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Determinants of Clinical Supervisor Self-Efficacy in Substance Use Disorder Counseling

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Walden University

College of Social and Behavioral Health

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Victoria Nagel

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Walden University
2026

Abstract

Determinants of Clinical Supervisor Self-Efficacy in Substance Use Disorder Counseling

by

Victoria Nagel

MA, Caldwell University, 2015

BS, Stockton University, 2011

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

February 2026

Abstract

Substance use disorder counselors face increasing challenges in responding to a growing and more severely affected population, often presenting with co-occurring mental health conditions and complex clinical needs. Clinical supervision plays a critical role in supporting counselor development, yet little is known about the factors that contribute to clinical supervisors' self-efficacy in providing supervision for alcohol and drug counselors. The purpose of this quantitative correlational study was to examine whether years of counseling experience, years of substance use disorder (SUD) counseling experience, years as a clinical supervisor, professional counseling credentials, and supervisory credentials predicted self-efficacy among clinical supervisors. This study was grounded in Bandura's self-efficacy theory, which posits that individuals' beliefs in their capabilities influence performance and persistence. A sample of 92 clinical supervisors completed a survey measuring demographic variables and the Clinical Supervisor Self-Efficacy Scale. Data were analyzed using multiple regression to identify significant predictors. Results indicated that counseling experience, SUD counseling experience, and credential attainment were not significant predictors, $F(6, 85) = 1.50, p = .186, R^2 = .032$. These findings highlight the importance of structured, experiential, and reflective supervisory training to cultivate confident and effective supervisors. Implications for positive social change include strengthening clinical supervision practices, improving counselor development, and ultimately enhancing the quality of care for clients with SUDs.

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Dedication

This dissertation is dedicated to my son, Russell, my nephew, Jack, and my niece, Margaret. You all are my constant source of love, motivation, and purpose. It is my hope that through this work, I have demonstrated the value of hard work, dedication, and perseverance, and that you will always believe in your ability to pursue your goals, even when the path is challenging. May you know that anything is possible with commitment, resilience, and belief in yourself.

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Chapter 1: Introduction to the Study

Introduction

Substance use disorder (SUD) counselors face increased pressures as they work with a growing and more severely affected population (Peavy et al., 2024). From the expansion of telehealth services to new designer drugs hitting the streets, alcohol and drug counselors (ADCs) must consistently be developing their skills in a rapidly shifting landscape (Peavy et al., 2024). The 2023 National Survey on Drug Use and Health indicated that 42.4% of individuals 18 years or older with any mental illness also used illicit drugs, and 51.9% of individuals 18 years or older with a serious mental illness used illicit drugs (Substance Abuse and Mental Health Services Administration [SAMHSA], 2024). With high rates of co-occurring mental illness and illicit drug use, professional counselors may encounter an individual who is using or misusing substances.

The training and education of counselors to provide services to this growing population vary (Kerwin, 2006). Historically, ADC training has relied heavily on an apprenticeship-style model, where much of the knowledge, skills, and abilities are acquired on the job under the guidance of a supervisor (Kerwin et al., 2006). This training model relies heavily on a clinical supervisor's skills and knowledge, underscoring the importance of well-trained and confident clinical supervisors. In contrast, professional counselors follow a different training path, which includes foundational knowledge about neurobiological etiology, theories of addiction, and the identification of substance use and misuse (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2023). Beyond this foundational knowledge, professional counseling

students learn about the complexities of treating addictions only if they choose addiction counseling as their specialized practice area (CACREP, 2023). This lack of education and the rate at which those with mental disorders are using illicit drugs highlight the need for further education, which could be provided through clinical supervision. Clinical supervision has been demonstrated to be an effective way to support counselors in feeling confident about their clinical skills and implementing evidence-based practices (Giannopoulos et al., 2021).

Clinical supervision is valuable to a counselor's professional competence (O'Donnell et al., 2022). Clinical supervision also protects against burnout (Peavy et al., 2024), increases occupational and organizational commitment, and decreases workforce turnover (O'Donnell et al., 2022). While a considerable body of scholarly literature exists on the influence of clinical supervision on counselor development and behavior, there is a notable lack of research on the factors that influence the development and behavior of clinical supervisors. Identifying this gap, Hendrick et al. (2021) conducted a study on perceptions of supervision training, supervision experiences, and perceived abilities in providing supervision to South African psychologists. Hendrick et al. (2021) found that while most supervisors felt confident in their ability to provide supervision, most lacked formal training and prematurely engaged in supervising interns. While this study may have focused on psychologists in South Africa, these results are alarming for the ADCs of the United States, as most supervision skills and processes are common across mental health professions and countries (Bernard & Goodyear, 2019).

My study aimed to investigate the variables that influence the self-efficacy of clinical supervisors. Self-efficacy influences motivation, decision-making, and consistent engagement (Bandura, 1977; Strauser, 1995). Understanding what influenced the self-efficacy of a clinical supervisor is important because self-efficacy impacts behavior and motivation. The results from this study could assist counselor educators and supervisors in promoting the self-efficacy of clinical supervisors providing clinical supervision to counselors treating SUDs. Ideally, this would lead to more consistent clinical supervision that meets the unique and complex needs of SUD counselors. With these unique needs being met, counselors may feel more supported in providing SUD treatment, which is important, as clinical supervision accounts for up to 16% of the variance in a client's SUD treatment outcome (Ramsey et al., 2017).

Presented in this chapter is background information that summarizes the literature related to SUD clinical supervision and self-efficacy. I review the problem statement; purpose statement; research question; the study's theoretical framework, self-efficacy theory (SET); the nature of the study; and definitions of key terms. Furthermore, I provide the assumptions made, the scope and delimitations, and the limitations of the study. Finally, I conclude this chapter by discussing the significance of this study in the field of counselor education and supervision and provide an overall summary.

Background

Clinical supervision is a complex didactic process in which a counselor with more experience in the counseling field guides a novice counselor in applying theoretical knowledge to practical skills (Bernard & Goodyear, 2019). This relationship is both

supportive and evaluative, extending over time to monitor the supervisee's professionalism and quality of work (Benard & Goodyear, 2019; Center for Substance Abuse Treatment, 2009). Clinical supervisors serve as teachers, coaches, mentors, and consultants. These roles are fluid and often overlap as they assist supervisees in improving self-awareness, developing clinical skills, and grounding their work in theoretical orientations (Center for Substance Abuse Treatment, 2009).

Lohani and Sharma (2023) conducted a systematic review of global quantitative and qualitative research since the 1980s related to the impact of supervision on counselors' or psychotherapists' self-awareness and self-efficacy, highlighting that the literature supports that counselors' self-efficacy is enhanced by clinical supervision. In addition to clinical supervision, a relationship exists between training, experience, and the perceived work environment, as well as counselor self-efficacy (Schiele et al., 2014). While the literature on counselor self-efficacy was extensive, there was a notable lack of research on clinical supervisor self-efficacy. Not understanding what influences clinical supervisor self-efficacy makes it challenging to train clinical supervisors properly. Results from this study address this challenge and assist counselor educators and supervisors in promoting the supervision self-efficacy of clinical supervisors, ensuring that they feel confident in providing effective supervision to counselors delivering SUD counseling.

Problem Statement

SUDs are complex disorders that require counselors who treat clients diagnosed with them to have knowledge of various evidence-based treatment options and the ability

to work within a multidisciplinary team of practitioners to effectively assist clients (The National Institute on Drug Abuse, 2018). A counselor's self-efficacy refers to their belief in their ability to successfully execute the necessary behaviors required to perform a task, and it plays a pivotal role in their ability to provide effective counseling (Bandura, 1997; Strauser, 1995). Self-efficacy also influences the type of setting someone chooses to work in, their behavior, and their persistence in performance (Bandura, 1977; Barnes, 2004; Strauser, 1995). Clinical supervision is crucial in enhancing counselor self-efficacy (Lohani & Sharma, 2023) and the overall counseling experience (Bernard & Goodyear, 2019). Most SUD counselors do not receive adequate supervision (Ramsey et al., 2017); clinical supervision can be brief, informal, and reactionary (Win et al., 2022). This is alarming, as the literature has documented that clinical supervision improves counselor self-efficacy (Lohani & Sharma, 2023) and is responsible for up to 16% of the variance in a client's SUD treatment outcome (Ramsey et al., 2017). As mentioned above, self-efficacy refers to the belief one has about their ability to be successful, influencing motivation for behavior and persistence in engaging in a task (Bandura, 1977). Self-efficacy has been demonstrated in the counseling field (Bandura, 1997; Barnes, 2004; Strauser, 1995). As a result, it was reasonable to conclude that self-efficacy would also impact counselors in their roles as clinical supervisors and influence their behavior, ability, and consistency in providing clinical supervision. Literature has minimally explored self-efficacy in the context of a clinical SUD supervisor's role. To fill this gap, my study examined the variables that influence the self-efficacy of clinical SUD supervisors. Beginning to fill this gap is important due to the complexity of treating

SUDs, and counselors working with this population must receive consistent supervision rather than the reactionary and brief supervision that is currently reported (Win et al., 2022). Self-efficacy has been demonstrated to influence motivation for behavior, ability, and persistence in engaging in a task, as seen in a counselor's counseling behavior (Bandura, 1997). As mentioned, the literature on self-efficacy and clinical supervisor behaviors has been minimal. Understanding the factors that influence the self-efficacy of clinical SUD supervisors, counselor educators, and supervisors can help better prepare clinical supervisors in training. Researchers could further explore self-efficacy as it relates to clinical supervisors.

Purpose of the Study

The purpose of this quantitative study was to examine whether years of experience in the field of counseling, years of experience providing SUD counseling, years of experience in the role of clinical supervisor, professional counseling credentials, and supervisory credentials of a clinical SUD supervisor predict supervision self-efficacy. The dependent variable was supervision self-efficacy, measured by the Counselor Supervisor Self-Efficacy Scale (CSSSES; Barnes, 2002). The independent variables were years of experience in the field of counseling, years of experience providing SUD counseling, years of experience in the role of clinical supervisor, professional counseling credentials, and supervision credentials.

Research Question and Hypotheses

RQ: Do years of experience in the field of counseling, years of experience providing SUD counseling, years of experience in the role of clinical supervisor,

professional counseling credentials, and supervision credentials predict clinical supervisors' self-efficacy as measured by the Counselor Supervisor Self-Efficacy Scale?

H₀: Years of experience in the field of counseling, years of experience providing SUD counseling, years of experience as a clinical supervisor, professional counseling credentials, and supervision credentials do not predict clinical supervisors' self-efficacy.

H₁: Years of experience in the field of counseling, years of experience providing SUD counseling, years of experience in the role of clinical supervisor, professional counseling credentials, and supervision credentials do predict clinical supervisors' self-efficacy.

Theoretical Framework for the Study

Bandura's (1977) Self-Efficacy Theory (SET) is the theoretical framework that grounded this study. SET provided a framework to explain individual motivation and decision-making, suggesting that an individual's self-efficacy is their confidence level in their ability to be successful, which in turn increases their motivation, decision-making, and engagement consistency (Bandura, 1977; Strauser, 1995).

A key concept of SET is efficacy expectations. Efficacy expectations refer to individuals' beliefs that they can successfully perform a behavior to achieve a desired outcome (Bandura, 1977; Strauser, 1995). Efficacy expectations impact an individual's choice of settings, behaviors, and persistence in performance (Bandura, 1977; Barnes, 2004; Strauser, 1995). Self-efficacy originates from four sources: performance accomplishments, vicarious experiences, verbal persuasion, and emotional arousal (Strauser, 1995). Performance accomplishments are the most influential source of

efficacy information, stemming from repeated successful experiences. Vicarious experiences occur when an individual observes another person successfully completing a task without experiencing negative consequences. Seeing someone else successfully complete a task makes one feel they could also be successful. Verbal persuasion occurs when an individual is steered to believe, through verbal validation, that they can be successful in a difficult situation. Finally, emotional arousal, an individual's physiological reaction, and emotion associated with a task influence their belief in success (Bandura, 1977; Strauser, 1995). Self-efficacy plays a significant role in a counselor's ability to provide effective counseling (Lohani & Sharma, 2023), a topic that will be further discussed in Chapter 2.

Literature has minimally explored self-efficacy related to the role of clinical supervision. Self-efficacy as a construct has been documented as influencing motivation for behavior, ability, and persistence in engaging in a task (Bandura, 1977) and has been demonstrated specifically in counselors providing counseling, as mentioned above (Bandura, 1997; Barnes, 2004; Strauser, 1995). As a result, I reached the reasonable conclusion that self-efficacy also impacts counselors in the role of clinical supervisor, influencing their behavior, ability, and consistency in providing clinical supervision. Previous studies had examined how training, level of experience, and clinical supervision affect counselor self-efficacy (Schiele et al., 2014). What had not been explored, and what this study explored, was the variables that influence clinical SUD supervisor self-efficacy.

Nature of the Study

This quantitative study addressed the research question using a correlational research design to determine whether years of experience in the field of counseling, years of experience in SUD counseling, years of experience in the role of clinical supervisor, professional counseling credentials, and supervision credentials predicted the self-efficacy of clinical SUD supervisors. The key study variables included were the independent variables: years of experience in the field of counseling, years of experience providing SUD counseling, years of experience in the role of clinical supervisor, professional counseling credentials, and supervision credentials. The dependent variable was clinical SUD supervisors' self-efficacy as measured by the Counselor Supervisor Self-Efficacy Scale.

