on how to provide effective supervision, relevant models of supervision, and what should be included in supervision training (Borders, 2014).

Despite overwhelming support for the critical importance and signature pedagogy of clinical supervision, inconsistencies in requirements to function as a clinical supervisor for Licensed Professional Counselors exist across the United States (Borders, 2014). Professional credentialing groups, program accreditation bodies, and state regulatory boards often set their own requirements for supervision (Bernard & Goodyear, 2018). For example, although graduate coursework in supervision is a requirement in CACREP accredited doctoral programs, state licensure boards do not require doctoral degrees as a prerequisite to perform the work of a clinical supervisor. Although most states do require a clinical supervisor to hold a master’s degree, many have never completed formal supervision training (Glossoff, Durham, & Whittaker, 2011; Nelson, Johnson, & Thorngren, 2000), and master’s level counseling curricula do not typically include training in supervision (CACREP, 2016; Nate & Haddock, 2014). Master’s level clinicians may opt to take a graduate class in supervision to meet supervision training requirements issued by state boards, or they can obtain supervision training through continuing education sessions. This practice may become problematic as the 2014 ACA Code of Ethics specifies, “prior to offering supervision services, counselors are trained in supervision methods and techniques” (F.2.a.).
American Counseling Association. The ACA recognizes the responsibility of professional counselors to seek supervision and receive adequate training in supervision before becoming a supervisor. Responsibilities of counseling supervisors outlined in the 2014 ACA Code of Ethics include monitoring the work of supervisees to protect client welfare (F.1.), maintaining professional boundaries within the supervisory relationship (F.3.), and evaluating supervisees’ performance and serving as gatekeepers to the profession (F.6). Furthermore, ACA describes the supervisory function as one that fosters meaningful and respectful professional relationships while maintaining appropriate boundaries with supervisees (ACA Code of Ethics, 2014). Supervisors are expected to possess knowledge of counseling theory, supervision models, and techniques. Additionally, supervisors provide gatekeeping responsibilities and remediation by monitoring the work of supervisees and exhibit honest and fair feedback in their assessment.

Association for Counselor Education and Supervision. In 2011, ACES produced Best Practices in Clinical Supervision that reflects an extensive review of interdisciplinary research, expert consensus in professional literature, legal precedents, input from a range of supervision practitioners, and consensus of the ACES task force members. The task force identified best practices in clinical supervision for 12 areas, including goal setting, providing feedback, conducting evaluations, dynamics of the supervisory relationship, diversity and advocacy, and cultural and ethical considerations. Characteristics, attitudes, and behaviors of the competent clinical supervisor are outlined, and components of effective supervisor preparation, including didactic instruction and supervised practice, are described (Borders, 2014).

Approved Clinical Supervisor. The ACS, established by the Center for Credentialing and Education [CCE], is granted to mental health professionals who have met national
professional supervision standards. “The ACS promotes the clinical supervisor’s professional identity, visibility, and accountability, and encourages professional growth” (CCE, 2020, ACS Approved Clinical Supervisor, Credentialing/ACS section, para. 2). As of 2020, 15 states recognize the ACS as the supervision credential of choice (CCE, 2020).

According to the CCE (2020), the requirements to obtain an ACS include a master’s degree in a mental health field, a license or certification as a mental health provider or certified clinical supervisor, five years of field experience, a 3-credit graduate course in clinical supervision from a CACREP accredited program or a 45-clock hour NBCC approved workshop training in clinical supervision, and a minimum of 100 hours of clinical supervision of individuals providing mental health services. Resembling the ACA Code of Ethics (2014) and the ACES Best Practices for Clinical Supervision (2011), ACS required training includes roles and functions of clinical supervisors, models of clinical supervision, supervisory techniques and styles, legal, ethical, and cultural issues in clinical supervision, and evaluation of supervisee competence (CCE, 2020).

Role of Clinical Supervision in Addiction Treatment

The clinical supervisor’s principle role in the addiction treatment milieu is to guide and support direct service staff in providing quality rehabilitation to clients (McAdam, 2010; Schmidt, 2012). Powell and Brodsky (2004) defined the three main purposes of clinical supervision in an addiction setting as nurturing the counselor’s professional development, promoting the development of specified skills and competencies, and ensuring counselor accountability. Furthermore, many in the addiction field perceive clinical supervision as the key to improved staff retention and turnover, job satisfaction, reduced counselor burnout, and the
quality of care delivered to individuals with SUD (Powell, 1991).

Historically, clinical supervision in substance use settings tended to be an informal and unstructured process evidenced by the paucity of research and literature written on the topic of addictions treatment supervision (DaRamsey et al., 2017; Laschober et al., 2012; Sias & Lambie, 2006). Experience was the only prerequisite to becoming an addiction counselor supervisor, and the assumption was often made that competent counselors, in turn, will be competent supervisors. Consequently, many addiction supervisors were often promoted without adequate preparation and most likely did not receive formal education or training in clinical supervision (Culbreth, 1999; McCabe O’Mara, 2009; Schmidt, Ybañez-Llorente, & Lamb, 2013).

Most practitioners agree that relying solely on one’s recovery status can no longer adequately prepare a counselor to address the complex issues of today’s clients (Hagedorn, Culbreth, & Cashwell, 2012). Additionally, good clinicians are not always naturally good supervisors as research has demonstrated that experience alone does not adequately prepare one to be an effective supervisor (Falender & Shafranske, 2004; Watkins, 2014; Worthington, 2006). Competent clinicians require distinct competencies (Falender & Shafranske, 2004) and more complex treatment issues, including the prevalence of co-occurring disorders, and more recently, the influx of the opioid epidemic necessitated a higher level of sophistication in the training and education of addiction professionals and their clinical supervisors. Some experts postulate that addiction supervision is more complex than clinical supervision practice than in other types of mental health fields (Madson & Green, 2012; McAdam, 2010). For example, treating addiction presents unique ethical challenges that vary by treatment setting, level of care, comorbidity, client motivation, recovery status of the supervisee, and the experience base of the supervisee.
Effective clinical supervisors help counselors identify issues and solutions relevant to SUD that often encompass a variety of complex patient needs (Laschober et al., 2013). Furthermore, clinical supervision prepares and sustains the substance use treatment field with better-qualified professionals that will contribute to stronger interventions resulting in improved care and outcomes. As addiction treatment agencies are increasingly feeling pressured to demonstrate positive treatment outcomes, appropriately trained clinical supervisors can support the ongoing education and development of staff counselors.

Clinical supervisors are the conduit to ensure ethical and effective addiction counseling services (Culbreth, 1999; Fulton, Kjellstrand Hartwig, Ybanez-Llorente, & Schmidt, 2016; Olmstead, Abraham, Martino, & Roman, 2012; Powell & Brodsky, 2004; Roche, Todd, & O’Connor, 2005) and fidelity to evidence-based practice to increase treatment efficacy. As the clinical supervisor promotes clinical competency of counselors working with SUD, co-occurring disorders, and integrated care (Milne, 2009; Todd & O’Connor, 2005), they need to be knowledgeable in all clinical areas in which they are supervising as well as keeping up-to-date with emerging advances in the field beyond general counseling theory (ACA Code of Ethics, 2014: ACES 2011; CSAT, 2009b; Falender & Shafranske, 2017; Stark, LaGuardia, & Trepal, 2014).

As effective addiction supervisors are experienced clinicians who are skilled in supervision, understand the addiction profession, and recognize the potential professional, personal, and ethical matters unique to addiction counselors (Geppert & Roberts, 2008; Madson
& Green, 2012; Morgen, 2017; Taleff, 2010), their competencies need to include knowledge of SUD and accepted research-based assessments, interventions, treatment, and recovery strategies (NIDA, 2018c). For that reason, effective clinical supervisors possess the required credentials, education, and passion for counseling to motivate and support counselors to achieve increased competence and skills that result in improved client outcomes (Powell & Brodsky, 2004). In the United States, two organizations set the supervisory standards for addiction counselor supervisors, the International Certification & Reciprocity Consortium (IC&RC), and the Association for Addiction Professionals (NAADAC, 2019a).

**International Certification & Reciprocity Consortium.** The International Certification & Reciprocity Consortium, created in 1981, establishes, monitors, and advances competency standards for several international addiction credentials, including the Clinical Supervisor (CS; IC&RC, 2018). The CS requires professionals to demonstrate competency through experience, education, supervision, and the passing of a certified clinical supervisor comprehensive examination. Adopted in 1992, one can obtain the CS in 40 countries and the United States.

The CS requires a master’s or doctorate in a counseling-related field, verification of a minimum of 60 hours of alcohol and drug education, and verification of a minimum 30-hour clinical supervisory course. The 30 hours of supervisory education must be completed in the following domains: counselor development, professional and ethical standards, program development and quality assurance, assessment of counselor competencies performance, and treatment knowledge (IC&RC, 2018).

**Association for Addiction Professionals (NAADAC).** NAADAC is a global membership organization of over 10,000 members that offers professional development
opportunities and advocacy for addiction professionals (NAADAC, 2019a). The organization champions a recovery lifestyle for individuals, families, and communities through prevention, intervention, treatment, and recovery support. NAADAC offers the National Clinical Supervision Endorsement credential which is intended to standardize supervisory competencies that encompass an elevated level of effective clinical supervision practice in the addiction field. The National Clinical Supervision endorsement requires a bachelor’s degree or higher in SUD/addiction and/or related counseling subjects (social work, mental health counseling, psychology) from a regionally accredited institution of higher learning, at least five years full-time or 10,000 hours overall of employment as an addiction counselor, and 30 contact hours of education and training specific to addiction clinical supervision (NAADAC, 2019b).

**A Blended Model**

One of the few addiction counseling supervision models was developed by Powell, a notable pioneer in the field (Powell, 1991). Powell described effective clinical supervisors as experienced and skilled senior counselors who possess a wealth of formal knowledge and professional experience regarding substance use treatment and evidence-based practice that they pass on to supervisees (Powell & Brodsky, 2004). He asserted that substance abuse counseling was a unique discipline requiring its own model of supervision, and thus proposed a blended model of supervision that integrated alcohol and drug counseling principles into existing supervision models. In Powell’s view, the focus of supervision in substance abuse counseling had been on skill acquisition (Powell & Brodsky, 2004). However, he understood the necessity to include the emotional/interpersonal dynamics and self-discovery of the counselor into their professional growth (Powell & Brodsky, 2004).
Powell asserted that one's supervisory approach is shaped by several contextual variables including gender, age, race, ethnicity, sexual orientation, recovery/nonrecovery history, formal academic training, religion, and culture (Powell & Brodsky, 2004). Additional contextual factors that affect clinical supervision practice are agency and environmental variables, such as in-patient, outpatient, employee assistance programs, criminal justice settings, duration of treatment, staffing composition, level of treatment provided, treatment philosophy, goals, and treatment outcomes. Furthermore, the training background of the agency, theoretical and philosophical framework for the setting, whether the agency is affiliated with an academic institution as a field placement site, public vs. private sector, sources of revenue, profit vs. not-for-profit, bureaucratic vs. entrepreneurial environment, are key factors that supervisors must take into consideration when providing effective clinical supervision in substance use settings.

**Competency-Based Clinical Supervision**

To conduct supervision effectively, supervisors must be highly knowledgeable about the scientific literature in all clinical areas in which they are supervising as well as the literature regarding clinical supervision that informs the practice. Supervisors overseeing the work of counselors in substance use settings must have competencies in general counseling as well as in addictions counseling. Research has presented guides and practice protocols in the addiction field that identify the knowledge, skills, and requirements individuals must have to effectively conduct addiction clinical supervision. However, the scant research in the addictions treatment field has promulgated a significant lack of support and direction to guide supervisory practice specific to clinical supervisor competencies. A few older articles delineate supervision within the addictions treatment field separately from supervision in the general mental health field (e.g.,
Allen, Szollos, & Williams, 1986; Culbreth, 1999; Culbreth & Borders, 1999; Powell, 1991). However, most of this research is outdated and does not consider the growing demand for clinical supervisors overseeing counselors providing addiction counseling specifically.

There have been a few quantitative studies that have gathered and measured clinical supervisors’ education and experience working with individuals who have SUD (West & Hamm, 2012). However, most of this research examined what supervisees liked about their supervisor and what supervisory interventions were most helpful (Laschober et al., 2013). Other research that has been published on clinical supervision in the addictions field has focused exclusively on dual relationships, recovery issues, ethical violations, and counselor self-disclosure (Gallagher, 2010). While significant, the focus on these specialized areas has left a void in measuring the level of supervisors’ knowledge surrounding addiction competencies.

Research on trends, including supervisor competencies and best practices in addictions in professional counseling, is scarce. For example, in a meta-analysis, Bernard and Luke (2015) found only three articles on substance use counseling supervision in their 10-year (2005–2014) content analysis review of 184 counselor supervision articles in 22 counseling journals. Charkow and Juhnke (2001) found only one article that was published on clinical supervision in the Journal of Addictions and Offender Counseling from 1979 to 1998. Moro, Wahesh, Likis-Werle, and Smith (2016) utilized content analysis to investigate the frequency and type of addictions content within a sample of ACES conference programs and four ACA-sponsored journals (Journal of Counselor Development, Counselor Education and Supervision, Counseling Outcome Research and Evaluation [CORE], and Measurement and Evaluation in Counseling and Development) that appealed to counselor educators. The authors found that only 2% of
conference sessions and articles between 2007 and 2011 addressed addictions counseling. Most of the articles identified in this analysis focused on treatment strategies, particularly among diverse populations.

Because of the scarcity of counseling research specific to addiction supervision and addiction competencies, operationalizing, identifying, and measuring supervisors’ self-perceived addiction competencies could provide the addiction field a systematic structure to identify and measure specialized addiction domains of knowledge, skills, and values. Addiction competencies can establish a set of expectations for clinical supervision in SUD treatment settings, describe the capabilities of fully proficient clinical supervisors, and provide a standard toward which organizations and supervisors can strive (CSAT, 2007; Falender & Shafranske, 2007). In fact, Falender and Shafranske (2007) presented a rationale for the use of a competency-based model of clinical supervision that centers on the careful and systematic formulation of competencies (or learning outcomes) for specific situations, supervision contexts, and for the scope of practice and discipline. Competency-based clinical supervision focuses on intentional use of competencies in supervision and training to provide a framework for understanding, learning, and implementing the multiple functions and tasks of clinical supervision (CSAT, 2017; Falender & Shafranske, 2007). Competencies in clinical supervision include models of supervision; counselor development; supervisory relationship dynamics; supervision methods and techniques; multicultural considerations; counselor assessment, feedback, and evaluation; executive/administrative skills; ethical, legal, and professional regulatory issues; and research on these topics (ACES Best Practices, 2011). A clinical supervisor could, therefore, engage in developing learning strategies and evaluation procedures to meet the addiction competencies and
best practices utilized in the provision of both general and addiction counseling (Falender & Shafranske, 2004). Furthermore, the ongoing identification and assessment of clinical supervisor self-perceived addiction competencies can serve as a platform for goal setting and skill development for the supervisee.