The rationale for using a quantitative approach to this study was to determine whether a relationship exists between years of experience in the field of counseling, years of experience providing SUD counseling, years of experience in the role of clinical supervisor, professional counseling credentials, supervision credentials, and clinical SUD supervisor self-efficacy. To address the research question, data were collected using a demographic questionnaire and the CSSES. The questionnaire and CSSES were distributed using a convenience sampling design. Participants had to be supervising ADCs or professional counselors providing SUD counseling and hold at least a professional counseling credential. I disseminated the demographic questionnaire and CSSES using a convenience sampling method via professional Listservs, social media (i.e., Facebook, LinkedIn, and the NAADAC Community Board), Walden University's

Participant Pool, and my professional networks. A multiple linear regression analysis was used to analyze the collected data.

Definitions

Clinical supervision: An ongoing professional relationship between an experienced counselor (clinical supervisor) and a novice counselor (supervisee), where the clinical supervisor provides support, guidance, and evaluation of the supervisee's professionalism and quality of work (Bernard & Goodyear, 2019).

Counseling credentials: In the United States, each state establishes requirements for individuals to practice mental health and addiction counseling (Kerwin et al., 2006). In this study, professional and addiction counseling credentials were accepted as determined by state standards.

Professional counselors: Individuals with a counseling degree at a graduate level from a CACREP-accredited program or a counseling program administered by an accredited institution, and complete postgraduate clinical counseling experience (National Board for Certified Counselors, 2025). Participants self-identified if their practicing state deemed them as a professional counselor.

Alcohol and drug counselors: Individuals who have had specialized training and experience in counseling individuals with substance use and related disorders and hold a specific ADC credential (NAADAC, 2025c). Participants self-identified if their practicing state deemed them as an ADC.

Supervision credentials: Clinical supervisors' credentialing is independently set by regulatory bodies (i.e., licensing boards or government designees, such as certification

boards) and varies across the United States (Bernard & Goodyear, 2019). Participants self-identified if their practicing state deemed them as appropriate to provide clinical supervision.

Self-efficacy refers to an individual's belief in their ability to complete a task, their motivation to engage in the task, and their persistence in engaging with it even when faced with adversity (Bandura, 1977).

Assumptions

I assumed that self-efficacy influences supervisors' motivation, ability, and persistence in counseling. Previous literature demonstrated that self-efficacy influences counselors' motivation, ability, and persistence in counseling (Bandura, 1997; Barnes, 2004; Strauser, 1995). I also drew the reasonable assumption that self-efficacy influences the motivation, ability, and persistence of clinical supervisors in providing clinical supervision. This assumption was made because self-efficacy can be applied more broadly to behavior outside of the counseling profession (Bandura, 1977), and clinical supervisors were once counselors to whom the self-efficacy phenomenon directly applies. Another assumption made was that clinical supervisors are self-aware and can set aside their biases. Finally, because surveys are susceptible to social desirability bias (Cox, 2020), I assumed that clinical supervisors would respond to survey instruments honestly and not in a way that would make them appear more positive or socially desirable.

Scope and Delimitations

The delimitations of the study were related to the gap in the literature on the self-efficacy of clinical SUD supervisors and contributed to the understanding of what

influences the self-efficacy of clinical SUD supervisors. I specifically focused on clinical supervisors who held at least a professional counseling credential and a supervisory credential required by their state (if required) and supervised SUD counselors or interns. The study excluded marriage and family therapists, psychiatric aides, advanced psychiatric practice registered nurses, psychiatric physician assistants/associates, psychiatrists, psychologists, and social workers. While individuals who hold these credentials are all mental health professionals, the scope of this study was focused on counselor training.

To explain supervisor behavior, SET was chosen due to its ability to explain motivation, ability, and persistence in the behavior of clinical supervisors. This theoretical framework was chosen because SET is well-documented in counseling literature concerning counselor behavior. A competency-based model was considered as a conceptual framework but was not ultimately chosen because it explained understanding and knowledge of clinical supervision rather than behavior in clinical supervision. While this research aimed to reach clinical SUD supervisors across the continental United States, the use of a convenience sampling design may have impacted the generalizability of the study's findings.

Limitations

A potential limitation of the study was the use of the CSSES instrument. An exhaustive literature review revealed that only two scales are available to specifically measure clinical supervisors' self-efficacy. The CSSES was chosen because it had been used in a few peer-reviewed publications on self-efficacy and clinical supervision.

Another potential barrier that had to be addressed was gathering enough complete surveys to meet statistical power. Multiple data source points (NAADAC community board, social media, and my professional networks) have been identified to address this barrier. An additional limitation of this study was that it was susceptible to social desirability bias. While the study was anonymous, to appear competent, a desirable quality of a clinical supervisor, participants may have overrated themselves on the CSSES.

Significance

This study was significant as it began to fill the gap in understanding the self-efficacy of clinical supervisors. Results from this study could assist counselor educators and supervisors in promoting the self-efficacy of clinical SUD supervisors. This could lead to more consistent clinical supervision that meets the unique and complex needs of the SUD counselor. The broader social change implications of this study were that if clinical supervisors of SUD counselors could provide more consistent clinical supervision, it would enhance the self-efficacy of SUD counselors, ultimately leading to improved client care. Furthermore, with the high prevalence of SUDs occurring in clients with mental disorders (42.4% of individuals with any mental illness and 51.9% of individuals with a serious mental illness reporting using illicit drugs; SAMHSA, 2024), understanding the factors associated with clinical supervisors' self-efficacy in providing supervision for SUD counseling services is critically important. Identifying predictor variables that support supervisors' self-efficacy has implications for workforce

development, supervisor training, and the quality of supervision in settings where SUDs are prevalent.

Summary

In this quantitative study, I explored the influence of years of experience in the field of counseling, years of experience providing SUD counseling, years of experience in the role of clinical supervisor, professional counseling credentials, and supervision credentials on the self-efficacy of a clinical SUD supervisor. This study began to fill the gap in literature regarding the self-efficacy of clinical SUD supervisors. Moreover, the results of this study could assist counselor educators and supervisors in promoting the self-efficacy of clinical SUD supervisors, leading to more consistent supervision that meets the SUD counselor's unique and complex needs. In Chapter 2, I outline my literature review strategy; provide an in-depth review of the theoretical framework, including SET; and conduct an analysis of the relevant literature.

Chapter 2: Literature Review

Introduction

According to the National Institute on Drug Abuse (NIDA; 2018), SUDs are complex disorders and require those working with this client population to have advanced knowledge of various evidence-based treatment options and the ability to collaborate with a multi-disciplinary team. While counselors can learn about the complexities of SUDs in their training programs, clinical supervision bridges learned knowledge and application (Bernard & Goodyear, 2019). Counselors who received consistently scheduled clinical supervision displayed higher levels of counseling self-efficacy when compared to those who received minimal supervision (Larson & Daniels, 1998). However, in SUD counseling, clinical supervision can be brief, informal, and reactionary (Win, et al., 2022). This is a cause for concern since, as briefly discussed in Chapter 1, the literature has demonstrated that clinical supervision improves counselor self-efficacy (Cashwell & Dooley, 2001; Clark et al., 2024; Li et al., 2023 Lohani & Sharma, 2023) and self-efficacy influences counselor motivation and behavior (Bandura, 1977; Bandura, 1997). Little is known about what influences the self-efficacy of a clinical supervisor, as literature has minimally explored self-efficacy related to the role of a clinical supervisor. This study begins to fill this gap as it examined whether years of experience in the field of counseling, years of experience providing SUD counseling, years of experience in the role of clinical supervisor, professional credentials, supervisory and clinical credentials of a SUD counselor predict supervisors' self-efficacy.

In this chapter, I review the literature search strategy used, the theoretical foundation used, and the literature related to key variables and concepts. Specifically, in the literature review, I discussed SUD counseling from the biopsychosocial lens, the training, education, and credentialing needed to become a qualified SUD counseling provider, as well as the training, education, and credentialing needed to become a qualified clinical supervisor for those providing SUD counseling. I wrap up the literature review discussing the concept of years of experience as a qualifier for being a clinical supervisor. This chapter concludes with a summary and reflection on current literature.

Literature Search Strategy

To access literature, the following library databases and search engines were used: APA PsychArticles, APA PsycInfo, Directory of Open Access Journals, Education Source, Index, and Academic Search Complete, Mental Measurement Yearbook, Google, and Research Gate. Key search terms used were as follows: Clinical supervisor and experience or perceptions or attitudes or views; clinical supervisor and confidence or self-esteem or self-efficacy; self-efficacy and counselors or therapist or psychologist or psychotherapist, or ADCs; supervision or supervising or supervisory or supervisor, and burnout and job satisfaction and turnover and mental health; clinical supervision and counseling or therapy or psychotherapy or treatment; self-efficacy theory, counselors or therapist or psychologist or psychotherapist, ADCs and self-efficacy; substance use disorder counseling or addiction counseling and social determinate of health; and SET and Albert Bandura. All literature searches had the criteria of being peer-reviewed. A five-year parameter was initially placed on the literature search; however, a 10-year filter

was applied after five years yielded minimal results. Even with allowing a 10-year gap, minimal research specific to the research topic was found. I found that bibliographic research was the most effective way to find relevant literature. Seminal literature on the theoretical foundation used the theory and the theorist's name; no date limitation was placed. One dissertation was used in the literature review, as this dissertation provided an instrument to measure clinical supervisor self-efficacy specifically.

Theoretical Foundation

SET was created by Albert Bandura in 1977. SET explains acquiring and retaining new behavioral patterns beyond a cognitive process (Bandura, 1977). A key assumption of SET is that, despite whatever intervention (i.e., training, skill-building) is used, the intervention works because it shapes a person's belief about their ability to succeed. SET distinguishes between two types of expectations: efficacy expectations and outcome expectations. An efficacy expectation is a person's estimate that they can successfully implement the behaviors needed to produce a desired outcome. Outcome expectancy is a person's estimate that behavior will lead to an outcome. These two concepts are distinct because an individual can believe that behavior will lead to a desired outcome (outcome expectation) but lack confidence in their ability to perform behaviors for the desired outcome (efficacy expectation; Bandura, 1977). I focused on what factors (i.e., years of experience in the field of counseling, years of experience providing SUD counseling, years of experience in the role of clinical supervisor, professional counseling credentials, and supervision credentials) influenced the efficacy expectations of clinical supervisors to answer the research question.

Self-efficacy influences an individual's choice of activities and settings, how successful they will be, and their coping abilities (Bandura, 1977). Efficacy expectations will influence how long and how much effort an individual will put into an activity when faced with obstacles or adverse experiences. The more self-efficacy an individual has, the more likely they are to persist when faced with difficulties. When an individual is successful in the face of adversity, it reinforces their sense of efficacy and reduces defensive behavior. Conversely, discontinuing effort in the face of adversity reinforces an individual's outcome expectation that they cannot be successful, which can lead to fearful and avoidant behavior. Expectations alone cannot produce desired behavior if an individual lacks the necessary skills, ability, and incentive. However, given skill, ability, and incentive, efficacy expectations play a significant role in an individual's choice of activity, how much effort they put into these activities, and how long they will persist when faced with adversity (Bandura, 1977).

Sources of Efficacy Expectations

Efficacy expectations come from four sources: performance accomplishments, vicarious experience, verbal persuasion, and emotional arousal (Bandura, 1977). These four sources help promote mastery of behavior and eliminate defensive behavior. Different interventions influence self-efficacy differently depending on their application. Interventions that increase confidence through direct experience provide more opportunities for building self-efficacy. In contrast, interventions that do not provide the opportunity to practice skills or experience emotional regulation make it harder to build self-efficacy (Bandura, 1977). For example, clinical supervisors who provide

opportunities to role-play and provide direct feedback allow supervisees to reduce performance anxiety, practice mastery of skills, and experience emotional regulation. Unlike clinical supervisors who use non-direct supervision methods like verbal discussions and case reviews, these supervisees depend solely on verbal reassurance from the supervisor that they are doing well. As a result, they may feel unprepared to handle real client sessions. Below is a general overview of the four sources of efficacy expectations.

Performance Accomplishments

Also known as enactive mastery experience, performance accomplishment is the most influential source of efficacy, as this source of efficacy provides the most concrete evidence that someone will succeed (Bandura, 1997). Performance accomplishment builds self-efficacy when an individual continuously completes a task or activity, while repeated failed attempts will lower self-efficacy (Bandura, 1977; Bandura, 1997). Once an individual builds their self-efficacy through repeated successful encounters (i.e., performance accomplishments), any future adverse events while engaging in the same task or activity will have less of a negative impact on the individual's performance, and the individual is more likely to be persistent in the face of adversity. Once established through performance accomplishments, self-efficacy is generalized to similar situations and activities (Bandura, 1977).

Vicarious Experience

Another opportunity for individuals to build self-efficacy is watching others complete a task or activity successfully without harm (Bandura, 1977). This is commonly

done through social comparison when others model behavior that an individual has not experienced yet and cannot self-assess their own capabilities (Bandura, 1997). For example, someone could quickly assess their ability to swim (either you can, or you cannot), but self-assessing whether someone can effectively run a group clinical supervision session is not as simple. The impact of this source of self-efficacy depends on the skills and talents of those individuals to whom they choose to compare themselves (Bandura, 1997). For example, suppose an individual compares themselves to someone whose skills and talents exceed theirs. In that case, they may misjudge their own capabilities, believing their skills are not good enough, thus decreasing their self-efficacy.

Verbal Persuasion

Verbal persuasion is the most accessible way to influence someone else's self-efficacy; however, its actual influence on self-efficacy is weaker than that of sources that provide authentic experiential evidence (Bandura, 1977; Bandura, 1997). Verbal persuasion involves being led to believing, through someone else's encouragement, that an individual can successfully complete an activity or task (Bandura, 1977). Verbal persuasion has the most significant impact on individuals who already have some belief in their abilities. Individuals who do not believe in themselves find little self-efficacy growth with verbal persuasion alone (Bandura, 1997).

Emotional Arousal

This source of self-efficacy stems from an individual's physiological responses and emotional states experienced when failure is perceived as a possibility (Bandura, 1977). Physiological responses, such as increased heart rate, tension, and feelings of

anxiety, can all influence an individual's belief in their ability to be successful.

Individuals often interpret their physiological response to stress as vulnerability or a sign of dysfunction, undermining their self-efficacy (Bandura, 1997). Emotional states like anxiety or fear can lead individuals to engage in avoidant behaviors and shy away from activities or tasks they feel they might not succeed in (Bandura, 1977). To positively influence self-efficacy, Bandura (1997) suggested reducing levels of stress and negative emotions, and correcting misinterpretations of physiological responses (i.e., anxiety or fear does not always indicate trouble or vulnerability; sometimes it is just the body and mind's way of saying proceed with caution).

Connecting SET and Clinical Supervision

As previously mentioned in Chapter 1, I investigated what influences the self-efficacy of clinical supervisors providing clinical supervision to counselors who provide SUD counseling. Self-efficacy has been well-documented in counseling literature related to counselor development and behavior, as reviewed briefly in Chapter 1, and will be demonstrated later in this chapter in the literature review section. While ample literature on counselor self-efficacy exists, there is not as much on clinical supervisor self-efficacy, which identifies a gap in the literature. Due to this gap, I drew the reasonable assumption that the theoretical framework of SET would apply to clinical supervisors because, one, clinical supervisors were once counselors themselves, and two, self-efficacy can be applied more broadly to behavior outside of the counseling profession (Bandura, 1977).

Literature Review Related to Key Variables and/or Concepts

Substance Use Disorder Counseling

As identified in Chapter 1, SUDs are complex. This complexity is due to SUDs being a brain disorder (National Institute on Drug Abuse, 2020b). The brain's reward circuit changes when an individual consistently uses substances (American Psychiatric Association, 2022; Goldstein & Volkow, 2011). This change in the reward circuit causes intensified attention to drug-related cues and reduced responsiveness to non-drug reinforcing stimuli and diminishes the capacity to self-regulate maladaptive behaviors, resulting in substance seeking and using to become an individual's primary motivational drive (Goldstein & Volkow, 2011). This neurobiological change in reward pathways presents a cluster of cognitive, behavioral, and physiological diagnostic features (American Psychiatric Association, 2022).

With rates of illicit substance use being over 40% for individuals with any mental illness (i.e., a mental, behavioral, or emotional disorder that interfered or limited at least one significant life activity) and over 50% for individuals with serious mental illness (i.e., a mental, behavioral, or emotional disorder that significantly interfered or limited at least one significant life activity; SAMHSA, 2024), it is important that counselors are aware of the diagnostic features of SUDs to be able to assess, diagnose, and treat clients appropriately. To conceptualize SUDs, a biopsychosocial approach is recommended since cognitive, behavioral, and physiological factors are all involved (Wangensteen & Hystad, 2021). The biopsychosocial approach views SUDs as a progressive disorder that includes biological, psychological, cognitive, and social factors (Belfiore et al., 2024;

Wangensteen & Hystad, 2021). The following outlines how biological, psychological, cognitive, and social factors manifest in SUD counseling.

Biological Factors in Substance Use Disorder Counseling

Individuals with SUDs are more likely, compared to the general population, to develop health issues such as cardiovascular disease, respiratory disorders, hepatitis C, diabetes, oral disease, and nutritional deficiencies (Osborne et al., 2022). Health issues can either be directly or indirectly caused by substance use. Contraction of a blood-borne virus due to intravenous drug use or cirrhosis of the liver caused by prolonged alcohol use are examples of health issues directly related to substance use. In contrast, poor diet due to the neglect of physical health, a common lifestyle factor associated with addiction, would be indirectly related (Osborne et al., 2022). Health issues directly or indirectly related to an individual's SUD impact treatment outcomes (Osborne et al., 2022; Tripp et al., 2013).

The behavioral health workforce that treats those with addictions is made up of ADCs, marriage and family therapists, professional counselors, psychiatric aides, psychiatric advanced practice registered nurses, psychiatric physician assistants/associates, psychiatrists, psychologists, and social workers (Health Resource and Service Administration, 2024). Of these professions, only three have medical training, making up approximately 8.8% of the behavioral health workforce (Health Resource and Service Administration, 2024). Thus, most of the workforce lacks formal medical training to address health concerns. Due to this workforce gap, counselors who

treat SUDs must be aware of health issues and make referrals to appropriate practitioners to ensure the client's health issues are addressed during treatment (Osborne, 2022).

Psychological and Cognitive Factors in Substance Use Disorder Counseling

According to the most recent National Survey on Drug Use and Health, 22.8% of individuals 18 years of age and older who are diagnosed with an SUD were also diagnosed with a mental illness, and 5.7% had a severe mental illness diagnosis (SAMHSA, 2024). Comorbid mental disorders that commonly present alongside SUDs are depression, anxiety disorder (specifically, generalized anxiety disorder and panic disorder), post-traumatic stress disorder, bipolar disorder, attention-deficit hyperactivity disorder, psychotic illnesses, schizophrenia, borderline personality disorder, and antisocial personality disorder (American Psychiatric Association, 2022).

These co-occurring disorders often mutually influence each other, intensifying and maintaining symptoms (Giannopoulos et al., 2021). One reason for poor treatment outcomes for individuals with co-occurring disorders is single disorder treatment (i.e., individuals only receiving treatment for one disorder or receiving treatment for one disorder and then the other; Giannopoulos et al., 2021). The recommended best practice is an integrated treatment approach (i.e., both the SUD and the other mental health disorder being treated simultaneously; Giannopoulos et al., 2021; SAMHSA, 2020). This approach requires an understanding of both mental disorders and SUDs to provide comprehensive treatment.

Social Factors in Substance Use Disorder Counseling

Historically, the Drug Treatment Career Framework has offered a basis for understanding the progression of an individual's substance use disorder and the connection between systemic, cultural, and socioeconomic contexts of their lived experience, now known as social determinants of health (SDoH; Lin et al., 2024). The U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion (n.d.) define SDoH as “conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks” (para 1). These conditions can be categorized into five domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context (U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, n.d.).

The connection between SDoH and SUD is multifaceted, with each domain playing a pivotal role in the development, maintenance, treatment, and recovery process (Lin et al., 2024). Employment status can significantly influence both substance use and the recovery journey. At the same time, school environments marked by racial or ethnic discrimination or segregation have been linked to increased initiation of substance use among students (Lin et al., 2024). Additionally, adolescents living in neighborhoods exposed to violence may be more likely to engage in substance use over the long term (Lin et al., 2024). Negative social influences also play a critical role (i.e., such as family members or peers who use substances), increasing the likelihood of initiation, and are

associated with greater severity of use. In contrast, supportive family environments and positive social connections serve as protective factors against substance use (Lin et al., 2024).

A counselor treating individuals with SUDs may need to coordinate different services to address each SDoH domain. This coordination of care is known as case management. Case management is designed to identify a patient's medical, psychosocial, behavioral, and functional needs through comprehensive screening and to address those needs directly or by coordinating with community resources, all while supporting the treatment of SUDs (SAMHSA 2021). Providing case management enhances treatment engagement and retention while reducing the broader impact of SUDs on the community (SAMHSA, 2021).

Qualifying as a Substance Use Disorder Counseling Provider

There are several different ways a counselor can become an SUD counseling provider. This study specifically focused on the pathways that professional counselors and ADCs take to becoming SUD counseling providers. These professionals have unique educational, credentialing, and supervisory pathways. Below outlines the various pathways.

Training and Education as a Professional Counselor

Those who become professional counselors receive addiction education during their master's programs. The amount of education they receive differs depending on their chosen specialized area. While the 2024 CACREP standards require that all counseling students learn about etiology, signs, symptoms, and diagnostic criteria of SUDs and

related disorders, beyond this, students must select addiction counseling as a specialized practice area for more in-depth training (CACREP, 2023).

For those who choose addiction counseling as their specialized area, they receive more in-depth training on etiology, signs, and symptoms, specifically learning about neurological, behavioral, psychological, physical, and social effects of psychoactive substances compared to the general clinical mental health track (CACREP, 2023).

Additionally, they also learn how to appropriately assess SUDs and several different modalities and strategies for treating SUDs. Furthermore, they learn how to work within a multi-disciplinary continuum of care and to navigate recovery support tools and systems. They also learn about third-party reimbursement and other practice and management issues specific to SUD counseling (CACREP, 2023).

Training and Education as an Alcohol and Drug Counselor

Individuals who enter the profession through the ADC route have more significant educational variability (Kerwin et al., 2006; Ramsey et al., 2017; Simons et al., 2017). While professional counselors need a master's degree, ADCs typically need a bachelor's degree (U.S. Bureau of Labor and Statistics, 2024). However, in some states, like New Jersey, ADCs require only a high school diploma or certificate of high school equivalency (Alcohol and Drug Counseling Statute, 2019, § 45:2D-5). Unlike professional counselors with CACREP to unify education programs, SUD counseling training programs do not have a single educational accreditation agency. The International Certification and Reciprocity Consortium (IC&RC) and the National Certification Commission for Addiction Professionals (NCC AP), under the auspices of

NAADAC, the Association for Addiction Professionals, both set minimum experience, education, supervision, and examination requirements (IC&RC, 2025a; NAADAC, 2025a). Then, the National Addictions Studies Accreditation Commission (NASAC) sets standards for addiction-focused major and minor programs at all higher education levels (i.e., bachelor's, master's, and doctoral; NASAC, 2018). The agencies by which an individual's education or training will be governed depend on the state's requirements and the level at which they receive their education.

The lack of a national training standard for SUD counseling (Ramsey et al., 2017; Simons et al., 2017; Vaughn et al., 2021) has led to an apprentice training model for ADCs (Kerwin et al., 2006). An apprentice training model relies heavily on ADC's learning knowledge, skills, and abilities while providing clinical services under supervision (Kerwin et al., 2006). Inconsistency in education and training of SUD counseling practices (Kerwin et al., 2006; Ramsey et al., 2017; Simons et al., 2017; Vaughn et al., 2021) for both professional counselors and ADCs has led to a reliance on clinical supervision for counselors to learn how to appropriately treat this client population (Kerwin et al., 2006; Ramsey et al., 2017). This highlights the need for consistent and quality supervision, especially since supervision can account for up to 16% of the variance in client outcomes (Ramsey et al., 2017). Given the variability in education and training standards across programs, many states have implemented credentialing requirements for those interested in providing SUD counseling to ensure competence and quality of care.

Credentialing of Substance Use Disorder Counseling Provider

There are several ways counselors can be credentialed to provide SUD counseling. Typically, counselors are licensed or certified to provide SUD counseling (Isvan et al, 2019; Simons et al., 2017). Both licensure and certification benchmark professional competence. Licensure is the state's official legal authorization to practice within a defined professional scope, whereas certifications are typically issued by non-governmental organizations and generally offer fewer practice rights (Isvan et al., 2019). In the United States, as of 2019, 31 states required specific ADC licensure to provide SUD counseling, and 20 states (including the District of Columbia) offered certification (Isvan et al., 2019). States requiring ADC licenses typically adopt standards from the national organizations IC&RC or NAADAC (Isvan et al., 2019). While there is a significant overlap between these organizations' standards, they are far from aligned in their definitions of the scope of practice and minimum credentialing requirements for ADCs (Isvan et al., 2019).

While some states require a specific license or certification in SUD counseling, not all do (Simons et al., 2017). SUD treatment can be provided by a range of professionals, including professional counselors, clinical social workers, psychologists, physicians, nurses, and physician assistants (Isvan et al., 2019). The professional counselor license in some states is considered adequate to provide SUD counseling (Simmons et al., 2017). In these states, SUD counseling is viewed as part of their scope of practice rather than its own specialized track (Morgen et al., 2012).

Clinical Supervision of Substance Use Disorder Counseling Providers

SAMHSA (2020) charges clinical supervisors with the responsibility of making sure that counselors are competent in delivering co-occurring disorder treatment services through professional development opportunities (i.e., supervision and staff training and education) and implementing burnout and turnover reduction techniques for those working with the co-occurring population. Clinical supervision is foundational in preparing counselors; it is a dynamic and multifaceted process that demands specialized skills and functions as it has its own distinct interventions, methods, and models (Bernard & Goodyear, 2019). Clinical supervision is vital in helping counselors translate academic knowledge into real-world applications, bridging the gap between the classroom and clinical settings (Center for Substance Abuse Treatment, 2009). Furthermore, it improves counselor self-efficacy in implementing evidence-based interventions (Giannopoulos et al., 2021). Clinical supervision is also protective at the individual and systemic levels, as it reduces counselor burnout (Beitel et al., 2018; Knudsen et al., 2008) and workforce turnover (Knudsen et al., 2008; O'Donnell et al., 2022). Addressing burnout and turnover is especially critical given the current workforce shortage in the behavioral health field. For example, in December 2023, the National Center for Health Workforce Analysis reported that in 2021, there were only 81,794 ADCs nationwide (Bureau of Health Workforce, 2023). Meanwhile, SAMHSA (2023) noted that in 2022, 4.8 million people aged 12 or older met the criteria for aSUD, highlighting the significant gap between workforce capacity and treatment needs. In addition to supporting the professional

growth of a counselor, as outlined, clinical supervision also protects the welfare of the clients to whom the supervisee is providing counseling (Bernard & Goodyear, 2019).

In the SUD treatment field, supervision is essential for fostering the growth and professionalism of counselors, promoting adherence to ethical standards, and enhancing client outcomes (Center for Substance Abuse Treatment, 2009). Supervision of ADCs has four specific and overlapping foci: administrative, evaluative, clinical, and supportive (Powell & Brodsky, 2004). The administrative aspect of supervision addresses the supervisee's role within their employing organization. The evaluative part involves assessing counselor performance, setting goals, and providing feedback. The clinical portion emphasizes enhancing counselors' clinical knowledge and skills while fostering self-awareness and professional growth. Lastly, the supportive focus highlights the supervisor's role in providing encouragement, preventing burnout, and promoting personal development through mentorship and motivation (Powell & Brodsky, 2004).