**Addiction Competencies and Ethical Considerations in Counselor Supervision**

Counselors specializing in SUD often face unique situations that result in ethical challenges that other counselors typically do not address. For example, a preponderance of alarming ethical issues surrounding values, boundaries, and relationship issues seem to consume the addiction field (Geppert & Esplin, 2018) and present unique ethical challenges that vary by treatment setting, level of care, comorbidity, client motivation, recovery status of the supervisee, and the experience base of the supervisee (Culbreth, 2000; Haley & Golden, 2015; Madson & Green, 2012; Powell & Brodsky, 2004). To effectively manage addiction treatment and ensure counselors practice within the confines of boards and credentialing and certifying organizations’ codes of ethics, clinical supervisors ensure their supervisees follow and understand standards of conduct. Codes of ethics reflect the profession’s aspirations, expectations, and responsibilities to client care. Furthermore, ethical guidelines protect clients and others, educate the public, and offer guidance in counseling theory, practice, and supervision principles, but also need to possess addiction competencies pertinent to working with individuals with SUD (CSAT, 2009b; Juhnke & Culbreth, 1994; McCabe O'Mara, 2009; Powell & Brodsky, 2004; Roche et al., 2007).

One of the few comprehensive studies on ethics violations in the addiction field conducted by St. Germaine (1997) covering the years 1990 and 1991 categorized national survey data collected from 40 state alcohol and drug counselor certification boards in the United States.
The study representing 32,991 certified addiction counselors with a total sample of 372 ethics complaints found that the most frequent ethics complaints were: 1) dual relationships with current and former clients (28.49%, n = 106), 2) incompetence in the counseling relationship (12.37%, n = 46), 3) practicing without proper certification (9.95%, n = 37), and 4) breach of confidentiality (8.33%, n = 31). Based on these findings, it is essential that clinical supervisors demonstrate addiction competency proficiency to ensure client care, protection, and professional development of their supervisees. Furthermore, because guidelines specific to ethical dilemmas in addiction counseling are not yet established for generalist counselors doing work of an alcohol and drug counseling nature, clinical supervisor oversight is critical (Geppert & Esplin, 2018). In the subsections below, I describe ethical issues noted above as well as describing other trends that often warrant clinical supervisor attention and competence in addiction practice.

**Supervisee Bias about Addiction**

Supervisees’ training, experience, beliefs, and views of addiction can influence the competencies they exhibit in their counseling practice regarding individuals with SUD. Some supervisees may have negative attitudes about addiction stemming from internal or external bias, which could compromise their objectivity in understanding client issues (Lassiter & Culbreth, 2017; McAdam, 2010; Mustaine et al., 2003; White, 1993). Other supervisees hold attitudes that often reflect conventional wisdom (e.g., addiction is a matter of willpower or disease; there is only one method to overcome addiction; people with addiction disorders have personal deficits). Additionally, certain supervisees might favor addiction as a biological or psychological problem and ignore a multifaceted expression of addiction. Other supervisees might hold the attitude that clients need to practice abstinence to receive treatment (Madson & Green, 2012).
An addiction competency for the clinical supervisor is to educate supervisees about the etiology and treatment options of addiction to dispel negative myths, stereotypes, and misconceptions (NAADAC, 2019b). It is vital for clinical supervisors to work with counselors to examine their self-awareness of personal beliefs and biases regarding addictions as aspects of effective and ethical counseling practice (ACA Code of Ethics, 2014; Broadus et al., 2010). For these reasons, it is important that the clinical supervisor addresses the supervisee’s treatment approach and underlying attitudes toward addiction to ensure they are conveying evidence-based practice (Madson & Green, 2012).

Despite the progress of neurobiology, conventional wisdom prevails as many question whether addiction is a brain disease, a medical condition, a personality flaw, a sin against God, or social problem (Geppert & Esplin, 2018). Counselors’ conceptualization of addiction will inform decision-making and ethical rationale (Geppert & Esplin, 2018). Without the guidance, teaching, and oversight of clinical supervision, the lack of contemporary and practical knowledge will continue to reinforce negative social attitudes about addiction, which in turn leads to lost opportunities to screen, diagnose, and treat addiction (Geppert & Esplin, 2018), thus violating standards of practice of counseling professionals.

**Recovering and Non-Recovering Counselors**

A challenge for the addiction clinical supervisor is mentoring recovering as well as non-recovering staff who have similar and varied issues surrounding addiction. Recovering counselors may be particularly vulnerable to imposing their subjective experiences and unconscious beliefs onto their clients (Doukas & Cullen, 2011; Shipko & Stout, 1992; Sias, Lambie, & Foster, 2006). For example, a client’s relapse may provoke unconscious responses in
the recovering clinician (i.e., loss of empathy, impatience) that may negatively affect the counseling relationship. The clinical supervisor’s attention to these potential issues is critical. Another issue causing an ethical dilemma is when a client asks the counselor about their recovery status (Doyle, Linton, Morgan, & Stefanelli, 2008; Madson & Green, 2012). The clinical supervisor needs to exhibit competency regarding the act of recovery self-disclosure and internalized stigma to mentor, counsel, and educate the supervisee. Specifically, the clinical supervisor assists the supervisee in investigating the underlying purpose of the inquiry and how to respond to the client appropriately.

Due to the high potential for ethical and multiple relationship issues present in the addiction field, supervision is necessary for counselors when faced with ethical dilemmas related to social relationships, sponsorship, and self-help group meetings. Addiction counselors, along with other mental health counselors, have an ethical obligation to avoid dual or multiple relationships that could impair professional judgment or jeopardize the welfare of clients (ACA Code of Ethics, 2014; American Mental Health Counselors Association, 2015; NBCC, 2016). Compared with other mental health counselors, substance use counselors have more opportunities to interact with clients outside of the therapy session. For example, counselors who are also in recovery may encounter clients in the 12-step community, former clients becoming colleagues, and relapse potential for the counselor (Powell & Brodsky, 2004). The clinical supervisor’s diligence in assisting supervisees in these areas is paramount to ensuring quality client care void of boundary violations.

**Burnout**

Counselors face a day-to-day regimen that puts them at a higher risk of burnout in
comparison to other professions (Madson & Green, 2012). Similarly, addiction counselors work under difficult conditions that often cause burnout including funding cuts, restrictions on the delivery of services, changing certification and licensure standards, mandated clients, and clients that need distinct care (Osborn, 2015; Oser, Biebel, Pullen, & Harp, 2013). Other situational factors such as low salaries, staff turnover, agency challenges, limited opportunities for advancement, challenges of working with clients who have high relapse rates (Festinger, Rubenstein, Marlowe, & Platt, 2001; Hubbard, Flynn, Craddock, & Fletcher, 2001), and high rates of psychiatric comorbidity create additional burdens for addiction counselors (McGovern, Xie, Seqal, Siembag, & Drake, 2006).

Competent clinical supervisors conduct themselves in a manner that models and sets an example in support of the agency mission, vision, philosophy, wellness, and recovery principles (ACA Code of Ethics, 2014; CSAT, 2009b; McAdam, 2010). They can make a substantial difference in the day-to-day work of counselors and help to mitigate burnout (Eby, Burke, & Birkelbach, 2006; Knudsen, Ducharme, & Roman, 2008; Roche et al., 2007; White, 2013). Furthermore, Knudsen et al., (2008) found that U.S. substance use counselors’ high rating of clinical supervision was associated with less intention to leave their jobs, less emotional exhaustion, greater feelings of autonomy, higher perception of fairness in decision making in the organization, and in job demands and rewards.

**Diversity**

Addiction treatment and recovery have many pathways that counselors tailor to fit the unique cultural, psychological, and behavioral health needs of individuals (HHS, 2016; NAADAC, 2019a; Pincus, Scholle, Spaeth-Rublee, Hepner, & Brown, 2016; SAMHSA, 2017a).
Because recovery is a highly individualized process, recovery services and supports must be flexible to ensure cultural relevance. Lack of culturally responsive services or culturally incompetent staff may be a reason for the underrepresentation of people of color and ethnic minorities in substance use and mental health treatment (Eliason & Amodia, 2006; HSS, 2016). Furthermore, when culture is ignored, individuals and families are at risk of not getting the support they need, or worse, receiving misdiagnosis and improper treatment (Zhang & Burkard, 2008).

It is the clinical supervisor’s responsibility to broach the subjects of race, ethnicity, and culture during supervision (Day-Vines et al., 2007). As part of their role in overseeing competent addiction counseling services, clinical supervisors address diversity in the delivery of services and seek to reduce health disparities in access and outcomes. Clinical supervisors assist counselors with understanding and developing cultural self-awareness to ensure they are not at risk of imposing their values onto clients (Cashwell, Looby, & Housley, 1997; Constantine, 2003; NAADAC, 2016; Stoltenberg, 2005). Additionally, clinical supervisors ensure that counselors are responsive and respectful to the health beliefs, practices, and cultural and linguistic needs of diverse people and groups (ACA Code of Ethics, 2014; CACREP, 2016; Sue & Sue, 2016). The result is counselors possessing higher levels of multicultural competence providing more effective care with their clients compared to counselors scoring at lower levels of competency (Arredondo, 1999; Ponterotto, Casas, Suzuki, & Alexander, 2010; Pope-Davis, Coleman, Ming Liu, & Toporek, 2003).

**Evidence-Based Treatment: Medication-Assisted Treatment (MAT)**

Today most states mandate that licensed, federally, and state-funded addiction treatment
facilities provide evidence-based practice affirming the necessity for clinical supervisors to be well trained in the implementation and monitoring of addiction treatment models (Glasner-Edwards & Rawson, 2010; SAMHSA, 2018c). Evidence-based programs have been shown to have positive outcomes through high quality research. Medication-Assisted Treatment (MAT), an evidence-based treatment, is the use of FDA-approved medications often in combination with counseling and behavioral therapies to treat SUD and to prevent opioid overdose and improve quality of life (NIDA, 2016, 2018d; SAMHSA, 2015, 2017a; Timko Schultz, Cucciare, Vittorio, & Garrison-Diehn, 2016). Unfortunately, many providers have negative or conflicting attitudes towards the use of medications used to treat opioid use disorders despite years of research supporting their effectiveness (Fitzgerald & McCarty, 2009; Knudsen, Ducharme, Roman, & Link, 2005; Matusow et al., 2013; Rieckmann, Daley, Fuller, Thomas, & McCarty, 2007; Rieckmann, Kovas, McFarland, & Abraham, 2011). Additionally, many clients report that they often feel misunderstood, looked down upon, and stigmatized by addictions counselors (Conner & Rosen, 2008). Subsequently, potential barriers to treatment occur as clients may choose not to enter treatment, may lack trust in the therapeutic relationship, and develop self-shame (Conner & Rosen, 2008; Smye, Browne, Varcoe, & Josewski, 2011).

One of the misconceptions surrounding the use of MAT is the belief that MAT is substituting one substance for another (NIDA, 2016, 2018d; White, 1998). As a result, many policymakers, criminal justice systems, treatment providers, clients, and family members have adhered instead to an abstinence-only philosophy that avoids the use of medications. Such views are not scientifically supported as research has demonstrated that MAT decreases opioid use, opioid-related overdose deaths, criminal activity, and infectious disease transmission (NIDA,
2016; 2018d). Additionally, MAT increases treatment retention and social functioning (Maglione et al., 2018; NIDA, 2016, Timko, et al., 2016). In this respect, clinical supervisors play a pivotal role in ensuring that counselors develop knowledge of SUD and accepted research-based assessments, interventions, treatment, and the pharmacological knowledge of the nature of addiction and treatment (CSAT, 2009a; Graves & Goodwin, 2008; Myers & Salt, 2012).

**Theoretical Framework**

The study was framed by Mezirow’s (1975) transformative learning theory (TLT). Transformative learning is a process resulting in a transition of an individual’s understanding of their values, beliefs, assumptions, and worldviews that results in opportunities to try out new strategies, views, and approaches (Brookfield, 1987; Cranton, 1994; Mezirow, 2012). TLT is focused on adult learning, particularly in the context of post-secondary education. Mezirow (1991) developed TLT as he studied the changes that occurred among adult women reentering higher education. He found that the study participants did not merely adapt to changing circumstances by applying old ways of learning. Instead, Mezirow (1978) theorized that adults bring to the learning experience preconceived thoughts and feelings that are influenced by values and feelings.

An important part of transformative learning is for individuals to change their frames of reference through an ongoing process of critical reflection (Baran, Correia, & Thompson, 2011). Critical reflection occurs when adults explore the implicit rules that inform their thinking and reflect upon the appropriateness of judgments and actions (Brookfield, 1987). Through the process of reflecting on their assumptions and beliefs, individuals consciously make and implement plans that expand their worldview. When confronted with situations in which
formerly established rules that govern thinking and behavior no longer work, individuals are challenged to consider the validity of these assumptions. Assumptions may be epistemological, logical, ethical, psychological, ideological, social, cultural, economic, political, ecological, scientific, or spiritual, or may pertain to other aspects of experience (Mezirow, 2000). It is making sense of these assumptions and experiences that can result in a change in belief, attitude, or perspective (Merriam, 2018). With transformational learning comes a new way of perceiving and understanding things more systemically, which allows a connection to a bigger picture (Carroll, 2009).

The main principle of transformative learning theory is the notion that adults bring life experiences in addition to knowledge to their learning experiences. These structures of meaning are significant and of interest to professional counselors and clinical supervisors because our sense of self, values, and beliefs are firmly grounded in these frames of reference. For instance, the transformative learning principles regarding self-awareness and professional development are complementary to the ACA Code of Ethics (2014). Furthermore, adult learning capabilities of critical self-reflection and challenging existing perspectives aligns with the counseling profession’s emphasis on personal values, respecting the diversity of clients, flexibility, self-growth, and seeking training especially when the counselor’s values and beliefs are inconsistent with those of the client (ACA Code of Ethics, 2014).

There are several other commonalities between transformative learning and counseling practice. For instance, both emphasize the importance of trust and forming relationships, using critical thinking and conceptualization skills, examining beliefs and value systems, and looking at assumptions and worldviews. As such, TLT corresponded fittingly with my study goal to
measure the self-perceived addiction competencies of clinical supervisors as concepts from the theories and models of TLT can be applied to the field of counseling and more specifically to teaching and learning counseling skills and methods (Fazio-Griffith & Ballard, 2016). From this perspective, Mezirow’s transformative theory offers a theoretical lens to understand how clinical supervisors may experience, learn, transform, and adapt knowledge, skills, and competencies surrounding the opioid epidemic and treatment of individuals with SUD.

Similar to TLT, the ACA Code of Ethics (2014) emphasize that counselors reflect on how their worldview can impact their work with clients. Additionally, counselors have a professional responsibility to evaluate their counseling practice and seek improvement as needed. The results are counselors who become reflective practitioners and actively strive to continually improve their practice (Helyer & Kay, 2015). From this perspective, counselors and their supervisors have an ethical and professional responsibility to recognize and analyze their assumptions about the causes of client behavior. Similar to counseling philosophy, Mezirow (2000) postulated that learning experiences depend on the context – biological, historical, cultural – in which they are embedded.

As clinical supervisors engage in the practice of critical reflection concerning existing frames of reference regarding their counseling skills and addiction competencies, an internal dialogue allows them the opportunity to examine assumptions and beliefs to determine their validity in light of information obtained from forming new relationships and learning experiences. Transformative learning may occur when clinical supervisors need to reevaluate their understanding of addiction, its causes, and treatment. Specifically, clinical supervisors who are working with individuals with substance use, particularly opioid use disorders, may be faced
with needing to learn new skills and strategies to confront the epidemic. Through a process Mezirow (1991, 1994, 2009) calls “disorienting dilemma,” old schemas of the nature of addiction as well as what constitutes someone with an opioid use disorder may require a change in thinking to embrace a new perspective. Subsequently, through critical self-reflection of their self-perceived addiction competencies, clinical supervisors may discover that it is beneficial for them to examine their frames of reference to acquire new skills. This includes identifying previous educational or work experiences and reflecting on cultural and historical assumptions that may color or bias their self-perceived attitudes and knowledge about the nature of addiction and its treatment.

Using the transformative theory lens, I identified and analyzed supervisors’ self-perceived addiction competencies to determine what variables assisted them in constructing new or revised interpretations related to their learning and understanding of addiction (Mezirow, 1991), opioid use, and the treatment modalities required to provide effective counseling services. Transformative learning results in a change of mindset or behavior rather than simply the transfer of ideas or knowledge alone (Carroll, 2009). A clinical supervisor who recognizes the need to develop greater addiction competencies would first determine how to make new knowledge fit within their existing beliefs and value structures. Additionally, the clinical supervisor may weigh evidence and assess arguments about the nature of addiction with greater awareness to critically reflect and challenge outdated assumptions. In this regard, addiction competence can manifest from clinical supervisors’ learning experiences that may include classroom instruction, mentorship, clinical supervision, treatment setting experience, personal and familial recovery experiences, or obtaining a clinical supervisor certificate specific to addiction counseling.
Through these experiences, clinical supervisors may come to realize their feelings of discontent in response to assumptions and schemas and thus challenge existing perspectives regarding their understanding of addiction competencies, strategies, and counseling practice. Subsequently, by identifying a need to enhance their knowledge of addiction competencies, clinical supervisors might participate in on-going professional development activities which may include completing or teaching classes in substance use counseling, consulting with peers, supervision of supervision, researching more accurate and complete information, or working with a mentor.

Chapter Summary

Although addiction research has increased, research on ethical standards pertinent to addiction counseling competency has not (Gallagher, 2010). To address this gap in the literature, I measured supervisors’ self-perceived addiction competency level to inform supervisory education, learning, practice, and development. Because of the limited research on the topic, measuring the self-perceived addiction competencies of clinical supervisors can offer valuable data that can prepare clinical supervisors to fulfill their role. Additionally, a measure assessing perceived addiction competencies could play a pivotal role in the provision of competent counseling services, the professional development of counselors-in-training, and client care (Culbreth & Cooper, 2008; Schmidt, 2012). Without this identification and evaluation, clinical supervisors lack guidance to provide effective oversight to addiction counselor practice. Outcome research that focuses on addiction counseling and self-perceived addiction competencies has the potential to bridge these gaps, particularly for counselor practitioners and educators who did not receive formal training in addiction counseling (Moro et al., 2016).
CHAPTER THREE: METHODOLOGY

The need for quality addiction counseling services is paramount to addressing the United States’ opioid crisis. The clinical supervisors who provide oversight of effective addiction counseling practice are professionally and ethically responsible for addressing many aspects of substance use and recovery (ACA Code of Ethics, 2014). To assess whether clinical supervisors can fulfill this role, I measured factors that contribute to ACSs’ level of self-perceived addiction competencies via two research questions. Research question 1 was “What are the self-perceived addiction competencies of Approved Clinical Supervisors (awareness, understanding, applied knowledge, and mastery)?” The second research question was “How do years of generalist counseling experience, addiction education, recovery status, and direct substance use counseling experience contribute to supervisors' self-perceived addiction competency level?”

By identifying clinical supervisors’ self-perceived addiction competencies and determining how contextual factors inform their supervisory practice, the study may add to the literature and provide valuable data to inform future counseling and supervision practice. Using multiple linear regression, I ran statistical analyses to determine the degree of relationship between the outcome variable, self-perceived addiction competencies, and the predictor variables, years of generalist counseling experience, addiction education, recovery status, and direct substance use counseling experience (Sprinthall, 2011).

This chapter is divided into several sections addressing the research design, participants, sampling procedures, instruments, data collection procedures, and methods of analyzing data. The goal of this chapter is to describe the procedures that were used to answer the study’s research questions.
Method

In order to answer the research questions, I used a quantitative design with cross-sectional survey data to identify and categorize supervisors’ self-perceived addiction competencies into five levels: awareness, understanding, applied knowledge, mastery, and no familiarity. I chose a quantitative research design because it utilizes survey-based methods to provide statistical estimates of a target population, in this case, Approved Clinical Supervisors (ACS). I administered an online survey to assess ACSs’ self-perceived addiction competencies because online surveys are a reliable and efficient method to collect information from multiple respondents in an efficient and timely manner (Nardi, 2018). After administering the survey, I analyzed ACSs’ addiction competency results with two statistical procedures. First, I used descriptive statistics to categorize the levels of supervisors’ self-perceived addiction competencies. Secondly, I used multiple linear regression to explore relationships among the predictor variables of years of generalist counseling experience, addiction education, recovery status, and direct substance use counseling experience to determine what factors contribute to supervisors’ self-perceived addiction counseling competencies.

Participants

The participant pool included ACSs in the United States. Only those participants who met the following criteria were eligible to participate in the study: (a) professional counseling licensure within the United States, (b) absence of licensure or certifications in addiction, (c) a graduate degree from a counseling program with a concentration other than addictions counseling, and (d) certification as an ACS. Because the study measured self-perceived addiction competencies of clinical supervisors practicing from a generalist counseling perspective, clinical
supervisors possessing a master’s degree, license, or certification in addiction counseling were excluded from the study.

**Instrumentation**

Participants were asked to respond to a two-part survey. The first part of the survey measured self-perceived addiction competencies, and the second asked participants to provide demographic information.

**Self-Perceived Addiction Competencies Survey.** To demonstrate effectiveness in overseeing the work of counselors working with individuals with SUD, it seems reasonable that clinical supervisors’ personal learning progresses toward an appropriate level of addiction competencies. However, a literature search found no valid and reliable measures for assessing clinical supervisors’ self-perceived addiction competencies or measuring the impact competencies have on supervisors’ practice. Consequently, it was necessary to develop an instrument to measure this construct.

I created an instrument measuring addiction competency adapted from the *Performance Assessment Rubrics for the Addiction Counseling Competencies [Rubrics]* (Gallon & Porter, 2011). The *Rubrics* were formulated based on the SAMHSA *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice as a Technical Assistance Publication: TAP 21* (CSAT, 2017). First published in 2006, the *TAP 21* competencies were developed through an expert and rigorous review process and have been revised nine times to keep up with emerging trends in the addiction field (CSAT, 2017). Furthermore, the *TAP 21* competencies have since become a standard in the field for the
development of addiction counseling curricula and the assessment of counseling proficiency (CSAT, 2017).

*TAP 21* identifies 123 competencies essential to the practice of addiction counseling; however, they do not speak to how a clinician might progress towards addiction counseling mastery over time. To assess such progress counselors, supervisors, and counselor educators need a series of benchmarks or descriptions of counselor addiction knowledge and behavior along a learning continuum. To that end, the *Performance Assessment Rubrics for the Addiction Counseling Competencies [Rubrics]* (Gallon & Porter, 2011) were developed to compliment *TAP 21* and describe in general terms what accomplished addiction counselors can do. The *Rubrics* are divided into two broad categories, Transdisciplinary Foundations and Practice Dimensions. The Transdisciplinary Foundations category comprises the core knowledge and attitudes thought to be requisite to the development of evaluation, brief intervention, treatment, and recovery support skills. The Practice Dimensions include competencies believed essential to the provision of effective intervention, treatment, and recovery services for individuals, families, and significant others. The Transdisciplinary Foundations section focuses on the beginning or initial application of addiction-focused competencies, whereas the Practice Dimensions section was developed to assess the practice of more seasoned alcohol and drug counselors who have worked specifically in the addiction field.

Because provider roles from all healthcare disciplines are changing due to the increase in substance use surrounding the opioid epidemic, it seems that professional counselors and their supervisors would benefit from increased understanding and skills surrounding addiction competencies. I chose questions from the *Rubrics*’ (2011) Transdisciplinary Foundations section
as opposed to the Practice Dimensions section to create the *Self-Perceived Addiction Competencies Survey*. The Transdisciplinary Foundations reflect a basic understanding of addiction, screening, brief intervention, recovery support skills, behavior change, and methods for professional readiness, which include issues related to self-awareness, diversity, and ethics, all of which align with the construct of interest.

Furthermore, the Transdisciplinary Foundations encompass multidisciplinary competencies that would benefit any professional providing work of an alcohol and drug counseling nature. I chose not to include the Practice Dimensions in the survey since they reflect competencies of more seasoned counselors with substantial addiction experiences. It is possible that less seasoned supervisors with a generalist counseling background or limited addiction experience might be unfamiliar with the advanced Practice Dimensions competency categories and thus cause outliers in the survey data. Therefore, I chose the Transdisciplinary Foundations because they comprise fundamental competencies of addiction practice, and it seems that they would provide a reliable measure of clinical supervisors’ level of self-perceived addiction competency.

I chose all but four of the 23 Transdisciplinary Foundation competency statements to be included in the survey. I excluded items or tasks that were not specific addiction-related responsibilities since the purpose of the study was to inform clinical supervisors’ learning and understanding of addiction-related concepts, particularly considering the opioid crisis. For example, I excluded an item that focused on utilization review, which is an administrative addiction agency function that a bachelor’s-level alcohol and drug counselor typically is responsible to perform. Additionally, competencies of a generalist counseling nature, which are
not specific to the addiction field, such as communicating with other professionals and knowing how to make a referral, were excluded. Furthermore, I chose not to include a question regarding clinical supervision as this competency is a requirement for ACS certification, and that credential is already part of the inclusion criteria (CCE, 2020).

I added one question to the survey to assess participants’ self-perceived knowledge and familiarity with the use of FDA-approved medications in treating opioid use disorders. Medication-Assisted Treatment (MAT) along with a combination of counseling and behavioral therapies have been found to be effective in providing a holistic approach in treating opioid use disorders (Kampman & Jarvis 2015; SAMHSA, 2015). However, the use of MAT is greatly underutilized (Volkow, Frieden, Hyde, & Cha, 2014). To expand the use of MAT in preventing overdose, normalizing brain chemistry, and saving lives, it seems reasonable that clinical supervisors overseeing the practice of counselors working in the addiction field minimally recognize and understand the pharmacological properties of MAT. Therefore, a question relating to the identification, efficacy, and importance of understanding and utilizing MAT therapies was included in the survey.

Finally, to test the literacy level of the survey items, I researched the most appropriate reading level to garner high survey response rates and ease of comprehension. I discovered that most surveys are constructed based on the average American reading ability of seventh to eighth grade (Kirsh, Jungeblut, Jenkins, & Kolstad, 1993). The Flesh Kincaid Grade readability statistics for the *Self-Perceived Addiction Competencies Survey* measured at Level 13.5. Since the study participants are master’s level clinicians and not average respondents, a 13.5
readability grade level is an adequate reading level for participants (Calderón, Morales, Liu, & Hays, 2006). The full survey can be viewed in Appendix A.

**Levels of self-perceived addiction counseling competency.** Participants were asked to respond to 20 questions measuring addiction competencies on the *Self-Perceived Addiction Competencies Survey*. The questions encompass a variety of issues pertinent to addiction counseling, including the effect of psychoactive substances, addiction treatment modalities, and the importance of family, social networks, and community systems in the treatment and recovery process of addiction. An explanatory statement precedes each question describing the content area specific to the competency that is being assessed. Following the explanatory statement are four descriptions of addiction competency proficiency categorized as awareness, understanding, applied knowledge, and mastery in understanding and applying the addiction concepts. Respondents are asked to rate their self-perceived addiction competencies by choosing the category with which they most identify. To avoid social desirability or response fatigue, I removed the response descriptors of awareness, understanding, applied knowledge, and mastery. An example of an explanatory statement and competency measures are described in the table below.

Table 1

**Self-Perceived Addiction Competencies Survey**

<table>
<thead>
<tr>
<th>Recognize Medication-Assisted Treatment (MAT), its use, and efficacy in the treatment of substance use disorders.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am familiar with the pharmacological properties of MAT.</td>
</tr>
<tr>
<td>I understand the pharmacological properties of MAT and how it acts in treating opioid use disorders.</td>
</tr>
</tbody>
</table>
Recognize Medication-Assisted Treatment (MAT), its use, and efficacy in the treatment of substance use disorders.

<table>
<thead>
<tr>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>I support the use of MAT in a combination of counseling and behavioral therapies to treat substance use disorders and to prevent opioid overdose.</td>
</tr>
<tr>
<td>I can differentiate between the different types of approved medications in the treatment of opioid use disorders and make recommendations to my clients, community members, and others regarding their use.</td>
</tr>
<tr>
<td>I am not familiar with any of the above.</td>
</tr>
</tbody>
</table>

The ratings corresponded to the participants’ awareness, familiarity, understanding, application, or integration of addiction-focused topics and their responsibilities in meeting the needs of clients who use substances. If a participant was not acquainted with the explanatory statement or its content, they were able to answer, “I am not familiar with any of the above.”