Like the variability observed in the training and education of SUD counseling providers, the preparation of clinical supervisors also varies across credentialing bodies and licensing types. Individuals interested in becoming clinical supervisors for SUD counseling providers have different pathways depending on their professional licensure (i.e., ADC versus professional counselor) and ultimately, the state in which they are licensed to practice. The next sections review the training, education, and credentialing needed for clinical supervisors who are professionally licensed as an ADC or a professional counselor.

Clinical Supervisor Training and Education for those Licensed as Alcohol and Drug Counselors

The IC&RC and NAADAC have established educational standards for clinical supervision, each requiring 30 hours of specialized training (IC&RC, 2025b; NAADAC, 2025b). IC&RC organizes its training requirements into six core domains: counselor development, professional and ethical standards, program development and quality assurance, assessment of counselor competencies and performance, and treatment knowledge. NAADAC, in contrast, offers the National Clinical Supervision Endorsement, comprising 30 hours of education, including 18 hours explicitly focused on SUD clinical supervision, 6 hours on professional ethics, and 6 hours on HIV and other pathogens (NAADAC, 2025b).

Credentialing of Clinical Supervisors for Those Licensed as Alcohol and Drug Counselors

As seen in the credentialing of counselors, the credentialing of clinical supervisors can vary depending on whether the state the supervisor is practicing in aligns with NAADAC, IC&RC, or has their own state-specific criteria. Because of this variability, aspiring supervisors must carefully review their state's statutes and regulatory board publications to determine the exact pathway to credentialing. Outlined below are the various pathways to credentialing that an ADC may take when trying to become a clinical supervisor.

NAADAC's National Clinical Supervisor Endorsement. NAADAC offers the National Clinical Supervision Endorsement (NAADAC, 2025b). In addition to the 30

hours of education specific to SUD clinical supervision, individuals looking to obtain this endorsement must hold a bachelor's degree or higher in SUD counseling or related counseling subjects, have 10,000 hours of SUD counseling experience, including 4,000 hours performing direct clinical supervision and 200 hours of supervision of their supervision, and a passing score on the National Clinical Supervisor Endorsement exam or the IC&RC clinical supervisor exam.

IC&RC Guidelines. IC&RC does not offer a specific credential but does provide credentialing standards to those states that follow their guidelines (IC&RC, 2025b).

These standards require that an individual hold a SUD-specific credential, have 10,000 hours of SUD experience, take the 30 hours of education specific to clinical supervision, pass the IC&RC clinical supervisor examination, sign the IC&RC clinical supervisor code of ethics statement or affirmation statement, and live or work at least 51% of the time in the state they are applying for the credential in (IC&RC, 2025b).

State-Specific Endorsements. Some states do not require any of the above endorsements, guidelines, or credentials, but have their own state-specific requirements. An individual seeking a supervision credential must consult with their state licensing regulation to determine which supervision credential is needed. Some states do not require any supervisory credentials (Fields et al., 2018).

Clinical Supervision Training and Education for Those Licensed as Professional Counselors

As identified, the pathway to clinical supervisor credentialing for professional counselors differs from that of ADCs. Those trained as professional counselors may look

to the Center for Credentialing and Education (CCE) or their state regulations for supervisory training and education standards. The CCE requires 45 hours of education in the following content areas: roles and functions of clinical supervisors, theoretical frameworks and models of clinical supervision, supervisory relationship issues, methods and techniques for clinical supervision, group supervision, evaluation, remediation, and gatekeeping in supervision, utilization of technology in clinical supervision, legal and ethical issues and responsibilities in clinical supervision, and culturally responsive clinical supervision (CCE, 2025a). While many states use CCE's standards, not all states do. Some states issue supervisory endorsements or designations with state-specific requirements.

Credentialing of Clinical Supervisors for Those Licensed as Professional Counselors

All states, including the District of Columbia, require supervisors to be licensed mental health providers (i.e., holding a state license as a professional counselor or in a related field), and 29.4% require supervisors to hold a specialty supervisor credential to work with counselor licensure candidates (Fields et al., 2018). Currently, 15 states require the Approved Clinical Supervisor (ACS) offered through the CCE (CCE, 2025b) to be recognized as a clinical supervisor. In states where the ACS is required, individuals must complete the 45 educational hours outlined earlier, hold a professional license for independent practice in the behavioral health field, or hold a National Certified Counselor certification in good standing, complete a professional disclosure statement, and have 4,000 hours of direct service experience with clients (CCE, 2025). Many states have developed their own criteria and do not recognize the ACS. Therefore, supervisors must

consult their state's licensing board to determine the specific credentialing requirements. Notably, several states do not require formal supervision credentials (Fields et al., 2018).

Years of Experience

With the various educational standards and credentialing requirements (or lack of credentialing requirements), experience has been assumed to be enough to provide clinical supervision rather than receiving formal education and credentialing (Falender & Shafranske, 2016). The idea that experience equates to competence in one's profession is standard practice across many professions, as typically a more senior professional will supervise less experienced professionals (Center for Substance Abuse Treatment, 2009). Competency in counseling is demonstrated by completion of educational requirements and the obtainment of licensure or certification (Ivan et al., 2019). Prior to 1990, established standards for supervision practice were largely absent (Borders, 2014; Fields et al., 2018). As noted throughout this literature review, standardization remains inconsistent across SUD counseling and supervision; hence, the various education and credentialing requirements seen in practice. Research examining clinical supervision in SUD treatment is relatively new and remains limited, with most studies emerging only after 2000 (Fields et al., 2018). While supervisory credentials often require a set number of years of experience, there is limited empirical evidence to suggest that experience alone equates to supervisory competence. However, years of experience may contribute to self-efficacy. Through time, individuals encounter varied situations that allow them to develop across Bandura's four sources of efficacy (mastery experiences, vicarious learning, verbal persuasion, and emotional arousal), which may bolster one's belief in

their ability to engage in supervisory roles. Frick and Glossoff (2014) found that when counselor education doctoral students were exposed to the four efficacy expectations over time during their practicum self-efficacy was improved.

Self-Efficacy Specific to Substance Use Disorder Counseling

Prior to this section, I discussed ADCs and professional counselors separately. In the literature on counselor self-efficacy, the broader term counselor is commonly used. To align with literature, I will use the term counselor. Furthermore, much of the literature includes professional counselors and ADCs in their research since both can provide SUD counseling, making it difficult to isolate the two. Counselors are expected to be effective with their clients in counseling sessions by engaging in multiple counseling skills based on their clinical judgment of the situation in session (Larson & Daniels, 2009). A counselor's self-efficacy is their belief that in their abilities to provide counseling (Larson & Daniels, 2009). A counselor's self-efficacy impacts the counselor's professional development and behavior, as discussed below.

Impact of Self-Efficacy on Counselor Development and Behavior

Counselors with higher levels of counseling self-efficacy tend to form stronger therapeutic alliances and demonstrate better clinical judgment in applying counseling skills effectively (Clarke et al., 2024). Li et al.'s (2023) study demonstrated this by highlighting that CITs in practicum whose counseling self-efficacy did not improve during the experience were more at risk for being less clinically effective with their clients. Moreover, counselor self-efficacy has been found to predict the quality, knowledge, and use of evidence-based practices (Schiele et al., 2014). Counselors with

higher levels of self-efficacy are at a lower risk for burnout and empathy fatigue, which in turn reduces the likelihood of counselor impairment and related competency concerns (Clark et al., 2024).

In contrast, those with low self-efficacy are more vulnerable to empathy fatigue, heightened anxiety, and professional burnout (Clark et al., 2024). Self-efficacy influences a counselor's development early in their training and is critical in shaping their professional development. For counselors in training (CIT), self-efficacy can determine whether their thoughts are self-aiding or self-hindering. When self-hindering thoughts take over, they can contribute to increased anxiety and reduce the trainee's ability to persist through the complex challenges encountered in counseling sessions (Larson & Daniels, 2009). Even when successful, if a CIT has low self-efficacy, the reward from performance mastery is quickly replaced with feelings of fear about meeting heightened expectations in future tasks (Clark et al., 2024). This maladaptive thinking pattern can result in procrastination, over-preparation, and impostor syndrome. Over time, impostor syndrome can significantly hinder a counselor's professional development, impairing their ability to adopt practical clinical skills and sound judgment (Clarke et al., 2024).

Self-Efficacy Specific to Clinical Supervisor of Substance Use Disorder Counseling Provider

While there is literature on counselor self-efficacy, there was minimal literature on clinical supervisor self-efficacy. It has been assumed that because one is a good counselor, they will be a good clinical supervisor; however, this is not true, as these two roles are distinct (Bernard & Goodyear, 2019). Given that self-efficacy influences

counselors' motivation, ability, and persistence (Bandura, 1997; Barnes, 2004; Strauser, 1995) and can be broadly applied to behavior beyond counseling (Bandura, 1977), it is reasonable to assume that self-efficacy similarly impacts clinical supervisors, who were once counselors themselves. This section reviews the limited research on the self-efficacy of clinical supervisors.

Frick and Glossoff (2014) studied the experience and perceptions of self-efficacy of counselor education doctoral students providing clinical supervision to master-level counseling students. Their results aligned with the theoretical assumptions of SET, as when a supervisor in training experienced efficacy expectations (vicarious experiences, performance accomplishments, verbal persuasion, or emotional arousal), they experienced a change in self-efficacy. For example, students reported activities like observing a faculty supervision session (vicarious experience), providing supervision (performance accomplishment), and receiving constructive feedback from peers, supervisors, and supervisees (verbal persuasion), all had improved their self-efficacy. Students also reported feelings of anxiety and self-doubt (emotional arousal) negatively influenced their self-efficacy (Frick & Glossoff, 2014).

Another study of South African psychologists focused on training clinical supervisors and their perceived competence (Hendricks et al., 2021). Hendricks et al. found many clinical supervisors had not completed formal training but still perceived themselves as competent and effective supervisors and prematurely engaged in providing clinical supervision to supervisees. These results can be generalized to professional counselors and master-level ADCs, as psychologists in South Africa hold master's

degrees in clinical psychology, counseling psychology, education psychology, or industrial psychology and complete a 12-month supervised internship. Furthermore, they are generalizable as most supervision skills and processes are common across mental health professions and countries (Bernard & Goodyear, 2019). In the Hendricks et al. (2021) study, the disconnect between training received and perceived competence and effectiveness as a supervisor shows how an individual's beliefs in their capabilities can overestimate their preparedness or skill. In this case, inflated self-efficacy led to premature engagement in supervision.

Both the Frick and Glossoff (2014) and Hendricks et al. (2021) studies demonstrated how clinical supervisors, similar to counselors, are developmentally and behaviorally impacted by self-efficacy. Since self-efficacy can impact clinical supervisors in similar ways as it does counselors, the assumption can be made that if a clinical supervisor has low self-efficacy, they may end clinical supervision sessions prematurely in the face of adversity or even avoid providing clinical supervision altogether if they do not believe they will be successful. Additionally, it could be assumed that clinical supervisors with lower levels of self-efficacy are at a higher risk of experiencing anxiety, empathy fatigue, and professional burnout.

Summary and Conclusion

Substance use disorders are highly complex conditions that require counselors to have advanced education and a biopsychosocial understanding to treat clients (NIDA, 2018) effectively. Despite this need, there is significant variation in both counselors' and clinical supervisors' training and educational preparation. Supervisor qualifications often

emphasize years of experience over demonstrated competency or education, even though research supporting years of experience as a reliable indicator of supervisory effectiveness is limited (Fields et al., 2018).

Counselors' self-efficacy is critical in their ability to be effective with this complex population. Counselors with high self-efficacy form stronger therapeutic alliances, appropriately use counseling skills, and are more likely to implement evidence-based practices (Clarke et al., 2024; Schiele et al., 2014). In contrast, those with low self-efficacy are more susceptible to empathy fatigue, anxiety, and professional burnout, and are less likely to persist when encountering complex clinical challenges (Clark et al., 2024; Larson & Daniels, 2009). Despite consistent supervision improving counselor self-efficacy (Lohani & Sharma, 2023), supervision for ADCs is inconsistent, informal, and reactionary (Win et al., 2022).

Research examining clinical supervisors' self-efficacy remains limited, indicating a clear gap in the literature that warrants further exploration. Since clinical supervisors are former counselors, it was logical to extend the concept of self-efficacy to their supervisory practices. This assumption is supported by theoretical concepts of SET that apply beyond counseling-specific contexts. Furthermore, preliminary studies confirm that clinical supervisors, like counselors, are developmentally and behaviorally influenced by their self-efficacy beliefs (Frick & Glosoff, 2014; Hendricks et al., 2021).

To begin to address this gap in literature, I conducted a quantitative study using a correlation research design to help identify if years of experience in the field, years of experience in the role of clinical supervisor, professional credentials, and supervision

credentials predict a clinical supervisor's self-efficacy. In Chapter 3, I provide my rationale for using a correlation research design. Furthermore, I discuss my methodology, including population, sampling, sampling procedures, procedures for recruitment, participants, data collection, instruments, operationalization of constructs, data analysis plan, threats to validity, and ethical procedures.

Chapter 3: Research Method

Introduction

The purpose of this quantitative study was to examine whether years of experience in the field of counseling, years of experience in SUD counseling, years of experience in the role of clinical supervisor, professional counseling credentials, and supervisory credentials of a clinical SUD supervisor predicted self-efficacy. This section reviewed the study's research design and rationale, and methodology, specifically the population, sampling procedures used, procedures used for recruitment, participants, data collection, the instruments used, and operationalization of constructs. Furthermore, this chapter reviews the data analysis plan used, threats to validity, and ethical procedures.

Research Design and Rationale

The independent variables of this study were years of experience in the field of counseling, years of experience providing SUD counseling, years of experience in the role of clinical supervisor, professional counseling credentials, and supervision credentials. The dependent variable was supervisor self-efficacy, measured by the CSSE. The CSSE provided an overall self-efficacy score and scores of self-efficacy on six subscales: theories and techniques, group supervision, supervisory ethics, self-in supervision, multicultural competence, and knowledge of legal issues. The overall self-efficacy score was utilized for data analysis.

A non-experimental quantitative approach using a correlational research design was used to determine if years of experience in the field of counseling, years of experience providing SUD counseling, years of experience in the role of clinical

supervisor, professional counseling credentials, and supervision credentials predict a clinical SUD supervisor's overall self-efficacy. A correlation research design was utilized to understand the relationship between variables that cannot be manipulated (Burkholder et al., 2020; Creswell & Creswell, 2018). I measured, not manipulated, both the dependent and independent variables to determine if any or all of the independent variables (i.e., years of experience in the field of counseling, years of experience providing SUD counseling, years of experience in the role of clinical supervisor, professional counseling credentials, and supervision credentials) predicted clinical supervision self-efficacy.

The type of correlation research design used was a cross-sectional design. A cross-sectional design allowed me to observe my target population at a single point in time and was useful in establishing preliminary evidence (Creswell & Creswell, 2018; Wang & Cheng, 2020). The research design had limited time constraints, as correlation cross-sectional studies have a quick data collection period, as they only involve data collection that occurs over a short period of time (Lau, 2017). Furthermore, there were minimal resource constraints due to the low financial cost, minimal personnel need, and no need for physical space to conduct the study (Lau, 2017; Wang & Cheng, 2020). Since clinical supervisor self-efficacy has been minimally explored, this cross-sectional correlation research design helped establish preliminary evidence of what predicts counselor self-efficacy. The preliminary findings of this research could lead to future research to identify the potential causal relationship between variables (Creswell & Creswell, 2018), advancing research on clinical supervision self-efficacy.

Methodology

In this section, I described the methodology, including the population, sampling method, and sample size used. I also reviewed procedures for recruitment, participants, and data collection. I reviewed instruments used, data analysis used, and threats to validity. Finally, the chapter concludes with ethical considerations.

Population

The population used for this study includes professional counselors and ADCs who are licensed or certified in the state in which they practice and who provided clinical supervision to ADCs or ADC interns. For this study, marriage and family therapists, psychiatric aides, psychiatric advanced practice registered nurses, psychiatric physician assistants/associates, psychiatrists, psychologists, and social workers were excluded. While these individuals are mental health professionals who could serve as supervisors for ADCs or ADC interns, depending on their state's supervisory requirements, the scope of this study was focused on counselor training. The sample size required to meet statistical power was 92.

Sampling and Sampling Procedures

Sampling Method

A convenience sampling design was used. Convenience sampling uses participants based on availability (Burkholder et al., 2020). Participants were sampled using professional email (emails were sent to individuals in my professional network and emails found via NAADAC's Community Board), listservs, social media (specifically, Facebook and LinkedIn), and the Walden University's Participant Pool. A convenience

sample was determined appropriate due to time constraints, the specific purpose of the study, and the focus on examining key variables. Participants included were individuals who held a license as either a professional counselor or an ADC and were currently providing clinical supervision to ADCs and/or ADC interns. Individuals excluded were those who do not hold a license or certification in professional counseling or SUD counseling. Specifically, marriage and family therapists, psychiatric aides, psychiatric advanced practice registered nurses, psychiatric physician assistants/associates, psychiatrists, psychologists, and social workers. Additionally, if a professional counselor or an ADC indicated they were not currently providing clinical supervision to ADCs or ADC interns, they were excluded.

Sample Size

There are limited quantitative studies that could be used to determine the effect size. Hendricks (2021) was the most closely related article, and they achieved a large effect size. Due to the limited number of studies, the sample size was determined using G*Power to conduct a power analysis. The test family type selected was F test, the statistical test chosen was linear multiple regression: fixed model, R^2 deviation from zero, and an a priori: compute required sample size – given x, power, and effect size was selected as the type of power analysis. The input parameters were as follows: effect size $f^2=.15$, alpha error probability $\alpha =.05$, power $1 - \beta=.8$, and number of predictors 5. When calculated a minimum total sample size of 92 was determined.

Procedures for Recruitment, Participation, and Data Collection

Recruiting Procedure

A recruitment flyer was shared through professional email (emails were sent to individuals in my professional network and members of NAADAC's community board), listservs, social media (specifically, Facebook and LinkedIn), and Walden University's Participant Pool. The recruitment invitation was Walden's IRB approved research survey template, used layperson language, and provided a brief overview of the study, the estimated length of time to engage in the study and identified the timeframe for data collection. The invitation instructed volunteers to click on a link to access the survey. Participants first reviewed the informed consent form. Participants who clicked "I consent" were prompted to complete the demographic form and the CSSES. Participants who clicked "I do not consent" were redirected to a page thanking them for their time.

Data collection occurred over approximately three months (September 30, 2025, to December 16, 2025). I shared the invitation to participate in the study on social media platforms weekly and on professional listservs monthly. Additionally, the survey was live on the Walden University Participant Pool for the same duration of time.

Informed Consent

Before engaging in the study, participants were required to review an informed consent form. The consent provided key details about the study, including its purpose, the expected time commitment, and a description of what participation entailed (i.e., the study's procedures). Additionally, the consent highlighted that the survey was anonymous and outlined any anticipated risks and benefits associated with participation.

The consent concluded with a reminder that participation was voluntary and that participants could withdraw at any time without penalty. At the end of the consent, there were two clickable button options: “I voluntarily consent” and “I do not consent.” Those who clicked “I voluntarily consent” were directed to the surveys. Those who clicked “I do not consent” were redirected to a screen thanking them for their time.

To ensure participants’ well-being, the consent form also referred participants who experienced emotional discomfort or distress to the national crisis hotline, 988. My contact information was also provided if the participants had questions about the research or wished to report any research-related concerns. No participants contacted the researcher directly. If a participant had initiated contact, confidentiality would have been maintained except in circumstances requiring mandatory reporting, such as threats of harm to self or others, harm to property, or abuse of vulnerable populations. These exceptions would have been explained to the participants at the initiation of conversations. Walden University’s Research Participant Advocate’s phone number was also provided in the event a participant wanted to talk about their rights as a participant or about any negative parts of the study.

Data Collection

Data collection was completed using Microsoft Forms. To ensure anonymity, I ensured the settings “anyone can respond” was selected, that the option to “record name” was disabled, and that email collection was disabled. Participants who reviewed the informed consent and selected “I consent” were prompted to fill out a brief inclusion criteria questionnaire. If the participant met the inclusionary criteria, they were then

prompted to complete the demographic questionnaire and the CSSES. Upon completion of data collection, the data were downloaded into a Microsoft Excel form, participants who did not meet inclusion criteria were removed from the data set, and then the data set was uploaded into SPSS. This occurred on my personal computer, which had anti-virus software and automatically updated to new operating systems when they became available. Furthermore, the computer used was password protected, and the folders that held the data were password protected. The computer also had a screen lock setting that locked the computer after 15 minutes of inactivity. All data collected will be stored on this computer for a period of five years, until December 16, 2033. After five years, all data related to this research study will be removed from my personal computer by deleting the associated password-protected folder where the dataset is stored and clearing the computer's recycling bin.

Instrumentation and Operationalization of Constructs

Demographic Questionnaire

The demographic data identified to be collected was based on Hughes et al. (2020) recommendations for improved and updated inclusive demographic questions. Demographic data includes participants' (a) age, (b) gender identity, (c) sex assigned at birth, (d) ethnicity, and (e) race. Additional demographic information related to professional characteristics included participants' (a) counseling certification or license, (b) how long they have been certified or licensed, (c) if they hold a clinical supervisory credential or designation and if so the specific credential or designation, (d) how long

they have been in the role of clinical supervisor, (e) how long they have provided SUD counseling. See Appendix A for the demographic questionnaire.

Counselor Supervisor Self-Efficacy Scale (CSSES)

The CSSES, developed by Barnes (2002) as part of her dissertation, measured participants' strength of efficacy beliefs. The scale was developed to assess supervision self-efficacy (Barnes, 2002). The scale measures efficacy beliefs over six factors: theories and techniques, group supervision, supervisory ethics, self-in supervision, multicultural competence, and knowledge of legal issues. For each question, participants rated their confidence with each item on a 10-point Likert scale, with one indicating not confident at all, five indicating somewhat confident, and ten indicating completely confident. The scale provided an overall self-efficacy score and a subscale score for each individual factor. For this study, I used the overall score. The overall score was obtained by calculating the sum of all items; the minimum score that could be achieved was 39, and the maximum score was 390. The higher the score, the stronger an individual's efficacy beliefs (Barnes, 2002). The CSSES supported general theoretical principles of self-efficacy as they relate to clinical supervision of counselors. Barnes' (2002) initial research on the scale indicated high internal reliability and was supported in Murphy's (2017) dissertation, which further evaluated the psychometrics of the scale. Barnes (2002) also found high construct validity. In both studies, participants were from CACREP-accredited counseling programs. Both Barnes (2002) and Murphy (2017) noted that the CSSES should be used for self-reflection and assessment. I chose to use this scale despite this recommendation, as no other self-efficacy scales specifically for

counseling supervisors had been developed at the time of data collection. See Appendix B for permission to use the scale.

Operational Definitions

Years of Experience in the Field of Counseling. Experience in the field was determined by how long the participants have been certified or licensed as a professional counselor. This variable was measured on the demographic form asking how many years they have been licensed or certified as a professional counselor or alcohol or drug counselor. Those who are licensed as both had the opportunity to enter experience for both credentials.

Years of Experience Providing Substance Use Disorder Counseling. Experience was further broken down into years of experience providing direct SUD counseling. This variable was measured by asking on the demographic form how many years they have been providing direct SUD counseling.

Years of Experience in the Role of Clinical Supervisor. Experience in the role of clinical supervisor was determined by the length of time a participant has been providing formal clinical supervision to ADCs and/or interns. This variable was measured by asking how many years they have been providing clinical supervision to ADCs and/or interns.

Professional Counseling Credentials. Credentials that were considered are those that allow someone to practice in their state as either a professional counselor or an ADC. Professional counselors were defined as individuals with a counseling degree at a graduate level from a CACREP-accredited program or a counseling program

administered by an accredited institution and completed postgraduate clinical counseling experience (National Board for Certified Counselors, 2025). ADCs were defined as individuals who have had specialized training and experience in counseling individuals with substance use and related disorders and hold a specific ADC credential (NADDAC, 2025c). This variable was measured by asking participants on the demographic questionnaire what type of credential they hold (i.e., professional counselor, ADC, or both).

Supervision Credentials. The requirement for a specific supervisor credential varies across the United States and is independently set by regulatory bodies (i.e., licensing boards or government designees, such as certification boards; Bernard & Goodyear, 2019). This variable was measured by asking if the participants held a supervisory credential or designation on the demographic questionnaire.

Self-Efficacy. Self-efficacy is an individual's belief that they can complete a task, their motivation to engage in a task, and their persistence when engaging in a task even when faced with adversity (Bandura, 1977). This variable was measured using the CSSSES.

Theories and Techniques. The CSSSES measured theories and techniques in fourteen items on the scale. Six of the items assess perceived knowledge of supervision models and counselor development, and eight focused on confidence in implementing supervision-specific interventions. The following was an example item, “*Select supervision interventions congruent with the model/theory being used*” (Barnes, 2002, p. 174).

Group Supervision. The CSSSES measured group supervision in five items. These five items measured tasks specific to the practice of group supervision. The following was an example item, “*Facilitate case discussion in group supervision*” (Barnes, 2002, p.180).

Supervisory Ethics. The CSSSES measured supervisory ethics in eight items. These items assessed a supervisor's perceived knowledge of ethical issues, ability to identify ethical issues, and ability to address ethical issues in supervision. The following was an example item, “*Articulate to a supervisee the ethical standards regarding supervision*” (Barnes, 2002, p.178).

Self-in Supervision. The CSSSES measured self-supervision in three items that assessed a supervisor's willingness to receive feedback on supervision and two items that assessed confidence in being able to respect individual differences in the supervisory relationship. The following was an example item, “*Receive critical feedback from a supervisee on my performance as a supervisor without becoming defensive or angry*” (Barnes, 2002, p.178).

Multicultural Competence. The CSSSES measured multicultural competence in four items that assessed a supervisor's confidence in addressing cultural issues in clinical supervision. The following was an example item, “*Address a supervisee’s racial or ethnic identity as a counseling process variable*” (Barnes, 2002, p.177).

Knowledge of Legal Issues. The CSSSES measured knowledge of legal issues in three items, specifically assessing a supervisor's confidence in addressing legal concerns.

The following was an example item, “*Describe the legal liabilities involved in counseling minors*” (Barnes, 2002, p.177).

Data Analysis Plan

Data Analysis Software

Data collection was completed using Microsoft Forms. The demographic form and CSSES were entered into Microsoft Forms and then distributed to participants. Once all data collection was complete results were converted into a Microsoft Excel document, the dataset was then cleaned by removing any missing or incomplete data from the dataset. Additionally, any dataset collected by a participant that did not meet the inclusion criteria was discarded from the dataset. After removing all incomplete or missing data and any participant that did not meet the inclusion criteria, the cleaned dataset was uploaded into SPSS for statistical analysis.