Gallon and Porter (2011) described the Transdisciplinary Foundation ratings as the following:

*Awareness* implies a limited or beginning understanding of the multiple factors involved in substance use disorders and the evidence-based interventions, treatment tools, and recovery models available. *Understanding* indicates a knowledgeable, well informed individual who may or may not provide addiction services directly. This level of knowledge is typically achieved only after several years of study and/or practice. *Applied knowledge* is achieved by individuals who are knowledgeable about addiction and recovery and who apply their knowledge either in general practice or specialty treatment/recovery settings. Typically, this level of expertise is achieved by specialists in addiction, but individuals at this level may also work in settings which are multidisciplinary with a special sensitivity, charge, or mission to identify and provide limited services to people.
with substance use disorders. *Mastery* is typically achieved as a result of several years practice in clinical settings, either generalist or specialist. The individual is often a clinical leader who continuously reviews client services and the professional literature to assure the most effective treatment design (p. 6).

Finally, because the *Performance Assessment Rubrics for the Addiction Competencies* were developed as a tool for supervisors to use in assessing counselor proficiency in performing substance use counseling and responsibilities, there has not been extensive use of the survey as a validated research instrument. Consequently, the psychometric properties of reliability and validity have not been tested. To address this, I conducted a reliability analysis of the participants’ responses to the survey. The results indicated that the self-designed inventory demonstrated good psychometric validity and was suitable for future research studies.

**Scoring**

The description of addiction competencies identified on the *Self-Perceived Addiction Competencies Survey* as awareness, understanding, applied knowledge, mastery, and no familiarity with any of the above, were converted to numeric scores based on a 5-point Likert type scale as follows: no familiarity = 0, awareness = 1, understanding = 2, applied knowledge = 3, mastery = 4. Converting the scores to numeric values allowed me to analyze the survey results quantitatively. To group scores in the most accurate manner, I determined individuals’ raw scores and then grouped them into the ranges below. I used descriptive statistics to calculate the minimum, maximum, mean, median, and standard deviation for each item as well as for the scale as a whole.
I determined the class intervals for categorizing scores using the formula: \( \text{Interval} = \frac{\text{Range}}{\text{Number of desired classes}} \). The range was calculated using the ends of the Likert scale \((4 - 0 = 4)\), then divided by five, since I planned to group responses into the same five categories \((4 ÷ 5 = .80)\). The ranges of the categories are 0 to .79 = little familiarity, .80 to 1.59 = awareness, 1.60 to 2.39 = understanding, 2.40 to 3.19 = initial application, and 3.20 to 4.00 = mastery. Additionally, participants were instructed to answer each item based on their current knowledge, ability, and skills, and not based on anticipated abilities.

**Demographic Information**

Participants were asked to answer demographic questions in addition to completing the adapted *Self-Perceived Addiction Competencies Survey*. First, I asked participants if they held certification as an ACS and a license as a professional counselor. These screen-out questions would not allow participants to proceed with the survey if they did not fit both criteria. The second, third, and fourth questions were also screen-out questions. The second question asked if participants had a master’s degree in addiction counseling or a master’s degree with an addiction concentration. The third question asked if participants have a license or certification in addiction counseling, which excluded them from the study. Finally, the fourth screen-out question asked participants if they had previously completed this same survey as part of an Approved Clinical Supervisor invitation sent by the Center for Credentialing and Education.

Because the intent of the study was to measure self-perceived addiction competencies of clinical supervisors without addiction specialization, these questions prevented those participants with addiction credentials from moving forward with the survey. Other questions were related to participants’ gender, age, ethnicity, years of direct substance use counseling experience,
addiction education that is independent of a master’s degree in counseling, recovery status, and experience working with individuals with addictions. The demographic survey can be found in Appendix B.

**Procedures**

**Pilot Study**

I conducted a small pilot study to determine if any modifications to the surveys were needed before conducting the study. After receiving approval from the Montclair State University Institutional Review Board, I asked a small group of Licensed Professional Counselors who previously worked as clinical supervisors to take the survey. After they completed the survey, I interviewed the participants to elicit their feedback; the interviews were conducted in-person when possible, but some were done via distance meetings due to scheduling and/or geographic considerations. Through open-ended questions, I asked the pilot study participants for feedback on the clarity of the explanatory and rating statements and their impression of the overall survey process. Qualtrics tracked how long it took each participant to complete the survey; I anticipated that the survey would require a time commitment of 30 minutes or less. Additionally, the study highlighted proofreading errors, ambiguous questions, and anything else that impaired the completion of the questionnaire (Fink, 2015; Teijligen & Hundley, 2001). I then made edits to the survey based on the pilot study participant responses. This included removing, editing, or restating items, so they were easily understood.

**Sampling Procedure**

I submitted a research participant request to the Center for Credentialing and Education (2018), the organization that provides credentialing for Approved Clinical Supervisors in the
United States. CCE sent an email outlining the purpose of the study to the entire population of 2,029 ACS credential holders. The email detailed the purpose of the study, which included a link directing participants to the recruitment letter, demographic questionnaire, and the survey instrument. The recruitment letter contained necessary information about the study including the risks, benefits, and a statement of consent prior to beginning the survey. Below the statement, there was an embedded link to take the survey. The email stated that the study was voluntary and that participants may withdraw at any time. Additionally, I informed study participants on how to request further information regarding the study and results. The CCE only sends notification of the survey one time, so a follow-up email was not possible. The recruitment letter can be found in Appendix C.

Sample Size and Power

One consideration when designing a research study is statistical power. Power is the probability of detecting an effect given that the effect truly exists (Sprinthall, 2011). It directly increases the likelihood of finding if an effect exists between predictor and criterion variables, and it also contributes indirectly to reducing the overall rate of Type I or Type II errors (Mertler & Reinhart, 2016). Generally, the aim of a power analysis is to predict the sample size required to achieve an acceptable level of power. Power analysis for a multiple linear regression is based on the total number of predictors used in the analysis (R²; Cohen, 1992). Four predictor variables were used in the study: years of generalist counseling experience, addiction education, recovery status, and direct substance use counseling experience.

Based on the number of predictor and outcome variables in my study, a G*Power (Faul, Erdfelder, Buchner, & Lang, 2009) analysis was conducted using an a priori multiple regression
approach. G*Power is a power analysis program that determines the appropriate *a priori* statistical sample size for the desired study and desired effect size. It is generally accepted that power should be .80 or greater (Cohen, 1992). Since only one participant responded as someone in substance use recovery, the variable recovery status was dropped from the study. With an alpha level of .05, minimum power established at .80, three predictor variables, and a moderate effect size of .15 (Cohen, 1992; Watson, Lenz, Schmit, & Schmit, 2016), the study required a sample size of at least 77 participants in order to determine statistically significant effects. Achieving a .05 significance level would indicate a 95% confidence level that the relationship between supervisors’ self-perceived addiction competencies and education, experience, and recovery status does not occur by coincidence. Furthermore, ensuring a sufficient sample size increases the likelihood of finding existing statistical significance and increases the generalizability of the results.

Finally, to allow for a possible shortage of CCE ACS respondents, I accessed a list of the names and addresses of Licensed Professional Counselors (LPCs), who also could be clinical supervisors, from the New Jersey Board of Marriage and Family Therapy Examiners’ Professional Counselor Committee. There are approximately 4,600 Licensed Professional Counselors in New Jersey (Professional Counselors Examiners Committee, 2019). I randomly selected 10 percent of this population and requested their participation in the study through U.S. mail. Because it is possible that LPCs who are also ACSs may have already received and completed the survey (as noted previously), the demographic survey contained a screen-out question that asked participants if they had already completed the survey. This question was necessary to control the sample and ensure that participants met the criteria of the study.
Survey Administration

I used a Qualtrics® electronic survey for data collection. Qualtrics® is an online, simple-to-use web-based survey tool that was created to conduct survey research and data collection (Qualtrics®, 2018). Using an internet survey and administering it online had several advantages over traditional survey methods. Online surveys are convenient for both the respondent and the researcher. For example, costs are minimized, participants can complete the survey at their leisure, and data is available almost immediately and can be easily imported into data analysis software (Sue & Ritter, 2012). Alternatively, online survey administration can present technological limitations that include computer or program compatibility, emails not delivered to the intended participants or categorized as spam, and some individuals’ discomfort with using websites or sending confidential information over the internet (Fink, 2015). Despite these challenges, however, I used an online survey as a method of survey administration and data collection due to the convenience and immediate access to data.

After consenting to participate, respondents were asked to complete the 20-item Self-Perceived Addiction Competencies Survey along with the demographic survey. The directions for completing the survey and the amount of time needed to complete the instrument were included within the email and recruitment letter. The email outlined the purpose of the research study, the approximate time it would take to complete the survey, and the procedures for data collection. Study data is secured with a confidential password-protected personal computer. Furthermore, the Qualtrics® (2018) survey data platform offers data security via high-end firewall systems that are monitored 24 hours a day. Qualtrics® also provides daily encrypted backup of data. Finally, in accordance with the Office for Human Research Protections (OHRP) and the
Montclair State University IRB (2016), I will retain research data for at least three years after the completion of the study. The recruitment letter and informed consent letter are found in Appendices C and D, respectively.

**Data Analysis**

The first step of data analysis was to ensure that the minimum target number of participants (N = 77) completed both the *Self-Perceived Addiction Competencies Survey* and the demographic survey in their entireties. Once collected, I imported data from Qualtrics® into the Statistical Package for the Social Sciences (SPSS), a computer software program that is used to analyze statistical data (IBM Corporation, 2015). Through SPSS, I performed data cleaning, an important part of preparing data for analysis, which involved reviewing the data to identify and correct any errors (Frankfort-Nachmias, Nachmias, & DeWaard, 2015; Salkind, 2010). The participant responses from the Qualtrics® electronic survey program was then compared to the SPSS file to ensure the presence of correctly entered raw data. Next, I performed an analysis of the descriptive statistics and provided information on outliers while also creating plots and graphs to visually represent the data set (Field, 2013). Finally, using SPSS analyses, I determined the characteristics of the sample and performed statistical calculations to answer the research questions (Field, 2013). The survey did not allow respondents to skip questions. Participants were unable to continue to the next question without answering the previous question. As such, the study did not contain missing data.

Using descriptive statistics, I generated frequency distributions that included measures of central tendency, range, variance, and standard deviation scores of all variables of interest. Using multiple linear regression, I demonstrated which predictor variables were better indicators of
self-perceived addiction competencies than others. In addition, multiple linear regression
determined how the predictor variables were intercorrelated. My goal was to determine what
proportion of the variance in the study’s criterion variable, self-perceived addiction
competencies, was explained by the predictor variables.

The predictor variables years of generalist counseling experience, addiction education,
and direct substance use counseling experience are continuous variables whose raw scores were
measurable in SPSS. Addiction education was measured in hours and included both graduate
courses in addiction counseling courses as well as non-credit addiction training, webinars, and
in-service presentations. The variable direct substance use counseling experience was measured
in the number of years participants have worked with individuals with substance use disorders.
Recovery status is a categorical variable representing group membership as someone in
substance use recovery or not. Because participants replied to this question with a yes or no
response, I translated this predictor to a dummy code to enter this response into the equation
(Warner, 2013). The dummy code corresponded to 1 = yes, 0 = no. Additionally, I tested the
multiple linear regression assumptions of (1) linearity (i.e., there is a linear relationship between
the criterion variable addiction competencies and the predictor variables), (2) normality (i.e.,
residuals are normally distributed), (3) multicollinearity (i.e., independent or predictor variables
are not correlated with each other, and (4) homoscedasticity (i.e., the variance of error terms are
similar across the value of the independent or predictor variables (Cronk, 2012; Osborne &
Waters, 2002; Williams, Grajales & Kurkiewicz, 2013).

Research Question 1
To determine the self-perceived addiction competencies of Approved Clinical Supervisors (awareness, understanding, applied knowledge, and mastery), I used descriptive statistics (i.e., mean, standard deviation, frequency, and percentage) to categorize how many participants rated their self-perceived addiction competencies in each rating response level (awareness, understanding, applied knowledge, and mastery). Additionally, I examined response totals by means of cross-tabulation and categorized the results of the survey by subgroups according to ranges.

Research Question 2

To determine how the predictor variables (years of generalist counseling experience, addiction education, recovery status, and direct substance use counseling experience) contributed to supervisors' self-perceived addiction competency level, I used a multiple linear regression equation. Multiple regression is useful in analyzing and predicting outcomes when there is more than one variable being investigated (Allison, 2009). This approach determined which predictor variables are better indicators of self-perceived addiction competencies than others. As a result, I determined how the predictor variables were intercorrelated with each other and what proportion of the variance in the study’s criterion variable, addiction competencies, is explained by the predictor variables.

Therefore, I used the standard or “Enter” method of data entry where I entered all of the predictor variables simultaneously into the equation. Rather than using the converted categorical scales to measure addiction competencies (i.e., 0 = no familiarity, 1 = awareness, 2 = understanding, 3 = applied knowledge, 4 = mastery), I entered participants’ totals, making this a continuous variable. Since the extant research did not offer definitive support that any one of the
described predictor variables in the study were more likely to influence the self-perceived addiction competencies of clinical supervisors than another, the “Enter” method was an appropriate approach to create the prediction equation. The regression analysis showed how much each predictor variable individually, and as a set, contributed to supervisors’ level of self-perceived addiction competencies. By exploring possible relationships among variables, I determined what factors contributed to clinical supervisors’ self-perceived addiction counseling competencies.

**Chapter Summary**

In Chapter Three I reiterated the purpose of the study and research questions. I also examined the justification for using a quantitative design and multiple regression analyses to determine the relationships between the predictor and criterion variables. Additionally, I addressed the research design, population, method of data collection, data analysis plan, and protection of participants required for the completion of the research design. In Chapter Four, I will provide a comprehensive description of recruitment response rates, demographics of the sample, results of descriptive statistics, and the regression data analyses. I will outline how the study results contributed to the areas of self-directed and transformative learning of supervisor attainment of addiction counseling knowledge, attitudes, and values.
CHAPTER FOUR: RESULTS

The purpose of this quantitative research study was to explore the relationship between clinical supervisors’ self-perceived addiction competencies and generalist counseling experience, addiction education, recovery status, and direct substance use counseling experience. The results of the study are presented in this chapter in three sections. In the first section, descriptive statistics describing the study participants and predictor variables are reported. In the second section, the research questions and data analyses are addressed. The last section of the chapter is a summary discussing the overall significance of the study results.

Data Collection

Participants

To assess the self-perceived addiction competencies of clinical supervisors, the Center for Credentialing and Education (CCE) emailed the Self-Perceived Addiction Competency Survey to their entire membership of 2,029 Approved Clinical Supervisors (ACSs) in the United States. Eighty-nine ACS’ participated in the study including 71 females, 16 males, and 2 individuals who chose not to identify their gender. Close to three-quarters of the participants identified as White (n = 63, 70.8%). Participants ranged from 28 to 71 years old (M = 45.67; SD = 10.88). Over two-thirds of the survey participants were between the ages of 30-39 (n=32, 36%) and 40-49 (n=26, 29.2%). A total of five separate types of counseling degrees were reported. Over half of the participants (n=48, 53.9%) earned their master’s degree in a clinical mental health counseling program. Only one participant identified as someone in substance use recovery. Because recovery status differed greatly from the other variables in the data set, I did not include it in the data analyses. Percentages and frequencies were calculated for all categorical variables.
for the entire sample and are presented in Table 2.