Research Question & Hypothesis

I developed the research question and hypothesis to examine whether years of experience in the field of counseling, years of experience providing SUD counseling, years of experience in the role of clinical supervisor, professional counseling credentials, and supervisory credentials of a clinical SUD supervisor predict self-efficacy. The research question and hypothesis for this study were:

RQ: Do years of experience in the field of counseling, years of experience providing SUD counseling, years of experience in the role of clinical supervisor, professional counseling credentials, and supervision credentials predict clinical supervisor self-efficacy as measured by the Counselor Supervisor Self-Efficacy Scale?

H₀: Years of experience in the field of counseling, years of experience providing SUD counseling, years of experience as a clinical supervisor, professional counseling credentials, and supervision credentials do not predict clinical supervisor self-efficacy.

H₁: Years of experience in the field of counseling, years of experience providing SUD counseling, years of experience in the role of clinical supervisor, professional counseling credentials, and supervision credentials do predict clinical supervisor self-efficacy.

Data Analysis

The dependent variable for this study was self-efficacy. Independent ratio variables being analyzed were years of experience in the field of counseling, years of experience providing SUD counseling, and years of experience in the role of clinical supervisor. Independent categorical variables being analyzed are professional counseling credential (professional counselor, ADC counselor, or both), and clinical supervision credential (state recognized designation, state recognized credential, nationally recognized credential). Categorical variables were dummy coded prior to regression analysis. For example, the professional credentials were represented by two dummy variables (with 'both credentials' as the reference group), and the clinical supervision credential was represented by three dummy variables (with 'no credential' as the reference group).

A standard multiple linear regression was conducted to determine the extent to which the independent variables predicted self-efficacy. Model fit was assessed using the coefficient of determination, which indicated the proportion of variance in self-efficacy

explained by the predictors. The standard error of the estimate was also examined to assess residual variation. Residual plots were reviewed to check for homoscedasticity and ensure that regression assumptions were met. An overall F test from the regression analysis of variance (ANOVA) output was used to evaluate whether the model significantly predicted the dependent variable. Statistical significance for all tests was set at $p < .05$. Additionally, each independent variable's contribution to the model was evaluated using its corresponding p-value and unstandardized regression coefficient. The assumption of multicollinearity was checked by using a collinearity diagnostics' procedure in the multiple linear regression.

Threats to Validity

Despite a non-experimental design there were some threats to validity. One threat was related to the training of the clinical supervisor. As highlighted, the training and education of clinical supervisors significantly varies depending on the counseling credential they hold and the requirements of the state they are practicing in. Based on the current literature, I had anticipated that those who took clinical supervisor training would have higher self-efficacy than those who did not. For those who did supervisory training, the quality of the training could also impact their level of self-efficacy.

Another threat to validity was self-selection biases. Since participation was voluntary, participants may have chosen to participate because they had strong opinions or an interest in the research topic compared to those who chose not to participate. These opinions or interests could have created a self-selection bias, leading to inaccurate or skewed results. A final example of a possible threat to validity is a violation of

assumptions, specifically multicollinearity. If two independent variables can be linearly predicted from others, this can lead to issues interpreting the results making it difficult to determine the individual effects of the independent variables on the dependent variables.

Ethical Procedures

Institutional Review Board (IRB)

Prior to the collection of any data, IRB approval was obtained from Walden University's Institutional Review Board (09-19-25-1060553). First, I defended my proposal with no recommended changes. Next, I completed Form A (Description of Data Courses and Partner Sites). After IRB approval was achieved on September 19, 2025, an adjustment to the demographic form was required. A Request for Change in Procedures was submitted on September 29, 2025, and approved on September 30, 2025. Once the IRB approvals were finalized for the recruitment details, data collection steps, and consent form, data collection commenced on September 30, 2025.

Ethical Concerns Regarding Recruitment

While the potential risks associated with participating in this study were minimal, it is important to acknowledge and address the ethical concerns related to recruitment and participation. It was possible that minimal psychological risk including feelings of embarrassment or distress could have occurred due to participants admitting a lack of confidence in their role as a clinical supervisor. To address this possible risk during the informed consent process participants were provided with the contact information for the national crisis hotline, 988. Additionally, my contact information was provided if participants had questions about the research or wished to report any research-related

concerns. Another potential concern was relationship risk as some of the individuals being recruited were known to me in a professional capacity and could have worried whether choosing to participate or not would influence their professional relationship with me. To minimize this risk, I collected data anonymously, ensuring responses could not be linked back to individual participants. Due to the anonymous nature of the survey collection, even if a research participant had reached out to me directly, I would not have been able to link the participant with their response. However, since the identity of the participant would have been known to me, I still would have kept their identity confidential except for a duty to report a scenario (i.e., harm to self, harm to others, harm to property, abuse of vulnerable populations).

Recruitment was conducted using low-pressure methods, such as general social media posts and email invitations, which allowed individuals to opt out without fear of retaliation or professional consequences. Additionally, debriefing resources were provided during informed consent in case a participant experienced emotional distress during or after survey completion. The overall risks and burdens associated with this study were considered reasonable especially considering the results from this research add to the limited research on clinical supervisor self-efficacy development.

Ethical Concerns Regarding Data Collection

To ensure the protection of participants' identities and maintain ethical standards in data collection, several safeguards were implemented. Demographic information was grouped and reported in an aggregate form rather than individually, preventing the possibility of identifying any participant through their responses. Furthermore, data

collection was done anonymously, ensuring that no identifying information can be linked back to individual participants. All datasets are securely stored on my personal laptop, which is protected by a password. Within the laptop, the data are kept in a separate, password-protected folder to provide an added layer of security. After 5 years, all data associated with this research study will be permanently deleted by removing the password-protected folder from the laptop and clearing the recycling bin.

Summary

This study aimed to explore the relationship between specific professional factors and clinical supervisor self-efficacy among clinical supervisors of ADC and ADC interns. The independent variables included were years of experience in the counseling field, years of experience providing SUD counseling, years of experience in the role of clinical supervisor, professional counseling credentials, and supervision credentials. The dependent variable was supervisor self-efficacy. A non-experimental, quantitative approach was utilized, employing a correlational research design, specifically a cross-sectional design, to examine whether these independent variables predicted a clinical SUD supervisor's overall self-efficacy. Participants were selected using a convenience sampling method. Data collection involved the completion of a demographic questionnaire and the CSSES. Datasets were analyzed using Pearson's Multiple Correlation Coefficient, Multiple Linear Regression, and ANOVA via SPSS.

Given that clinical supervisor self-efficacy has received limited attention in the literature, the use of a cross-sectional correlational design was appropriate to establish preliminary evidence regarding the factors that may influence clinical supervisor self-

efficacy. The findings of this study have the potential to guide future research that may further explore causal relationships between these variables (Creswell & Creswell, 2018), ultimately contributing to the advancement of knowledge in the field of clinical supervision.

Chapter 4: Results

Introduction

The purpose of this quantitative study was to examine whether years of counseling experience, years of experience providing SUD counseling, years of experience as a clinical supervisor, professional counseling credentials, and supervisory credentials predicted supervisor self-efficacy among clinical supervisors providing clinical supervision to ADCs. The study sought to answer the research question: Do years of experience in the field of counseling, years of experience providing SUD counseling, years of experience in the role of clinical supervisor, professional counseling credentials, and supervision credentials predict clinical supervisors' self-efficacy as measured by the Counselor Supervisor Self-Efficacy Scale? The null hypothesis was that years of experience in the field of counseling, years of experience providing SUD counseling, years of experience as a clinical supervisor, professional counseling credentials, and supervision credentials do not predict clinical supervisors' self-efficacy. While the alternative hypothesis was years of experience in the field of counseling, years of experience providing SUD counseling, years of experience in the role of clinical supervisor, professional counseling credentials, and supervision credentials do predict clinical supervisors' self-efficacy. This chapter will review the data collection and present the study's results.

Data Collection

Data collection took approximately three months to complete, from September 30, 2025, to December 16, 2025. Participants were recruited through a convenience sampling

design, using an IRB-approved invitation template shared via professional listservs, social media (Facebook and LinkedIn), Walden's Participant Pool, and the researcher's professional network. The survey was engaged with 138 times. A total of $N=92$ participants were included in the analysis. There were 24 responses that were removed due to the participants reporting having credentials or licensure that did not meet the inclusionary criteria (i.e., reported being licensed as a social worker, marriage and family counselor, or psychologist), there were eight responses that were removed because the participant declined having a professional counseling or ADC license or credential, and 14 responses were removed due to reporting they were not eligible to supervise. There were no discrepancies between the data collection plan presented in Chapter 3 and how the data were collected.

Participants reported their age, gender, ethnicity, race, and the state in which they practiced. Age was treated as a continuous variable and summarized using descriptive statistics. Gender, ethnicity, race, and practicing state were categorical variables and are summarized using frequencies and percentages. The most frequently occurring age group was 45-54 years old, accounting for 30.4% of the total sample, and the least frequently occurring age group was 75+ years old, accounting for 3.3% of the total sample. Table 1 displays the frequency of participants' ages. Most participants self-identified their gender as female (63%), followed by male (31.5%). Outside of these two categories, 4.3% identified as "cis-gendered" and 1.1% as "gender fluid." All participants self-identified with at least one ethnicity, and four selected two ethnicities. The most reported ethnicity was White or European American (79.3%), followed by Black or African American

(10.9%). Tables 2 and 3 provide details of participant ethnicity. Like ethnicity, all participants self-identified at least one race, and three selected two. The two most reported races align with reported ethnicity: white (81.5%) and black (10.9%). Tables 4 and 5 display the frequency of participants' race. Thirty-six states were represented in the data set. Most participants reported practicing in a single state, but 14 participants reported practicing in multiple states. Table 6 provides details on the states in which participants practiced.

Table 1

Participants' Age

Age	Frequency	Percent
25–34	8	8.7
35–44	22	23.9
45–54	28	30.4
55–64	15	16.3
65–74	16	17.4
75+	3	3.3
Total	92	100

Table 2

Participants' Ethnicity

Ethnicity	Frequency	Percent
Arab, Middle Eastern, or North African	2	2.2
Asian or Asian American	2	2.2
Black or African American	10	10.9
Hispanic or Latino	3	3.3
Native American or Alaska Native	1	1.1
White or European	73	79.3
I prefer not to answer	1	1.1
Total	92	100

Table 3*Participants' Ethnicity (Identified More Than One)*

Ethnicity	Frequency	Percent
Native American or Alaska Native	1	25
White or European	3	75
Total	4	100

Table 4*Participants' Race*

Ethnicity	Frequency	Percent
Asian	2	2.2
Black	10	10.9
Indigenous, Aboriginal, or First Nations	1	1.1
Latino or Hispanic	2	2.2
Middle Eastern	1	1.1
White	75	81.5
I prefer not to answer	1	1.1
Total	92	100

Table 5*Participants' Race (Identified More than One)*

Ethnicity	Frequency	Percent
Latino or Hispanic	1	33.3
White or European	2	67.7
Total	3	100

Table 6*Participants' State*

State	Frequency
NJ	28
PA	4
NY	4
VA	5
FL	4
MI	4
OH	1
WI	2
TX	3
NC	7
SC	6
CO	2
WA	2
ID	1
NV	1
AZ	2
KY	1
TN	3
VT	2
NH	4
LA	2
CA	1
NM	3
MA	3
IN	6
MD	2
OR	1
AR	1
MO	1
AL	1
ND	1
AK	1
MT	1
HI	1

The sample was obtained using non-probability sampling methods; therefore, proportional representativeness to the broader population of professional counselors and ADCs cannot be assumed. Therefore, inferences regarding external validity should be made with caution. However, examination of key demographic characteristics suggests that the sample aligns with nationally reported workforce trends in the behavioral health field. Specifically, the distributions of age, gender, and race within the sample are consistent with existing workforce data, although direct proportional comparisons were not conducted.

National workforce data indicates that the behavioral health workforce is predominantly female and non-Hispanic White (American Psychological Association, 2023). Estimates specific to behavioral health and substance use counselors similarly indicates that approximately 74.1% of professionals identify as female and 62.6% identify as White, with age distributions concentrated primarily in the early- to mid-career range (25–39 years; Data USA, 2023). The demographic composition of the current sample reflects these broader patterns, suggesting that the findings may be transferable to similar professional populations. Nonetheless, generalizability to the full population of alcohol and drug counseling professionals remains limited due to the use of non-probability sampling; however, the sample was heavily representative of professionals practicing in New Jersey, which strengthens the relevance of the findings to that state context.

Participants in the study included professional counselors, alcohol and drug counselors, and dually licensed professionals, reflecting the range of licensure types

commonly represented within the alcohol and drug counseling workforce. Variability in training and educational preparation among counselors serving this population has been well documented (Kerwin, 2006), and the inclusion of professionals with diverse licensure backgrounds is consistent with this reality. The sample further included individuals with varying lengths of professional practice and supervisory experience, encompassing early-career, mid-career, and more experienced practitioners. Additionally, participants were drawn from multiple states (although of note, $N=28$ of the total sample represented New Jersey), providing a degree of geographic diversity that enhances the contextual relevance of the findings.

Results

Descriptive statistics were used to characterize the sample with respect to professional licensure status and counseling and supervisory experience. Participants were asked to identify whether they were licensed as a professional counselor, an alcohol and drug counselor, or held both a professional and an alcohol and drug counselor license. Most participants held only alcohol and drug counseling licensure (55.1%). The distribution of licensure types is presented in Table 7. In addition, participants indicated whether they held supervision credentials specific to alcohol and drug counseling. Most participants came from states that required a specific credential to provide supervision to alcohol and drug counselors (70.7%). The proportion of participants holding supervision credentials is summarized in Table 8. Participants reported the length of time they had been certified or licensed as a professional counselor and as alcohol and drug counselors, respectively. They also reported the length of time they had been providing alcohol and

drug counseling services. These variables were analyzed descriptively and are reported using means, standard deviations, and ranges. Descriptive statistics for professional experience variables are presented in Table 9. Finally, the length of time they have been providing supervision to ADCs. Descriptive statistics for supervision experience, including years providing clinical supervision, are presented in Table 10.

Table 7

Participants' Licensure

License	Frequency	Percent
Alcohol and drug counselor	47	51.1
Professional counselor	14	15.2
Both	31	33.7
Total	92	100

Table 8

Supervision Credential

Holds supervision credential	Frequency	Percent
Yes	62	67.4
No	30	32.6
Total	92	100

Table 9

Counseling Experience and Credentials

	Years holding professional counseling credential	Years holding alcohol and drug counseling credential	Years of providing SUD counseling
<i>M</i>	6.2	13.26	17.91
<i>SD</i>	7.19	10.13	11.70
Range	28	40	55

Table 10*Supervision Experience*

	Years providing supervision to alcohol and drug counselors/interns
<i>M</i>	10.07
<i>SD</i>	9.5
Range	50

Prior to conducting the multiple linear regression analysis, assumptions related to normality, multicollinearity, and influential cases were evaluated. Pearson correlation coefficients indicated high correlations among several predictor variables. Specifically, years licensed as an alcohol and drug counselor were strongly correlated with years providing substance use disorder counseling ($r = .876$) and years providing supervision to alcohol and drug counselors ($r = .797$). These correlations exceeded recommended thresholds and suggested the presence of multicollinearity among experience-related variables. Although multicollinearity among experience-related predictors likely reduced statistical power for detecting individual effects, the inclusion of these variables was theoretically justified, and non-significant findings should be interpreted cautiously with respect to individual predictors. Examination of multicollinearity indicated tolerance values ranging from .160 to .934 and VIF values ranging from 1.071 to 6.25 (see Table 11). Minimal multicollinearity was observed for years licensed as an ADC, years providing SUD counseling, and years supervising ADC. Moderate multicollinearity was observed for years licensed as a professional counselor and supervision credential and licensure type. Conceptually, these results are unsurprising, as individuals licensed longer

as ADCs are likely to have more experience in SUD counseling and supervision. No correlations between predictor variables and the dependent variable exceeded .30. Visual inspection of the normal probability (P–P) plot of standardized residuals (Figure 1) indicated minor deviations from normality, largely driven by three lower-tail residuals that produced a slight negative skew. The distribution of residuals otherwise approximated normality. Standardized residual values ranged from -3.62 to 1.40 , indicating the presence of a potential outlier, which is displayed in Figure 2. Cook's distance values ranged from .000 to .215. All values were well below the commonly accepted threshold of 1.0, indicating no influential cases that would compromise the stability of the regression estimates. Given the sample size ($n = 92$) and the robustness of multiple linear regression to moderate violations of normality, the assumptions were considered adequately met.

Table 11

Unstandardized and Standardized Regression Coefficients

	Unstandardized B	Coefficient std. error	Standardized coefficients beta	<i>t</i>	Sig.	Correlations			Collinearity tolerance	Statistics VIF
						Zero-order	Partial	Part		
(Constant)	332.206	11.414		29.106	< .001					
Years licensed as Professional Counselor	-.091	.764	-.015	-.120	.905	-.003	-.013	-.012	.981	1.019
Years licensed as ADC	.375	.936	.087	.401	.690	.214	.043	.041	.228	4.385
Years providing SUD counseling	-.395	.968	-.105	-.408	.684	.214	-.044	-.042	.164	6.11
Years supervising ADC	1.268	.790	.274	1.606	.112	.270	.171	.166	.364	2.747
Licensure type	.677	6.164	.014	.110	.913	-.20	.012	.011	.654	1.53

Holds supervision credential	-13.353	9.948	-.143	-1.342	.183	-.180	-.144	-.138	.934	1.53
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Figure 1

Normal P-P Plot of Regression Standard Residual

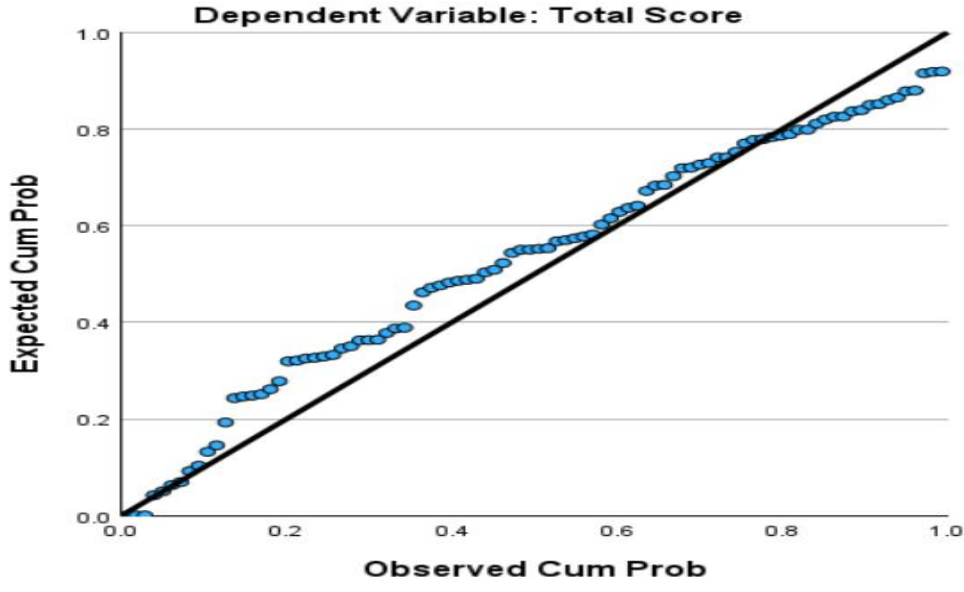
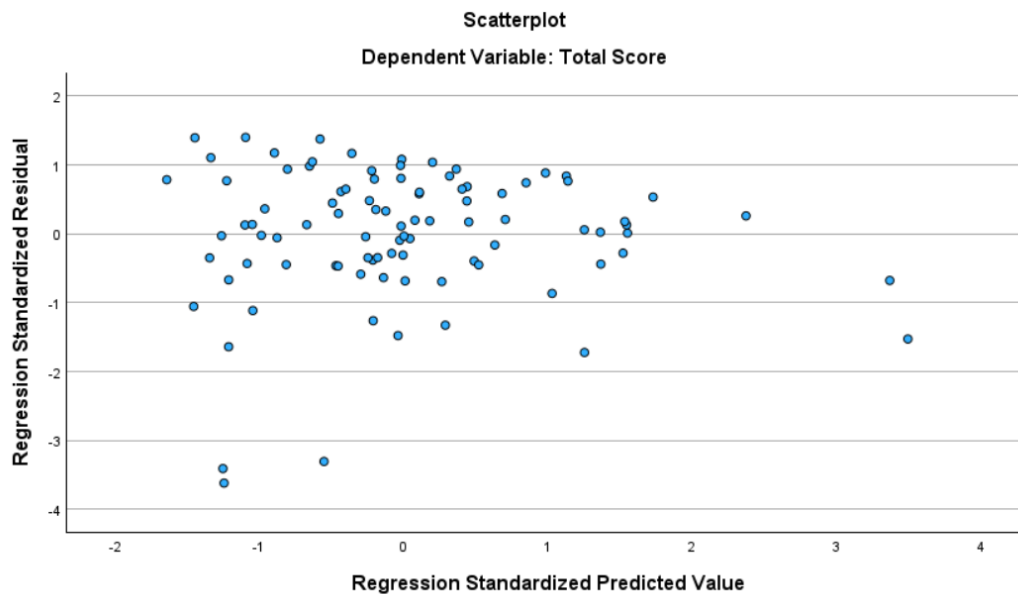


Figure 2*Scatterplot of Regression Standard*

A multiple linear regression analysis was conducted to examine whether licensure status, years of professional counseling experience, years of experience in alcohol and drug counseling, years of supervising, and possession of supervision credentials predicted total scores on the CSSSES. The overall regression model was not statistically significant, $F(6, 85) = 1.50, p = .186$. The adjusted R^2 value was .032, indicating that approximately 3.2% of the variance in clinical supervisor self-efficacy was explained by the combined set of predictor variables. Given the number of predictors and the sample size, adjusted R^2 was used as the primary indicator of model fit. None of the predictor variables significantly contributed to the model at the .05 significance level. Table 11 presents the unstandardized and standardized regression coefficients. Although none of the predictors were statistically significant, the number of years providing supervision to alcohol and

drug counselors ($\beta = .274, p = .11$) exhibited the strongest relative association with supervisor self-efficacy among the variables examined.

Summary

The results of the multiple linear regression analysis indicated that years of counseling experience, years of SUD counseling experience, years of supervision experience, professional counseling credentials, supervision credentials, and license type did not significantly predict clinical supervisors' self-efficacy as measured by the CSSES. Therefore, the null hypothesis was not rejected. While the overall model was not statistically significant, the pattern of standardized coefficients suggests that supervision-specific experience may be more closely related to supervisor self-efficacy than clinical mental health counseling experience or licensure duration. These findings are discussed further in Chapter 5.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this quantitative study was to examine whether years of experience in the counseling field, years of experience providing SUD counseling, years of experience as a clinical supervisor, professional counseling credentials, and supervisory credentials predicted supervisor self-efficacy among clinical supervisors providing clinical supervision to ADCs. Years of experience in the counseling field, SUD counseling experience, professional credentials, supervision credentials, and license type were not statistically significant predictors of clinical supervisor self-efficacy. Years providing supervision to ADCs demonstrated the strongest relative association with self-efficacy, although not statistically significant. Taken together, these findings suggest that clinical supervisor self-efficacy may not be adequately explained by experience duration or credential attainment alone. Experience and credentials did not translate into confidence in providing supervision. While results were not statistically significant and the null hypothesis failed to be rejected, these results provide insight into the supervisor's developmental experience. This chapter will discuss what information the findings provide, review limitations of the study, provide recommendations for future research, and identify implications.

Interpretation of the Findings

Although none of the predictor variables reached statistical significance, the findings are meaningful when interpreted through the lens of Bandura's SET. Bandura (1977, 1997) conceptualized self-efficacy as an individual's confidence level in their

ability to be successful, which in turn increases their motivation, decision-making, and engagement consistency (Bandura, 1977; Strauser, 1995). Self-efficacy is shaped not by the passage of time or accumulation of experience, but by the quality, interpretation, and contextual meaning of experiences, particularly mastery experiences, vicarious learning, social persuasion, and physiological and affective states (Bandura, 1977).

From this theoretical perspective, the absence of statistically significant relationships between years of counseling experience, years of SUD counseling experience, professional credentials, and supervisor self-efficacy suggests that duration of practice alone may be insufficient to foster strong supervisory self-efficacy beliefs. Although professional experience may increase exposure to clinical situations, it does not necessarily provide the supervision-specific mastery experiences that Bandura identified as the most influential source of self-efficacy (Bandura, 1977). Clinical supervision requires a distinct set of competencies, including evaluative judgment, feedback delivery, gatekeeping, and the development of a supervisory alliance (Bernard & Goodyear, 2018), which may not be adequately developed through counseling practice alone. Watkins (2012) similarly argued that supervisor development occurs through deliberate practice, reflection, and feedback rather than through years of clinical experience. The current findings support these assertions, as neither general counseling experience nor SUD counseling experience emerged as significant predictors of supervisor self-efficacy, which may further suggest that counseling and clinical supervision represent distinct skill sets.

The absence of a significant relationship between supervision credentials and supervisor self-efficacy also warrants consideration. While supervision credentials may reflect completion of required training or coursework, Bandura's theory emphasizes that efficacy beliefs are strengthened through active engagement, successful performance, and reflective integration of learning experiences (Bandura, 1977; Strauser, 1995).

Accordingly, possession of a supervision credential does not guarantee that supervisors have accumulated sufficient mastery experiences or received meaningful feedback to internalize confidence in their supervisory role. This finding aligns with prior research suggesting that supervision-specific experience plays a critical role in the development of supervisory identity and competence (Borders et al., 2014; Falender & Shafranske, 2014). Frick and Glossoff (2014) further demonstrated that counselor education doctoral students exposed to the four sources of self-efficacy over time during practicum reported increased supervisory self-efficacy, underscoring the importance of sustained, experiential learning opportunities.

Notably, years of experience providing supervision to alcohol and drug counselors demonstrated the largest standardized coefficients among the predictors in the present study, although this relationship did not reach statistical significance. This finding is conceptually consistent with Bandura's (1977, 1997) self-efficacy framework, which emphasizes the primacy of mastery experiences over passive exposure. The direction and relative strength of this association suggest that supervision-specific experience may be more relevant to the development of supervisory self-efficacy than general clinical mental health experience or credential attainment. The lack of statistical significance may

reflect limited statistical power, multicollinearity among experience variables, or variability in the quality and structure of supervisory experiences.

Taken together, these findings suggest that clinical supervisor self-efficacy is a perceptual and developmental construct that cannot be fully explained by experience duration or credential attainment alone. In alignment with Bandura's SET, the results underscore the importance of intentional, reflective, and contextually meaningful supervisory experiences in the development of confidence and perceived competence in the supervisory role. Although the predictors examined in this study did not significantly explain variance in supervisor self-efficacy, the findings highlight the need to move beyond time-based and credential-based assumptions when conceptualizing supervisor readiness and effectiveness.