Table 2

*Summary of Categorical Variables among the Study Participants.*

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>71</td>
<td>79.8</td>
</tr>
<tr>
<td>Male</td>
<td>16</td>
<td>18.0</td>
</tr>
<tr>
<td>No response</td>
<td>2</td>
<td>2.2</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>2</td>
<td>2.2</td>
</tr>
<tr>
<td>30-39</td>
<td>26</td>
<td>29.2</td>
</tr>
<tr>
<td>40-49</td>
<td>32</td>
<td>36.0</td>
</tr>
<tr>
<td>50-59</td>
<td>13</td>
<td>14.6</td>
</tr>
<tr>
<td>60-69</td>
<td>13</td>
<td>14.6</td>
</tr>
<tr>
<td>70-79</td>
<td>2</td>
<td>2.2</td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>63</td>
<td>70.8</td>
</tr>
<tr>
<td>Black</td>
<td>10</td>
<td>11.2</td>
</tr>
<tr>
<td>Asian</td>
<td>4</td>
<td>4.5</td>
</tr>
<tr>
<td>Hispanic</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td>Middle Eastern or Northern African</td>
<td>2</td>
<td>2.2</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>7</td>
<td>7.9</td>
</tr>
<tr>
<td>Master’s degree</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Mental Health Counseling</td>
<td>48</td>
<td>53.9</td>
</tr>
<tr>
<td>Community Counseling</td>
<td>14</td>
<td>15.7</td>
</tr>
<tr>
<td>School Counseling</td>
<td>6</td>
<td>6.7</td>
</tr>
<tr>
<td>Higher Education</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>20.2</td>
</tr>
<tr>
<td>Substance use recovery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>No</td>
<td>88</td>
<td>98.9</td>
</tr>
</tbody>
</table>

*Note.* Due to rounding, percentages may not equal 100%.
**Predictor Variables**

The demographic survey provided data to calculate the sample mean, standard deviation, and range for each of the predictor variables (generalist counseling experience, addiction education, and direct substance use counseling). The generalist counseling experience variable was measured in years and ranged from 0 to 50, with a mean of 14.49 ($SD = 8.71$). Direct substance use counseling experience measured the number of years participants had worked with individuals with substance use disorders; this ranged from 0 to 40 years, with a mean of 10.29 ($SD = 9.86$).

Addiction education was measured in hours and included both time spent in graduate courses in addiction counseling as well as non-credit addiction training, webinars, and in-service presentations. The number of graduate addiction courses ranged from 0 to 10. These courses were converted to hours using a conversion of 45.00 hours per graduate course. Following this conversion, the number of addiction graduate course hours ranged from 0 to 450 ($M = 51.47; SD = 60.51$). Hours of addiction training completed ranged from 0 to 500 ($M = 51.47; SD = 98.97$). The total addiction education hours were calculated by summing graduate course hours and training hours and ranged from 0 to 590 ($M = 103.04; SD = 121.43$).

**Data Analysis**

In this section, I describe the research questions, discuss evidence of instrument reliability, and present the results of the multiple linear regressions. Additionally, I report the results of assumptions of multiple linear regression.

**Evidence of Instrument Reliability**
Prior to distributing the *Self-Perceived Addiction Competencies Survey*, I assessed the evidence of its internal consistency. Internal consistency “is an indication of how well the different items in a survey complement each other in their measurement of different aspects of the same variable or quality” (Litwin, 2003, p. 22). Values closer to zero indicate lower consistency and values closer to one indicate higher consistency. I chose the Cronbach’s alpha test of reliability. The coefficient alpha for the *Self-Perceived Addiction Competencies Survey* was .91; this indicates excellent internal consistency and reliability (George & Mallery, 2016).

**Research Question 1**

Research Question 1 was, “What are the self-perceived addiction competencies of Approved Clinical Supervisors (awareness, understanding, applied knowledge, and mastery)?” The composite score for self-perceived addiction competency was computed through an average of 20 survey items from the *Self-Perceived Addiction Competency Survey*. Individual responses were provided on a 5-point Likert type scale corresponding to the participants’ awareness, understanding, applied knowledge, and mastery. Raw scores were grouped into ranges of .80 - 1.59 = awareness, 1.60 - 2.39 = understanding, 2.40 - 3.19 = applied knowledge, and 3.20 - 4.00 = mastery.

These ranges represent four categories of addiction competency that assess an individual’s familiarity, application, and knowledge of substance use interventions, treatment, and recovery models (Gallon & Porter, 2011). In my sample, the scores for addiction competency ranged from 1.20 to 4.00 ($M = 2.79; \ SD = 0.68$). The mean of 2.79 suggests that on average, the participants were in the “applied knowledge” stage for addiction competency. The distribution for the addiction competency categories is presented in Table 3.
Table 3

*Frequency Table for Addiction Competency Groups*

<table>
<thead>
<tr>
<th>Addiction competency groups</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little familiarity (0.0 – 0.79)</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Awareness (0.80 – 1.59)</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td>Understanding (1.60 – 2.39)</td>
<td>20</td>
<td>22.5</td>
</tr>
<tr>
<td>Applied Knowledge (2.40 – 3.19)</td>
<td>39</td>
<td>43.8</td>
</tr>
<tr>
<td>Mastery (3.20 – 4.00)</td>
<td>27</td>
<td>30.3</td>
</tr>
</tbody>
</table>

*Note.* Due to rounding, percentages may not equal 100%.

**Research Question 2**

The second research question was, “How do years of generalist counseling experience, addiction education, recovery status, and direct substance use counseling experience contribute to supervisors’ self-perceived addiction competency level?” To address research question 2, a multiple linear regression was conducted to examine the predictive relationship between generalist counseling experience, addiction education, and direct substance use counseling experience, and supervisors' self-perceived addiction competency level. In this analysis, the predictor variables were generalist counseling experience, addiction education, and direct substance use counseling experience. The variable recovery status was removed from the analyses because only one participant identified as being in substance use recovery. The criterion variable was supervisors' self-perceived addiction competency level. The selection process for the multiple regression was the enter method. Using the enter method, all of the predictor variables (generalist counseling experience, addiction education, and direct substance use counseling experience) were given equal treatment and entered into the equation simultaneously.
**Multiple linear regression assumptions.** Prior to the regression analysis, the multiple linear regression assumptions of (1) linearity, (2) normality, (3) multicollinearity, and (4) homoscedasticity were tested. The normality assumption was assessed with a visual inspection of a P-P scatterplot. The raw data in the scatterplot did not greatly deviate from the normality trend line, suggesting that the assumption of normality was met. To assess for the absence of multicollinearity, variance inflation factors (VIFs) were utilized. VIF values explain how an independent or criterion variable is influenced by its interaction with other independent variables (James, Witten, Hastie, & Tibshirani, 2017). VIF values below 10 suggest that the assumption was met. Absence of multicollinearity was met because each of the VIFs was below 10. Homoscedasticity, which measured the variability among the predictor variables generalist counseling experience, addiction education, and direct substance use counseling experience was visually assessed with a scatterplot of the residuals. Since the residuals were approximately equal for all the predictor variables, the assumption of homoscedasticity was met.

**Pearson correlations.** A series of Pearson correlations was conducted prior to running the regression model to examine how the predictor variables were related to addiction competency. I used an alpha level of .05 to determine statistical significance of all tests. A two-way association between the predictor variables, generalist counseling experience, addiction education, and direct substance use counseling experience demonstrated that none of the variables were statistically correlated to addiction competency. All three variables were found to be moderately correlated with addiction competency: generalist counseling experience \[ r (87) = .13, p = .220 \], addiction education \[ r (87) = .12, p = .283 \], and direct substance use counseling experience \[ r (87) = .18, p = .090 \]. According to Cohen (1988, 1992), the effect size is low if the
value of $r$ varies around 0.1, medium if $r$ varies around 0.3, and large if $r$ varies more than 0.5. Because the Pearson correlations indicated a significant relationship among variables, I proceeded with regression analysis to determine the nature of the relationship more definitely.

**Multiple linear regression.** Results of the overall model of the multiple linear regression were statistically significant ($F(3, 85) = 4.25, p = .008, R^2 = .130$), suggesting that combining the three variables of generalist counseling experience, addiction education, and direct substance use counseling experience with supervisors’ self-perceived addiction competencies demonstrated a significant relationship. The data suggest that approximately 13.0% of the variance in addiction competency can be explained by the predictor variables. Generalist counseling experience ($t = -3.06, p = .003$) was a significant predictor in the model, suggesting that with every one-unit increase in generalist counseling experience, addiction competency decreased by approximately 0.03 units. Direct substance use counseling experience ($t = 3.01, p = .003$) was also a significant predictor in the model, suggesting that with every one-unit increase in direct substance use counseling experience, addiction competency increased by approximately 0.03 units.

Effect size, calculated using Cohen's $f^2$, measures the magnitude of the difference between groups. The greater the effect size, the greater the differences between variables. Cohen (1988) suggested that $f^2$ is typically interpreted as 0.02 = small, 0.15 = medium, 0.35 = large. The results of Cohen’s $f^2 = .149$ demonstrated a medium effect. This indicated that there is a probable effect that a meaningful impact exists between the study variables. Too small of an effect would indicate that there is predictability in the change in study variables, thus affecting the statistical significance of the study. The results of the multiple linear regression are presented in Table 4.
Table 4

*Results for Regression with Generalist Counseling Experience, Addiction Education, and Direct Substance Use Counseling Experience as Predictors of Addiction Competency*

<table>
<thead>
<tr>
<th>Source</th>
<th>B</th>
<th>SE</th>
<th>B</th>
<th>t</th>
<th>p</th>
<th>VIF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generalist Counseling Experience</td>
<td>-0.03</td>
<td>0.01</td>
<td>-40</td>
<td>-3.06</td>
<td>.003*</td>
<td>1.64</td>
</tr>
<tr>
<td>Addiction Education</td>
<td>0.00</td>
<td>0.00</td>
<td>0.03</td>
<td>0.23</td>
<td>.819</td>
<td>1.19</td>
</tr>
<tr>
<td>Direct Substance Use Counseling</td>
<td>0.03</td>
<td>0.01</td>
<td>0.42</td>
<td>3.01</td>
<td>.003*</td>
<td>1.88</td>
</tr>
</tbody>
</table>

*Note. F (3,83) = 4.25, p = .008, R^2 = .130.*

*Significance at the p < .005 level

Multiple linear regression 2. A second, post hoc, multiple linear regression was conducted to examine the predictor variable addiction education more closely. In this model, addiction education graduate hours and addiction training hours were calculated as two separate variables to determine if there were significant differences from the initial model. In this analysis, the predictor variables were generalist counseling experience, addiction graduate hours, addiction training, and direct substance use counseling experience. The criterion variable was supervisors' self-perceived addiction competency level. As with the initial regression analysis, the assumptions of linearity, homoscedasticity, and absence of multicollinearity were assessed and met.

Similar to the initial regression analyses, prior to calculating the model, a series of Pearson correlations were conducted to examine how the predictor variables were related to addiction competency. A two-way association between the predictor variables, generalist counseling experience, addiction graduate hours, addiction training hours, and direct substance use counseling experience demonstrated that none of the variables were statistically correlated to addiction competency. Generalist counseling experience and addiction competency were found
to have a moderate inverse correlation, \( r(87) = -0.13, p = 0.220 \); addiction graduate course hours and addiction competency indicated a small negative correlation, \( r(87) = -0.06, p = 0.595 \); addiction training hours and addiction competency were found to have a moderate positive correlation \( r(87) = 0.11, p = 0.321 \), and direct substance use counseling and addiction competency also indicated a moderate positive relationship \( r(87) = 0.18, p = 0.090 \).

Results of the overall model of the multiple linear regression were statistically significant, \( F(4,84) = 3.17, p = 0.018 \), \( R^2 = 0.131 \), suggesting that combining the four variables of generalist counseling experience, addiction education graduate hours, addiction training hours, and direct substance use counseling experience with supervisors' self-perceived addiction competencies demonstrated a significant relationship. Results of the regression analyses were similar to the first model. The \( R^2 \) suggested that approximately 13.0% of the variance in addiction competency can be explained by the predictor variables.

Generalist counseling experience \( (t = -3.05, p = 0.003) \) was a significant predictor in the model, suggesting that with every one-unit increase in professional counselor experience, addiction competency decreased by approximately 0.03 units. Direct substance use counseling experience \( (t = 3.01, p = 0.003) \) was also a significant predictor in the model, suggesting that with every one-unit increase in direct substance use counseling experience, addiction competency increased by approximately 0.03 units. Overall, the results of this regression did not demonstrate a difference in clinical supervisors' addiction competency, whether completing addiction graduate course hours or addiction training hours. Thus, separating this variable into two distinct variables demonstrated no change in the original model. The results of the multiple linear regression are presented in Table 5.
Table 5

*Results for Regression with Generalist Counseling Experience, Addiction Graduate Course Hours, Hours of Addiction Training, and Direct Substance Use Counseling Experience as Predictors of Addiction Competency*

<table>
<thead>
<tr>
<th>Source</th>
<th>B</th>
<th>SE</th>
<th>B</th>
<th>t</th>
<th>p</th>
<th>VIF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generalist Counseling Experience</td>
<td>-0.03</td>
<td>0.01</td>
<td>-0.40</td>
<td>-3.05</td>
<td>.003*</td>
<td>1.67</td>
</tr>
<tr>
<td>Addiction Graduate Course Hours</td>
<td>0.00</td>
<td>0.00</td>
<td>0.04</td>
<td>0.33</td>
<td>.742</td>
<td>1.06</td>
</tr>
<tr>
<td>Addiction Training Hours</td>
<td>0.00</td>
<td>0.00</td>
<td>0.01</td>
<td>0.05</td>
<td>.960</td>
<td>1.16</td>
</tr>
<tr>
<td>Direct Substance Use Counseling</td>
<td>0.03</td>
<td>0.01</td>
<td>0.42</td>
<td>3.01</td>
<td>.003*</td>
<td>1.89</td>
</tr>
</tbody>
</table>

Note. $F (4, 84) = 3.17, p = .018, R^2 = .131$.
*significance at the $p < .005$ level

Summary

The purpose of the study was to identify ACS’ self-perceived addiction competencies and to determine how contextual factors inform the supervisory practice of overseeing the work of counselors who work with individuals with SUD. In this chapter, the findings of the data analyses were presented. Reliability evidence for the addiction competency inventory was excellent. Most of the participants were in the “applied knowledge” stage of addiction competency. The findings of the multiple linear regression suggested that collectively years of generalist counseling experience, addiction education, and direct substance use counseling experience contribute to supervisors' self-perceived addiction competency level. Generalist counseling experience and direct substance use counseling experience were statistically significant predictors in the regression model. However, the addiction education predictor variable did not demonstrate statistical significance to the model. In the next chapter, the findings of the data analyses will be explored, particularly as the results relate to transformative learning theory.
CHAPTER FIVE: DISCUSSION

The opioid epidemic in the United States has resulted in the necessity of Licensed Professional Counselors and the clinical supervisors who oversee their practice to be proficient in understanding substance use disorders (SUD). Clinical supervisors are expected to be knowledgeable in all clinical areas in which they are supervising, as well as remaining up to date with emerging advances in the field to provide effective supervision (ACA Code of Ethics, 2014; ACES, 2011; Falender & Shafranske, 2017). Clinical supervision has considerable influence on a clinician’s training, professional development, and deployment of knowledge, skills, and competencies (Cashwell & Dooley, 2001). Identifying supervisors’ self-perceived addiction competencies may help professionals to mentor and improve counselor effectiveness in treating individuals with SUD and co-occurring disorders.

In this chapter, I will identify the results of the analyses in relation to the project’s research questions. The purpose of the study was to measure the factors that contribute to supervisors’ level of self-perceived addiction competencies. I attempted to determine if self-perceived addiction competence had any relation to clinical supervisors’ generalist counseling experience, addiction education, and direct substance use counseling experience. In addition, I will discuss how transformative learning theory guides clinical supervisors’ attainment of skills, knowledge, and attitude changes through a process of learning, doing, and experiencing. I will also outline implications for clinical supervisor practice, training, knowledge, and experience that focuses specifically on the specialization and learning outcomes for SUD practice, study limitations, and recommendations for future research.
Discussion

In this study, I explored how ACSs’ counseling practice and learning experiences correlated with their level of self-perceived addiction competencies. Results indicated that when ACSs have had direct substance use counseling experience, their level of self-perceived addiction competency increased. In other words, with each year of substance use counseling experience, clinical supervisors’ knowledge, understanding, and application of self-perceived addiction competencies improved. However, when measuring the self-perceived addiction competencies of ACSs with generalist counseling experience, the level of self-perceived addiction competencies decreased. In this instance, self-perceived addiction competency decreased for each additional year of generalist counseling experience. Consequently, it appears that the more substance use counseling experience the clinical supervisor gains, the higher they report their level of self-perceived addiction competency.

Self-Perceived Addiction Competency

This study was designed to explore supervisors’ level of self-perceived addiction competency in relation to years of generalist counseling experience, addiction education, and direct substance use counseling experience. The results indicated that when all three components are combined on average, study participants exhibited competency in the applied knowledge category of addiction competency. The combination of direct substance use counseling, addiction education, and generalist counseling experience (doing, learning, reflecting, reframing, absorbing) contributed to the transformation of clinical supervisors’ development of self-perceived addiction competencies. The category of applied knowledge indicates that the study participants are knowledgeable about addiction and recovery and are typically able to transfer
this knowledge either in general practice or specialty treatment/recovery settings (Gallon & Porter, 2011). It appears, therefore, that ACSs in this category believe they can apply self-perceived addiction competency knowledge and skills to provide effective guidance and monitoring of counselor supervisees who treat individuals with SUD. In the next section, I will discuss how transformative learning theory offers a theoretical lens to understand how clinical supervisors may experience, learn, transform, and adapt knowledge, skills, and competencies surrounding SUD.

**Transformative Learning Theory**

Transformative learning theory (TLT), originally developed by Jack Mezirow (2012), is described as the development of learning by doing and reflecting. Mezirow found that the most significant variable in an individual’s transformation in developing competence was experiential immersion. He posited that the best way to learn is to absorb oneself into an activity, task, or phenomena to invoke change and expertise. I attempted to discover where and how clinical supervisors perceive that they develop addiction competencies by means of the TLT lens. Specifically, I attempted to identify what variables affect the transformation of learning and meaning.

I adapted an existing addiction competencies survey to measure how generalist counseling experience, addiction education, and direct substance use counseling experience could promote clinical supervisor learning of addiction competencies alone or in combination with each other. I questioned if learning and self-reflection that took place for clinical supervisors vis-à-vis the completion of addiction coursework, training, and counselor experience influenced the development of addiction competencies. Since TLT focuses on instrumental and
communicative learning, I sought to understand if task-oriented problem solving and realizations gained through education and generalist and direct substance use counseling experience corresponded to clinical supervisors’ attainment of addiction knowledge, skills, attitudes, and beliefs.

My inclination when framing my research questions was that clinical supervisors would acquire self-perceived addiction competencies primarily through addiction training and education. My partiality, no doubt, originates from my own experience as a counselor educator and supervising training development specialist for alcohol and drug counselors and graduate counseling students. In contrast to my partiality, the study results suggested, however, that self-perceived addiction counseling competencies were most significant when combined with ACSs’ substance use counseling experiences. Despite the fact that self-perceived addiction competency had a positive relationship with years of substance use counseling, TLT does attribute the transformation of knowledge through a metamorphosis of self-discovery through both experience and learning. Therefore, clinical supervisors’ attainment and levels of self-perceived addiction competencies could be influenced by their work experience that leads to self-learning from doing and reflection of their substance use practice.

**Direct Substance Use Counseling Experience**

The study results indicated that direct substance use counseling experience was a significant predictor of ACSs’ self-perceived addiction competency. Specifically, as clinical supervisors’ years of addiction counseling experience increased, so did the level of self-perceived addiction competencies. These findings correspond with TLT, as Mezirow (2000) postulated that learning experiences depend on the context in which they are embedded. With
each year of substance use counseling experience, clinical supervisors have the opportunity to focus on task-oriented problem solving. Consequently, it seems plausible that as clinical supervisors immerse themselves in experiential addiction counseling, their knowledge, understanding, and application of addiction competencies (and their self-perceptions of those competencies) continued to develop. Accordingly, Velciu (2014) considered learning via employment to be a critical component contributing to the development of competence. In these instances, reflective practice can provide valuable opportunities for clinicians to learn through their counseling practice work experiences (Cox, 2015).

**Generalist Counseling Experience**

The study results indicated that generalist counseling experience affected ACSs’ self-perceived addiction competency level, but in an inverse fashion. With each year of generalist counseling experience, self-perceived addiction competency decreased. A possible reason for this decrease could be that 30% of the study participants graduated from school counseling, higher education, and other counseling-related discipline programs (e.g., marriage and family therapy) where addiction coursework and experiential activities may have been less prevalent than in community and clinical mental health counseling programs. Since over 68% of the study participants are 40 years or older, it is possible that they attended graduate school before CACREP required addictions content in the curriculum with their 2009 standards. Attending graduate school before the inclusion of addiction standards could have limited ACSs’ knowledge of addiction core competencies (Chasek et al., 2015). This lack of focus on the dynamics of addiction may explain the inverse relationship between generalist counseling experience and self-perceived addiction competencies.
When examining generalist counseling experience through the TLT lens, it is possible that the lack of supervisor experiential substance use counseling experience could affect the development of self-perceived addiction competencies. In this respect, many ACSs did not have opportunities to engage in internship or work experiences in addiction counseling (Tabor et al., 2011). Once again, these counselors may have not had opportunities to acquire knowledge and skills from practice experience or experiential activities leading to the transformation of new learning and the application of addiction competencies. In this instance, the inverse relationship between self-perceived addiction competencies and generalist counseling experience may be attributed to lack of opportunities to engage in internship or work experiences in addiction counseling (Tabor et al., 2011). From another perspective, seasoned counselors with generalist counseling experience and committed theoretical counseling orientations may provide counseling services only within their chosen modality, thus affecting their response in the survey. It is possible too, that seasoned counselors who graduated from counseling programs before the inclusion of addiction course electives and the integration of substance use and mental health employment or internship opportunities may not have had opportunities to develop self-perceived addiction competencies.

**Addiction Education**

In the study analyses, both addiction graduate course hours and addiction training hours did not indicate an effect on ACSs’ self-perceived addiction competency. That is, addiction education by itself did not contribute positively or negatively to supervisors’ addiction competency. These results seem to concur with research regarding the effect of addiction education on practitioner’s addiction competencies. For example, one study predicted that
practitioners had feelings of being prepared to use the knowledge provided by addiction education (Bina et al., 2011). In another study, researchers demonstrated that addiction education is in fact a predictor in health care practitioners’ increased confidence, improved knowledge, and attitudes when working with individuals with SUD (Rassool, 2004). When examining addiction education through the TLT lens, it is possible that counselor and clinical supervisor preparation in the area of addiction did not incorporate both reflective and experiential learning activities leading to greater adaptation of changes in attitudes and skills (Osborn & Lewis, 2005; Sias & Goodwin, 2007).

**Implications**

This research study has yielded a number of professional implications for clinical supervisors, counselor educators, and other stakeholders involved in the practice and oversight of SUD education and practice. Consistent with the theoretical framework that informed this study, professional implications are based on years of experiential experience. It appears that the development of self-perceived addiction competencies is most significant when a practitioner has participated in substance use counseling practice.

**Substance Use Counseling Experience**

The study results indicated that ACSs’ self-perceived addiction competence can manifest from substance use counseling experience. These findings correspond with the TLT lens that directed this research. Namely, clinical supervisors’ substance use counseling experiences may have allowed them the opportunity to acquire an understanding of addiction and addiction counseling practice through knowledge, action, and feelings. For instance, when clinical supervisors’ experiences and activities are grounded in real and concrete life events connections
between new concepts and those previously learned can occur (Ferch, St. John, Reyes, & Ramsey, 2006).

When clinical supervisors and the counselors they oversee practice addiction counseling or experiential addiction activities, their reflection of these experiences shapes their understanding of addiction. These experiences can greatly contribute to self-awareness, skill development, personal, and professional development (Caldwell, 2007; Giordano, Stare, & Clarke, 2015; Harrawood, McClure, & Nelson, 2011; Kolb, 2015; Luke & Kiweewa, 2010). To facilitate a broader approach to applying and developing self-perceived addiction competencies, counselor educators, clinical supervisors, and supervisees that participate in practicums, internships, work-based, and other experiential addiction activities and practices (Payne, Schreiber, & Riley, 2005) have opportunities to achieve an increased understanding and applied knowledge of SUD, OUD, and addiction counseling practice.

Another approach to promote clinical supervisors’ self-perceived addiction competence, particularly in response to the influx of individuals with OUD, is for counseling programs to simulate real-life addiction counseling experiences that mirror substance use counseling experience. These activities can provide a forum for transformative and reflective learning leading to the application and understanding of self-perceived addiction competency. Activities could be embedded in counselor program curricula, particularly as part of addiction and clinical supervision coursework. Examples of experiential activities include case studies, case conceptualization, role-plays, creative teaching methods, self-reflection projects, and simulation, in addition to practicum and internships. For clinical supervisors and other clinicians that possess substance use counseling experience, participation in ongoing professional development
activities, which may include taking classes or trainings in addiction competencies, consulting with peers, seeking a clinical supervisor with addiction specialty certification, researching more accurate and through information, forming relationships with addiction agencies and community partners, and working with a mentor can enhance existing self-perceived addiction competency.

Clinical Supervision

Whether supervisors provide services in substance use treatment agencies or function as generalist counselors they can initiate, sustain, or maintain the self-perceived addiction competencies of their supervisees. As gatekeepers of the counseling profession, clinical supervisors’ ongoing identification and assessment of their own and their supervisees’ addiction competencies can serve as a platform for goal setting and skill development. Specifically, self-reflection can clarify values around addiction, view individuals through a multicultural lens, and explore the intersectionality of addiction with contextual variables such as culture, race, class, and gender on patterns of SUD and recovery. Using core clinical supervision models and techniques, any strategy that integrates addiction competencies into new or existing supervisory methods can contribute to critical reflective learning and enhance both supervisor and supervisee application of addiction counseling methods.

As clinical supervisors engage in learning by doing, either personally, with a supervisor, or a supervisee they have opportunities to participate in critical reflection to challenge assumptions and perspectives about their experiences. Critical reflection allows the participant to go beyond the surface of an experience. It is a reasoning process that uses descriptive, analytical, and critical reflection to make meaning of a situation. It often occurs in response to an awareness of a contradiction among one's thoughts, feelings, and actions. Clinical supervisors’ critical
reflection and subsequent learning from these experiences can shape their understanding of addiction which is the crux of TLT (Carroll, 2010). Clinical supervisors facilitate this phenomenon by modeling critical reflection and allowing their supervisees the opportunity to assess their value system and worldview about substance use. Through reflective learning, both the supervisor and supervisee can take a perspective outside of themselves and pay greater attention to their practice (Brookfield, 2009; Mezirow, 1991). The goal is for new or revised interpretations about addiction to take place which is then transformed into practice and ultimately enhanced work with SUD and the individuals they serve (Jacoby, 2010; Mezirow, 2009; Quinnan, 1997; Taylor, 2000).

**Limitations of the Study**

There were limitations to the study that would lead one to use caution when interpreting and generalizing the results. Some of these limitations involved the sample of ACSs surveyed for this study. Although the total national population of 2,029 ACSs was invited to participate in the study, the study response rate was less than 10% of the targeted sample. The low response rate is indicative of email surveys that have an average response rate of 30% as opposed to in-person surveys (57%) and mail surveys (50%; Lindemann, 2018). Another limitation of the study was the diversity of the participants. Of the total sample, 80% of the participants were female, and 70.8% identified themselves as White/Caucasian. Although this data is indicative of the demographics in the counseling field, it does not necessarily reflect diversity (Crook, 2010).

Because I relied on self-report survey research for this study, participants may have demonstrated bias when responding. For instance, participants may have attempted to answer questions based on what they think is the expected answer to assist in the research process or to
present themselves in a positive light. Pertinent to this study, participants could have rated their self-perceived addiction competencies higher because of self-bias when assessing their own competencies. This is understood as the concept of Social Desirability Responding (SDR), which is a general tendency to give desirable answers to self-report questions (Paulhus, 2017). This results in difficulty determining if high scores are capturing agreeableness or the tendency to give desired answers. Subsequent research is needed to reduce the effect of SDR on the constructs in the present study. In addition, study participants may have rated their self-perceived addiction competencies higher or lower based on their interpretation of the survey questions (Brace, 2018). Similarly, because the Self-Perceived Addiction Competencies Survey responses were limited to pre-selected categories (i.e., awareness, understanding, applied knowledge, mastery, and no familiarity) and not a tangible measure of self-perceived addiction competencies, participants may have indicated higher self-perceived addiction competencies, thus creating another example of response bias.