Limitations of the Study

Clinical supervisor self-efficacy is a multifaceted construct, and several limitations should be considered when interpreting the findings of this study. First, the limited availability of validated instruments specifically designed to assess clinical supervisor self-efficacy constrained measurement options. Although the CSSSES has demonstrated acceptable reliability and validity, it may not have fully captured the complexity of supervisory self-efficacy across diverse clinical contexts, particularly within SUD treatment settings. As noted in Chapter 1, achieving an adequate sample size to meet statistical power requirements was identified as a potential limitation. Although a sufficient number of surveys were collected to conduct the planned analyses, the resulting sample size was modest relative to the number of predictors included in the regression

model. Consequently, the study may have limited power to detect statistically significant relationships, particularly those associated with small effect sizes. This limitation was further compounded by overlap among experience-related variables, which may have reduced individual predictor effects. Another limitation involved multicollinearity among several predictor variables. Multiple experience-based measures were correlated, suggesting overlap in the constructs being assessed.

Self-efficacy is inherently a self-perceived construct (Bandura, 1997; Strauser, 1995). Reliance on self-report measures was appropriate; however, responses may have been influenced by social desirability bias. Despite the anonymous nature of the survey, participants may have overestimated their supervisory confidence to align with professional norms or expectations. In addition, this study did not account for contextual variables associated with the development of self-efficacy, such as vicarious experiences, performance accomplishments, and verbal persuasion. Prior research has demonstrated that these factors play a role in strengthening self-efficacy beliefs. For example, Frick and Glossoff (2014) found that observing faculty-led supervision sessions (vicarious experience), actively providing supervision (performance accomplishments), and receiving constructive feedback from peers, supervisors, and supervisees (verbal persuasion) were all associated with increased supervisor self-efficacy.

Finally, the cross-sectional design of the study limits conclusions regarding the development of supervisory self-efficacy over time. Additionally, the use of non-probability sampling limits the generalizability of the findings beyond the study sample. Participants who elected to respond may differ systematically from those who did not,

particularly in terms of motivation, professional engagement, or perceived confidence in the supervisory role.

Recommendations

The findings and limitations of the present study suggest several directions for future research. First, longitudinal research designs are recommended to better examine the development of clinical supervisor self-efficacy over time. Bandura's SET emphasizes the cumulative impact of mastery experiences, feedback, and contextual influences on efficacy beliefs (Bandura, 1977, 1997). A longitudinal approach would allow researchers to capture changes in supervisory self-efficacy as supervisors gain experience, engage in formal training, and encounter varying supervisory challenges, thereby providing a more nuanced understanding of how efficacy beliefs evolve across developmental stages.

Second, future studies may benefit from the use of qualitative or mixed methods designs to explore clinical supervisor self-efficacy in greater depth. While quantitative measures are useful for identifying patterns and relationships, qualitative approaches such as interviews or focus groups may allow for richer exploration (Burkholder et al., 2020) of how supervisors conceptualize self-efficacy, interpret mastery experiences, and integrate feedback into their supervisory identity. Qualitative inquiry may also illuminate contextual and relational factors (i.e., organizational support, supervision structure, or access to consultation,) that are difficult to capture through standardized instruments alone.

Finally, future research should consider using a developmental model, such as the Integrated Developmental model (IDM), to examine supervisor self-efficacy. The IDM conceptualizes counselor development based on professional development needs rather than relative to standards (like credentialing standards; Bernard & Goodyear, 2019). Stoltenberg and McNeil (2010), the founders of the IDM, emphasized that supervisors, similar to counselors, move through three developmental stages characterized by changes in competence, autonomy, and self-awareness. Applying this model may provide a structured framework for understanding how supervisory self-efficacy develops across levels of professional growth and how supervisors perceived competence aligns with their developmental stage. Incorporating IDM with Bandura's SET may offer a comprehensive theoretical lens through which to examine the complex interplay between experience, training, and supervisory confidence.

Implications

The findings of this study have meaningful implications for positive social change, particularly within the counseling and SUD workforce. Clinical supervision plays a critical role in counselor development, ethical practice, and service quality (Center for Substance Abuse Treatment, 2009); therefore, factors that influence supervisor effectiveness have downstream effects on counselors, clients, and the broader systems of care. Although the predictors examined in this study did not significantly explain variance in clinical supervisor self-efficacy, the results challenge long-standing assumptions about the role of experience and credentials in supervisory readiness and highlight opportunities for systemic improvement. Improved supervision quality is

foundational to counselor development and professional growth. Research and expert consensus indicate that supervision fosters professional development, enhances clinical competence, and supports counselor learning (Center for Substance Abuse Treatment, 2009). Quality supervision provides a structured process in which supervisors observe, mentor, coach, and evaluate clinicians, helping them integrate theoretical knowledge into practice and expand clinical skills (Center for Substance Abuse Treatment, 2009). Thus, strengthening supervision practices can enhance the preparedness and confidence of supervisees, supporting a more competent and resilient workforce.

Clinical supervision also has implications for ethical practice and quality of care. The Center for Substance Abuse Treatment (2009) identifies clinical supervision as an essential strategy for ensuring quality services, ethical adherence, and professional accountability. Through supervision, counselors receive ongoing feedback that reinforces ethical standards and supports sound clinical decision-making (Center for Substance Abuse Treatment, 2009). Thus, when supervisors possess strong self-efficacy and engage in reflective practice, they are better positioned to model ethical behavior, and guide supervisees through complex clinical situations.

Although direct evidence linking supervision to client outcomes is still emerging, the available literature suggests that supervision interventions are associated with formative improvements in clinician competence and therapeutic alliance, which are foundational to effective client care (Bradley & Becker, 2021). Further supported specifically in the SUD treatment setting by Ramsey et al., (2017) who found that clinical supervision accounts for up to 16% of the variance in a clients SUD treatment outcome.

Moreover, clinical supervision is explicitly intended to improve quality client care and ensure that counselors respond effectively to diverse clinical situations (Center for Substance Abuse Treatment, 2009). Robust supervisory support promotes adherence to evidence-based practices and may contribute to enhanced treatment outcomes over time.

Conclusion

The purpose of this quantitative study was to examine whether years of experience in the counseling field, years of experience providing SUD counseling, years of experience as a clinical supervisor, professional counseling credentials, and supervisory credentials predicted supervisor self-efficacy among clinical supervisors providing clinical supervision to ADCs. None of these predictor variables significantly predicted supervisor self-efficacy and the null hypothesis failed to be rejected. Despite this, the results do provide meaningful insight into how supervisory self-efficacy may develop.

Taken together, the findings suggest that clinical supervisor self-efficacy is not determined by time in the field or credential attainment alone. Instead, supervisory confidence appears to be influenced by the quality and context of supervision-specific experiences, particularly experiences providing supervision to SUD counselors, recognizing that supervisory roles can vary substantially across settings, populations, and service environments. While this variable did not reach statistical significance, it demonstrated the strongest relative association with self-efficacy, aligning with Bandura's SET, which emphasizes mastery experiences as the primary source of efficacy beliefs (Bandura, 1977; 1997).

This study highlights the need to move beyond experience-based assumptions, specifically the notion that years of SUD counseling or time spent in supervisory roles automatically translate into supervisory readiness and effectiveness. Simply accumulating years of practice or obtaining credentials may be insufficient to foster confidence in complex supervisory skills. Instead, intentional, reflective, and well-supported supervisory experiences may be essential to the development of clinical supervisor self-efficacy.

Overall, the findings underscore the critical need for supervision models and training programs that prioritize competency development and experiential learning. SUD counselors operate in an increasingly complex and high-stakes environment, responding to rising rates of co-occurring disorders, emerging designer drugs, and the rapid expansion of telehealth services (Peavy et al., 2024; SAMHSA, 2024). In this context, traditional measures of experience, such as years of practice or credential attainment, are insufficient to prepare supervisors for the challenges of guiding counselors effectively. By centering intentional, reflective, and contextually rich supervisory experiences, the counseling profession can cultivate supervisors who possess the self-efficacy, judgment, and ethical grounding necessary to support counselor development and enhance client outcomes. These findings call for a shift in how supervision is conceptualized and implemented, emphasizing quality over quantity and positioning supervisors as pivotal agents in advancing both the profession and the well-being of those it serves.

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Appendix A: Inclusion Criteria Questionnaire

1. Do you hold either of the following licenses or certifications in The United States of America?
 - a. Professional Counselor
 - b. Alcohol and Drug Counselor
 - c. Both
 - d. None
2. Do you currently provide clinical supervision to counselors who provide alcohol and drug counseling services?
 - a. YesNo

Appendix B: Demographic Questionnaire

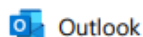
1. What is your age in years?
 - a. 18-24
 - b. 25-34
 - c. 35-44
 - d. 45-54
 - e. 55-64
 - f. 65-74
 - g. 75 or older
 - h. I prefer not to answer
2. In research, we often must present demographic information in categories, though we recognize these labels can be limiting and may not fully reflect your identity. If you had to choose, how would you describe your gender identity (e.g., Female, Gender non-confirming, Male, etc.)? Please type your answer below.
3. Ethnicity reflects the cultural traditions, values, and practices that are shared by people across generations. When you consider your personal and familial cultural values, traditions, and practices, what labels best describe your ethnicity? (mark ALL that apply)
 - a. Arab, Middle Eastern, or North African, for example, Algerian, Egyptian, Iraqi, Jordanian, Sudanese, Syrian, Yemeni.
Please specify: _____
 - b. Asian or Asian American, for example, Asian Indian, Chinese, Filipino, Japanese, Korean, Nepalese, Vietnamese.
Please specify: _____
 - c. Black or African American, for example, Ethiopian, Haitian, Jamaican, Nigerian, Somalian.
Please specify: _____
 - d. Hispanic or Latino, for example, Colombian, Cuban, Dominican, Mexican or Mexican American, Puerto Rican, Salvadoran.
Please specify: _____
 - e. Native American or Alaska Native, for example, Arapaho, Blackfeet Tribe, Mayan, Native Village of Barrow Inupiat Traditional Government, Navajo Nation, Nome Eskimo Community
Please specify: _____
 - f. Native Hawaiian or Other Pacific Islander, for example, Chamorro, Fijian, Marshallese, Native Hawaiian, Samoan, Tongan.
Please specify: _____
 - g. White or European American, for example, English, French, German, Irish, Italian, Polish.
Please specify: _____
Some other race, ethnicity, or origin.
Please specify: _____ I prefer not to answer

4. When thinking about physical attributes usually ascribed to race, which of the following labels describe how others would describe you racially: (mark ALL that apply)
 - a. Asian
 - b. Black
 - c. Indigenous, Aboriginal, or First Nations
 - d. Latino or Hispanic
 - e. Middle Eastern
 - f. White
 - g. Other, please specify: _____
 - h. I prefer not to answer
5. Which of the following counseling certifications or licenses do you hold (mark ALL that apply)?
 - a. Professional Counselor (for example, LPC, LPCC, LCPC, LPC-MHSP, LMCH, LPC)
 - b. Alcohol and Drug Counselor (for example, CADC, LADC, LADAC, CAC, LCADC, CSAC)
 - c. Other, please specify: _____
6. Please specify counseling certification or license.
7. What state(s) do you hold your counseling certifications or licenses?
8. How long have you been certified or licensed as a Professional Counselor (if applicable, enter NA if not applicable)?
9. How long have you been certified or licensed as an Alcohol and Drug Counselor (if applicable, enter NA if not applicable)?
10. How long have you been providing drug and alcohol counseling (in years)?
11. Do you hold supervision credentials or designation (for example, ACS, CCS, LPC-S)?
 - a. Yes (links to question 12)
 - b. No (links to question 13)
12. What specific supervision credential or designation do you hold and for what state(s)?
13. How long have you been providing formal clinical supervision to alcohol and drug counselors and/or interns?

Appendix C: Permission to Use CSSES

6/1/25, 9:45 AM

Mail - Victoria Nagel - Outlook



Re: Counselor Supervisor Self-Efficacy Scale

From Kristin Trivisonno <kristinbphd@yahoo.com>**Date** Sat 3/22/2025 9:01 AM**To** Victoria Nagel <victoria.nagel@waldenu.edu>

Hello there! You certainly have my permission to use thr CSSES. I haven't been in academia for almost 20 years, (gasp!) so I've not kept up the research, but I wish you luck in all of your endeavors :)
Kristin Barnes Trivisonno

[Yahoo Mail: Search, Organize, Conquer](#)

On Thu, Feb 27, 2025 at 10:16 AM, Victoria Nagel <victoria.nagel@waldenu.edu> wrote:

Hello Dr. Barnes,

My name is Victoria Nagel, and I am a Ph.D. student in Counselor Education and Supervision working on my dissertation. My research focuses on the self-efficacy of clinical supervisors supervising addiction counselors.

In my literature review, I came across your dissertation *Development and Initial Validation of a Measure of Counselor Supervisor Self-Efficacy*. Your scale is the most appropriate scale for my research. I am requesting permission to use the CSSES scale in my research.

Also, I noticed that it has been used in several dissertations and, recently the multicultural subscale in some work by Dr. Lyons from the University of Virginia. I was wondering if you were aware of any other recently published works that used this scale.

Thank you!

Victoria Nagel, LCADC, LPC, ACS, NCC, BC-TMH

Appendix D: IRB-Approved Invitation Template for Emails, Social Media, and Flyers

Hello,

You are invited to complete a 10-minute anonymous survey for a study titled:
Determinants of Clinical Supervisor Self-Efficacy in Substance Use Disorder Counseling.

Seeking volunteers that meet these requirements:

- Must hold a professional counseling and/or alcohol and drug counseling credential, as defined by practicing state(s) licensing or credential boards, and
- Must currently be providing clinical supervision to alcohol and drug counselors or counseling interns delivering primarily alcohol and drug counseling services. Supervisors may be credentialed or designated as “approved supervisors” by their state licensing or credentialing boards. If your state does not have specific requirements for providing supervision, you are still eligible.
-

The survey will be open until the end of December. Questions should be directed to Victoria.nagel@waldenu.edu.

To complete the survey, please click <https://forms.cloud.microsoft/r/TZpUVzR8Ak>