Another limitation of the study was that participants did not have the option to specify which type of addiction training they had completed nor evaluate the effectiveness of the training. As a result, the study results produced a limited understanding of the quality and nature (e.g., online courses, experiential education) of participants’ addiction training. Identification of specific addiction courses and trainings may have enriched the data to determine what aspects of training were most effective. In addition, the study results did not indicate when clinical supervisors’ SUD training occurred or the content of the curriculum. Furthermore, for ACSs that completed graduate counseling programs where addiction courses were part of the curriculum, their self-perceived addiction competencies may not match the SAMHSA adapted Self-Perceived
Addiction Counseling Competencies Survey characteristics and, thus, their understanding of addiction may not be reflected in the study. Moreover, the study sample included only ACSs without addiction specialization thus limiting the sample size and further opportunities to explore and contrast self-perceived addiction competencies of clinical supervisors with varying addiction education and credentialing.

The adapted Self-Perceived Addiction Competencies Survey has not had extensive use as a validated research instrument and, therefore, the self-designed inventory lacks psychometric properties. In addition, one of the study variables, recovery status, was dropped from the study since only one participant self-identified in this category. As a result, the relationship of recovery status with general counseling, substance use counseling experience, and addiction education was unable to be measured in connection to ACS’ self-perceived addiction competencies. A few questions on the demographic survey allowed only yes or no answers. Adding a “prefer not to discuss” response may have enhanced the authenticity of the study results. Furthermore, some participants may have had technological or reading comprehension challenges, and others may have been concerned regarding the confidentiality of the survey responses. Finally, since the study focused on the self-perceived addiction competencies of counselors and not clinical supervisors, there are limitations to the applicability of the results.

Finally, many counselors maintain a moralistic view of addiction (Chasek, Jorgensen, & Maxson, 2012) and possess an inflated sense of competence in the provision of addiction treatment despite little or no training (Chandler et al., 2011). In relation to TLT, Mezirow (1975) theorized that adults bring to the learning experience preconceived thoughts and feelings that are influenced by values and feelings. These preconceived ideas and outdated assumptions regarding
addiction and SUD can negatively affect clinical supervisors and supervisees’ understanding of addiction competencies and development of self-perceived addiction competencies. Regrettably, there was not a mechanism to measure this phenomenon in the study.

**Recommendations for Further Research**

This study focused on identifying the self-perceived addiction competencies of ACSs. It also examined clinical supervisors’ self-perceived addiction competencies in relation to their counseling work experiences and addiction training. However, since the survey instrument was designed to assess counselor competency, further research using a tool that is specific to clinical supervisor competency could more specifically indicate what predictive factors affect supervisors’ self-perceived addiction competencies. Previous research involving clinical supervisor self-perceived addiction competencies is limited. Therefore, additional studies that focus on outcome research on addiction counseling and self-perceived addiction competencies has the potential to bridge learning gaps, particularly for counselor practitioners and educators who did not receive formal training in addiction counseling (Moro et al., 2016). Additionally, qualitative research could illuminate clinical supervisors’ experiential learning experiences in relation to addiction competency beyond the classroom. Participant interviews might detect what supervisors require to increase addiction competency and how critical reflection may affect their learning and experiences.

An alternative quantitative study could have supervisees assess clinical supervisors’ knowledge of addiction competencies and identify their helpfulness and guidance in this area. To capture clinical supervisors’ critical thinking skills when engaging in substance use counseling, a more tailored survey instrument might enhance outcomes measuring self-perceived addiction
CLINICAL SUPERVISOR ADDICTION COMPETENCIES

competencies. Moreover, an experimental design could analyze the impact of experiential learning assignments resulting in data about skill development. Various illustrations of addiction competencies (e.g., standardized testing, role play) in addition to survey data could offer a greater measure of clinical supervisors’ proficiency in performing and understanding addiction-related counseling concepts. Additionally, a research study that examined clinical supervisors’ attainment of addiction knowledge over time could detect more definitive data on enhancing competencies and skills. For example, supervision of supervision or mentors could address, track, and monitor competency progress in the provision of treatment services, counseling strategies and techniques, attitudes and self-awareness of addiction, biases regarding diversity, as well as an openness to different pathways of recovery particularly surrounding OUD (ACA Code of Ethics, 2014; Broadus et al., CSAT, 2017).

To increase the clinical supervisor participant pool and perhaps extend the diversity of the study, further research could include supervisors with different certification requirements from other states. Only 17 states required a clinical supervisor of Licensed Professional Counselors to possess the Approved Clinical Supervisor certificate at the time of this study. Information such as gender, age, and counseling program were part of a demographic survey. However, analyzing how these study variables correlate with participant responses could provide additional information to inform learning and the development of addiction competencies.

Other areas of future study would be to add other variables of interest into the model. For example, including the type of addiction counseling education or training, not just the number of courses study participants have completed, could provide more definitive information on how education affects the development of self-perceived addiction competencies. A possible study
could investigate the relationship between addiction competencies and generalist and substance use counseling experiences and addiction education by adding the variable of counseling setting (e.g. SUD or mental health treatment facility, private practice, hospital-based). In addition, a future study could include a survey or interview question asking participants when they completed their formal graduate training and the CACREP accreditation status of their programs. A subsequent study could ask participants if they attended CACREP programs pre or post 2009 when addiction content was added to accreditation standards.

Future research could measure the interaction between generalist counseling experience and addiction education in order to evaluate the effectiveness of addiction counseling coursework and its impact on self-perceived addiction competencies. Perhaps a study could examine the relationship among clinical supervision, professional development, or possession of a clinical supervisor certificate specific to addiction counseling while simultaneously practicing in substance use treatment facilities. Equally important, is to examine how face-to-face and online addiction courses are taught and whether experiential components are part of the curricula. Finally, a subsequent study could examine the nuances of education, experiences, and training for seasoned counselors in relation to their self-perceived addiction competencies.

Although not a significant result in the present study, research indicates that practitioners reported considerable need for and interest in additional addiction training (Knudsen, Johnson, & Roman, 2003). Other research supports specialized and ongoing training for those who provide substance use counseling services (Miller et al., 2010). In this regard, CACREP recognized the necessity to prepare counselors to engage in effective counseling practice with individuals with SUD. As a result, in 2009 they added addiction counseling as an entry-level specialty area
Moreover, current CACREP accreditation standards recommend an increased emphasis on addiction counseling throughout master’s counseling programs curriculum (CACREP, 2020). A future study in this area could measure the relationship between expanded addiction training requirements in counseling programs and clinical supervisors’ SUD practice and competencies.

Finally, many clinical supervisors may have entered the counseling field with insufficient personal or professional experience that would hinder an understanding of SUD. This lack of understanding may increase stereotypes and stigma and reduce a professional’s ability to display unconditional positive regard, develop addiction competencies, and utilize other vital skills (Winfield, n.d.). A future research study could examine the results of how embedding experiential and reflective course assignments specific to SUD in clinical supervisors’ graduate school coursework could facilitate changes in perspectives that provide opportunities for stigma to be challenged (Lay & McGuire, 2008; Winfield, n.d.).

**Conclusion**

This study examined the relationship between Approved Clinical Supervisors’ (ACSs) generalist counseling experience, substance use counseling experience, addiction education, and self-perceived addiction competencies. Results indicated that when ACSs have had experience practicing as a generalist counselor combined with coursework or training in addiction studies and direct substance use counseling experience, their level of self-perceived addiction competency increased. Substance use counseling experience had a significant positive relationship with self-perceived addiction competency. Addiction education by itself was not a predictor of ACSs’ self-perceived addiction competency. Generalist counseling experience
demonstrated a decrease in self-perceived addiction competency for each year of counseling experience.

These findings have important implications for clinical supervisors, supervisees, counselor educators, and stakeholders, as they indicate that direct substance use counseling experience is closely related to the self-perceived addiction competencies of understanding, applied knowledge, and mastery. Additionally, experiential counseling experiences via the transformative learning theory lens, could increase clinical supervisors’ self-perceived addiction competencies. By enhancing substance use counseling experience opportunities within addiction training coursework, clinical supervisors have greater opportunities to provide effective supervision to counselors providing services to individuals with OUD.
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Appendix A

*Self-Perceived Addiction Competencies Survey*

Adapted from: Performance Assessment Rubrics for the Addiction Competencies by Steven Gallon and John Porter
Addiction Technology Transfer Center Network, 2011

INSTRUCTIONS: Below is a list of questions describing addiction competencies. For each statement, please indicate the answer you most *closely identify* your current ability to perform each item. Please answer each question based on how you feel now and not on your anticipated abilities. Remember, this is not a test, and there are no right or wrong answers.

<table>
<thead>
<tr>
<th>1. Understand a variety of models and theories and the problems related to substance use.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can identify a variety of models and theories of addiction and other problems related to substance use.</td>
</tr>
<tr>
<td>I am able to discuss a variety of models and theories of addiction and other problems related to substance use.</td>
</tr>
<tr>
<td>I can apply knowledge and models of theories of addiction and other substances related to problems to clinical practice.</td>
</tr>
<tr>
<td>I can use knowledge of a variety of models and theories of addiction and other substance-related problems to design interventions and resolve issues in clinical settings.</td>
</tr>
<tr>
<td>I am not familiar with any of the above.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>2. Recognize the social, political, economic, and cultural context which addiction and substance use exist, including risk and resiliency factors that characterize individuals and groups and their living environments.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am able to recognize a variety of contexts within which addiction and substance use exist.</td>
</tr>
<tr>
<td>I appreciate the variety of contexts in which addiction and substance use occur, including factors that characterize individual and groups and their living environments.</td>
</tr>
<tr>
<td>I can demonstrate sensitivity and can utilize knowledge of contextual variables in the planning and delivery of addiction services.</td>
</tr>
<tr>
<td>I am able to fully integrate knowledge of the contextual variables into treatment planning, service delivery and problem solving.</td>
</tr>
<tr>
<td>I am not familiar with any of the above.</td>
</tr>
</tbody>
</table>
### 3. Describe the behavioral, psychological, physical health, and social effects of psychoactive substances on the individual using substances and significant others.

<table>
<thead>
<tr>
<th>I am aware of the behavioral, psychological, physical health, and social effects of using various psychoactive substances.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I understand the various short and long-term effects of psychoactive substances on the individual using substances and their significant others.</td>
</tr>
<tr>
<td>I understand the variety of short and long-term effects of psychoactive substances in the identification of substance use disorders.</td>
</tr>
<tr>
<td>I can incorporate knowledge of the multiple effects of substance use in assessment and treatment planning for individuals who use substances and their significant others.</td>
</tr>
<tr>
<td>I am not familiar with any of the above.</td>
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</tbody>
</table>

### 4. Recognize the potential for substance use disorders to mimic a variety of medical and mental health conditions and the potential for medical and mental health conditions to coexist with addiction and substance use.

<table>
<thead>
<tr>
<th>I have beginning knowledge that substance use disorders have the potential to mimic a variety of medical and mental health disorders.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can recognize the symptoms and understand the potential for substance use disorders to coexist with mental health conditions.</td>
</tr>
<tr>
<td>I am able to recognize and differentiate substance use disorders from other medical or mental health conditions without judgment.</td>
</tr>
<tr>
<td>I can accurately access co-occurring health, mental, and substance use disorders and am able to plan integrated treatment services.</td>
</tr>
<tr>
<td>I am not familiar with any of the above.</td>
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</tbody>
</table>

### 5. Describe the philosophies, practices, policies, and outcomes of the most generally accepted and scientifically supported models of treatment, recovery, relapse prevention, and continuing care for addiction and other substance-related problems.

<table>
<thead>
<tr>
<th>I can identify the philosophies, practices, policies, and outcomes of the most generally accepted therapeutic models.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am able to discuss the most generally accepted and scientifically supported model of care for addiction and other substance-related problems.</td>
</tr>
<tr>
<td>I can utilize with fidelity a limited number of accepted and researched based models of care for substance use disorders.</td>
</tr>
<tr>
<td>I can adapt to a variety of models of care including new evidence-based approaches in individualizing the care for substance use disorders.</td>
</tr>
<tr>
<td>I am not familiar with any of the above.</td>
</tr>
<tr>
<td><strong>6. Recognize the importance of family, social networks, and community systems in the treatment and recovery process.</strong></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>I appreciate the importance of addressing family, social networks, and community systems in the treatment and recovery process.</td>
</tr>
<tr>
<td>I can describe the importance of incorporating family and social networks in the planning for recovery-oriented services from substance use disorders.</td>
</tr>
<tr>
<td>I include relevant family members, social networks, and community systems in recovery planning.</td>
</tr>
<tr>
<td>I am able to integrate family and social networks into individualized recovery plans on a routine basis.</td>
</tr>
<tr>
<td>I am not familiar with any of the above.</td>
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<tr>
<th><strong>7. Understand the value of an interdisciplinary approach to addictions treatment.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>I can describe an interdisciplinary approach to addictions treatment.</td>
</tr>
<tr>
<td>I am able to articulate the roles and contributions of multiple disciplines to treatment efficacy.</td>
</tr>
<tr>
<td>I can use relevant terms and concepts to communicate effectively across disciplines.</td>
</tr>
<tr>
<td>I can contribute to an interdisciplinary team in planning and delivering treatment services.</td>
</tr>
<tr>
<td>I am not familiar with any of the above.</td>
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<table>
<thead>
<tr>
<th><strong>8. Understand the established diagnostic criteria for substance use disorders and describe treatment modalities and placement criteria within the continuum of care.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>I am familiar with established diagnostic and placement criteria.</td>
</tr>
<tr>
<td>I can describe diagnostic criteria and treatment modalities for substance use disorders and their relationship to placement criteria.</td>
</tr>
<tr>
<td>I can apply diagnostic and placement criteria in the assignment of individuals with substance use disorders to appropriate treatment modalities.</td>
</tr>
<tr>
<td>I consistently assign individuals with substance use disorders to appropriate treatment modalities, including persons with co-existing disorders.</td>
</tr>
<tr>
<td>I am not familiar with any of the above.</td>
</tr>
</tbody>
</table>
### 9. Describe a variety of helping strategies for reducing the effects of substance use and addiction

<table>
<thead>
<tr>
<th>Competency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I can list a variety of helping strategies for reducing the negative effects of addiction.</td>
</tr>
<tr>
<td>2.</td>
<td>I can describe the relationship between a variety of helping strategies and how they work to effectively reduce substance use and addiction.</td>
</tr>
<tr>
<td>3.</td>
<td>I am able to apply a variety of helping strategies tailored to meet the unique needs of persons with substance use disorders.</td>
</tr>
<tr>
<td>4.</td>
<td>I am able to integrate strategies into treatment services that reduce the negative effects of substance use and addiction.</td>
</tr>
<tr>
<td>5.</td>
<td>I am not familiar with any of the above.</td>
</tr>
</tbody>
</table>

### 10. Tailor helping strategies and treatment modalities to the client's level of substance use, change, or recovery.

<table>
<thead>
<tr>
<th>Competency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I can identify the level of the individual’s substance use disorder, stages of change, and recovery.</td>
</tr>
<tr>
<td>2.</td>
<td>I can relate a client’s change readiness to helping strategies and treatment modalities.</td>
</tr>
<tr>
<td>3.</td>
<td>I can tailor helping strategies to a client’s stage of readiness to engage in recovery-oriented activities.</td>
</tr>
<tr>
<td>4.</td>
<td>I am able to account for the client’s racial, ethnic, cultural and socioeconomic status when planning recovery strategies consistent with the client’s readiness for change.</td>
</tr>
<tr>
<td>5.</td>
<td>I am not familiar with any of the above.</td>
</tr>
</tbody>
</table>

### 11. Provide treatment services appropriate to the personal and cultural identify and language of the client.

<table>
<thead>
<tr>
<th>Competency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I am familiar with cultural norms, values, beliefs, and behaviors for predominant subgroups in local areas.</td>
</tr>
<tr>
<td>2.</td>
<td>I understand the relationship between specific treatment services and the personal and cultural identities of client populations including predominant languages.</td>
</tr>
<tr>
<td>3.</td>
<td>I am able to provide services to the personal identity and culture of the client.</td>
</tr>
<tr>
<td>4.</td>
<td>I can individualize services appropriate to specific cultural groups who may communicate in a language unique to their cultures.</td>
</tr>
<tr>
<td>5.</td>
<td>I am not familiar with any of the above.</td>
</tr>
</tbody>
</table>
### 12. Recognize medical and pharmacological resources in the treatment of substance use disorders.

| I can describe the range of available medical and pharmacological resources. |
| I can assess the strengths and liabilities of medical and pharmacological interventions. |
| I can access health practitioners and pharmacy resources in the community who are knowledgeable about addiction and recovery. |
| I can strategically select medical and pharmacological practitioners to assist in recovery services for substance use disorders. |
| I am not familiar with any of the above. |

### 13. Recognize that crisis may indicate an underlying substance use disorder and may be a window of opportunity for change.

| I am aware of the relationship between crisis, readiness for change, and available resource for the management of crisis situations. |
| I can describe the types of crises that frequently occur in persons with substance use disorders and the principles for intervening to facilitate entry into treatment. |
| I can assist with management of crisis situations, utilizing established intervention principles and available resources for assistance. |
| I can independently manage and stabilize complex crisis situations, including collaboration with and referral to available resources. |
| I am not familiar with any of the above. |

### 14. Understand the need and use of methods for measuring treatment outcomes.

<p>| I recognize researched-based methods for measuring treatment outcomes. |
| I understand the need to measure treatment outcomes using appropriate scientific methods. |
| I am able to collect outcome measures as directed and use the measures in treatment progress. |
| I am able to routinely analyze and utilize outcome data to evaluate treatment service delivery. |
| I am not familiar with any of the above. |</p>
<table>
<thead>
<tr>
<th>15. Understand diverse cultures and the relevant needs of culturally diverse groups, as well as people with disabilities, into clinical practice.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am familiar with resources broadly defining diversity and the importance of culture, including the needs and rights of persons with a variety of disabilities.</td>
</tr>
<tr>
<td>I am knowledgeable about the diversity of cultures and their implications for services in substance use disorder treatment settings.</td>
</tr>
<tr>
<td>I am able to demonstrate an understanding of diversity principles and culturally sensitive counseling methods relevant to local populations and people with disabilities.</td>
</tr>
<tr>
<td>I am able to promote integration of culturally sensitive counseling practices in the planning and delivery of clinical services.</td>
</tr>
<tr>
<td>I am not familiar with any of the above.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>16. Understand the importance of self-awareness in one’s personal, professional, and cultural life.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have some awareness of personal, professional, and cultural strengths and challenges.</td>
</tr>
<tr>
<td>I appreciate the relationship between personal and professional traits and their impact on client interactions and relationships.</td>
</tr>
<tr>
<td>I am able to interact with clients in a manner demonstrating accurate self-awareness.</td>
</tr>
<tr>
<td>I can utilize accurate self-knowledge in the development of relationships with a diversity of client outcomes.</td>
</tr>
<tr>
<td>I am not familiar with any of the above.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>17. Understand the addiction professional’s obligations to ethical and behavioral standards of conduct in the helping relationship.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am familiar with contemporary ethical and behavioral codes of conduct.</td>
</tr>
<tr>
<td>I can appreciate and discuss the application of ethical and behavioral codes of conduct.</td>
</tr>
<tr>
<td>I am able to comply with ethical and regulatory guidelines in the delivery of clinical services.</td>
</tr>
<tr>
<td>I can assess, clarify, and help resolve incidents which are potential violations of existing ethical and regulatory guidelines.</td>
</tr>
<tr>
<td>I am not familiar with any of the above.</td>
</tr>
<tr>
<td>18. Understand the obligation of the addiction professional to participate in prevention and treatment activities.</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>I am aware of the relationship between prevention and treatment.</td>
</tr>
<tr>
<td>I can describe the most commonly accepted prevention models and their relationship to treatment.</td>
</tr>
<tr>
<td>I can integrate prevention resources in the delivery of clinical services when appropriate.</td>
</tr>
<tr>
<td>I can seek opportunities to integrate prevention and treatment services to enhance the overall continuum of care.</td>
</tr>
<tr>
<td>I am not familiar with any of the above.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>19. Understand and apply setting-specific policies and procedures for handling crisis or dangerous situations, including safety measure for clients and staff.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I am familiar with policies and procedures related to crisis management.</td>
<td></td>
</tr>
<tr>
<td>I can describe how agency policies and procedures apply to potential crisis situations.</td>
<td></td>
</tr>
<tr>
<td>I adhere to agency policies, procedures, and practices in the management of crises and dangerous situations.</td>
<td></td>
</tr>
<tr>
<td>I provide leadership in the development and implementation of policies and procedures related to crisis management.</td>
<td></td>
</tr>
<tr>
<td>I am not familiar with any of the above.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>20. Recognize Medication Assisted Treatment (MAT), its use and efficacy in the treatment of substance use disorders.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I am familiar with the pharmacological properties of MAT.</td>
<td></td>
</tr>
<tr>
<td>I understand the pharmacological properties of MAT and how it acts in treating opioid use disorders.</td>
<td></td>
</tr>
<tr>
<td>I support the use of MAT in a combination of counseling and behavioral therapies to treat substance use disorders and to prevent opioid overdose.</td>
<td></td>
</tr>
<tr>
<td>I can differentiate between the different types of approved medications in the treatment of opioid use disorders and make recommendations to my clients, community members, and others regarding their use.</td>
<td></td>
</tr>
<tr>
<td>I am not familiar with any of the above.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix B

Demographic Questions

INSTRUCTIONS: For each question below, please indicate the answer you most closely identify.

1. Do you currently hold a license as a professional counselor and a certification as an Approved Clinical Supervisor granted by the Center for Credentialing and Education in the United States?
   a. yes
   b. no

2. Do you have a master’s degree in addictions counseling or a master’s degree in counseling with an addiction concentration?
   a. yes
   b. no

3. Do you have a license or certification in addictions counseling?
   a. yes
   b. no

4. Have you previously completed this survey as part of an Approved Clinical Supervisor invitation sent to you by the Center for Credentialing and Education?
   a. yes
   b. no

5. In which type of program did you earn your master’s degree in counseling?
   a. community counseling
   b. clinical mental health counseling
   c. school counseling
   d. higher education
   e. other, please specify: _______________

6. In what year did you earn your master’s degree?
   Please specify: _______________

7. How many graduate addiction courses have you completed?
   Please specify: _______________

8. How many hours of addiction training (e.g., non-credit training, webinars, in-service) have you completed?
   Please specify: _______________
9. How long have you provided counseling services for individuals with substance use disorders?
   Please specify years: ______________

10. How long have you been practicing as a professional counselor post master’s degree?
    Please specify years: ______________

11. Do you identify as someone in substance use or addiction recovery?
    a. yes
    b. no

12. What is your age?
    Please specify: ______________

13. To which gender identity do you most identify?
    a. male
    b. female
    c. other, please specify: ______________
    d. I prefer not to answer

14. Which categories describe you? Check all that apply
    a. American Indian, Native American, or Alaska Native
    b. Asian
    c. Black or African American
    d. Hispanic, Latino, or Spanish Origin
    e. Middle Eastern or Norther African
    f. Native Hawaiian or Other Pacific Islander
    g. White
    h. Some other race, ethnicity, or origin, please specify: ______________
    i. I prefer not to answer
Appendix C

Letter to Participate in Research Study

Dear Colleagues,

My name is Elizabeth Conte, and I am a doctoral candidate in the Counselor Education and Supervision program at Montclair State University. I am conducting a doctoral research study on *The Self-Perceived Addiction Competencies of Approved Clinical Supervisors in Response to the Opioid Epidemic*. The purpose of the study is to identify clinical supervisors’ addiction competencies and to determine how contextual factors inform their supervisory practice of overseeing the work of counselors who work with individuals with substance use disorders.

I am requesting clinical supervisors who meet the following criteria to participate in the study:

a) professional counseling licensure within the United States;

b) absence of licensure or certifications in addiction;

c) a graduate degree from a counseling program with a concentration other than addictions counseling; and

d) certification as an Approved Clinical Supervisor.

Individuals who meet the above criteria can participate in the survey after a review of the informed consent and completion of a demographic survey. It is expected that the survey should take approximately 20 minutes to complete. Please know participation in this study is completely voluntary, and participants may withdraw at any time. The current study has been approved by the Montclair State University IRB, and all data collected will be kept private and confidential.

If you would like to participate in the study, please complete the attached survey and return it in the enclosed self-addressed stamped envelope. Alternately, you may access the survey via the Internet by cutting and pasting the following link: [https://montclair.co1.qualtrics.com/jfe/form/SV_e4jOrYbOso2Bnil](https://montclair.co1.qualtrics.com/jfe/form/SV_e4jOrYbOso2Bnil).

Please contact me at conteel@montclair.edu with questions or concerns about the informed consent, the survey, or with general questions about the study. You may also contact my dissertation chair, Dr. Dana Levitt at levittd@montclair.edu.

Thank you in advance for your consideration and participation!

Sincerely,

Elizabeth Conte
Doctoral Candidate
Montclair State University
Appendix D

Informed Consent

You are invited to participate in a research study, Clinical Supervisor Self-Perceived Addiction Competencies in Response to the Opioid Epidemic. The research is being conducted by Elizabeth Conte, doctoral student at Montclair State University. The survey will take about 20 minutes to complete. You may complete the enclosed survey and return it to me in the pre-addressed and stamped envelope or complete the survey online through the link at the end of this letter. Participating in this study is optional.

- **Goal of Study:** The goal of this study is to better understand how to prepare and support clinical supervisors overseeing the practice of professional counselors working with individuals who have substance use disorders. I hope to measure Approved Clinical Supervisors’ awareness, understanding, applied knowledge, and mastery of their self-perceived addiction competencies.

- **Study Participation:** You were selected to participate in this study because you are an Approved Clinical Supervisor practicing in the United States. You will be asked to answer questions about your knowledge, skills, understanding, and self-awareness related to addiction and individuals who have substance use disorders.

- **Confidentiality:** The survey is anonymous, and no one will be able to link your answers back to you. If you are completing the survey by mail, please do not record your name on the survey or list a return address. If you are completing the survey online, it is strongly advised that you do not use an employer issued electronic device, laptop, phone or WIFI, as many employers monitor use of all devices.

- **Likely Risk:** Please note that this study does not test your ability to perform your job correctly or your overall competence as a clinical supervisor. Any discomfort or inconvenience to you may include feeling uncomfortable responding to questions regarding your specific knowledge, experience, and confidence regarding addiction competencies and your practice.

- **Data Collection:** Data will be collected using either U.S. mail or the Internet. If you choose to complete a paper survey, your responses will be stored in a locked cabinet without any identifying information. Paper surveys will be destroyed and shredded at the completion of the study. While there are no guarantees on the security of data sent on the Internet, we will maximize confidentiality by not collecting your name or job location.

- **Benefits:** You may not directly benefit from this research. However, by completing the survey you will be contributing to the field of clinical supervisor learning, education, training, and professional development.
Questions? Please contact me at contee1@montclair.edu or 609-851-6784. You may also contact my Faculty Advisor, Dr. Dana Heller Levitt, at levittd@montclair.edu. If you have questions or concerns about your rights as a research participant, you can call the MSU Institutional Review Board at 973-655-7583 or email reviewboard@montclair.edu.

If you choose to participate in this study, please complete the attached survey and return it in the self-addressed stamped envelope, or you may access the survey through the following link: https://montclair.co1.qualtrics.com/jfe/form/SV_e4jOrYbOs02Bnil

Thank you for your time and participation!
March 27, 2019

Dr. Dana Levitt and Elizabeth Conte
Montclair State University
Department of Counseling and Ed. Leadership
1 Normal Ave.
Montclair, NJ 07043

Re: IRB Number: IRB-FY18-19-1323
Project Title: SS Clinical Supervisor Self-Perceived Addiction Competencies

Dear Ms. Conte:

After an exempt review:

- Category 3. (i)(A). Research involving benign behavioral interventions in conjunction with the collection of information from an adult subject through verbal or written responses (including data entry) or audiovisual recording if the subject prospectively agrees to the intervention and information collection. The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects.

Montclair State University's Institutional Review Board (IRB) approved this protocol on March 26, 2019. Your exempt study will require an Administrative Check In, every two years, updating our office with the status of your research project. Your check in date is March 2021. We will send you a reminder prior to that date.

All active study documents, such as consent forms, surveys, case histories, etc., should be generated from the approved Cayuse IRB submission.

When making changes to your research team, you will no longer be required to submit a
Modification, unless you are changing the PI. As Principal Investigator, you are required to make sure all of your Research Team members have appropriate Human Subjects Protections training, prior to working on the study. For more clarification on appropriate training contact the IRB office.

If you are changing your study protocol, study sites or data collection instruments, you will need to submit a Modification.

When you complete your research project you must submit a Project Closure through the Cayuse IRB electronic system.

If you have any questions regarding the IRB requirements, please contact me at 973-655-7583, cayuseIRB@montclair.edu, or the Institutional Review Board.

Sincerely yours,

Katrina Bulkley
IRB Chair

cc: Ms. Caren Ferrante, Graduate School, Program Assistant