Advanced Doctoral Students' Knowledge and Understanding of Clinical Supervisor Ethical Responsibilities: A Brief Report

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ABSTRACT. Ten advanced counseling psychology doctoral students participated in semi-structured telephone interviews designed to investigate their knowledge and understanding of clinical supervisors' ethical responsibilities. They responded to questions about clinical supervisor responsibilities and risks; inclusion of clinical supervision in professional codes of ethics; definition and use of informed consent for clinical supervision; approaches for addressing concerns about supervisee competence; ethical reasons to refuse to supervise an individual; and ethical obligations to different constituencies. Using an inductive analysis process, seven themes were extracted. These themes are described, and training and research recommendations are given. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2004 by The Haworth Press, Inc. All rights reserved.]*

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Supervision ethics is a critical content area for clinical supervisors because they ultimately are responsible for supervisee behavior and client welfare (Bernard & Goodyear, 1998; Harrar, VandeCreek, & Knapp, 1990; Sherry, 1991; Tarvydas, 1995; Vasquez, 1992). However, experienced supervisors have been found to vary in knowledge and understanding, and some engage in ethically questionable practices (Dickey, Housely, & Guest, 1993; Erwin, 2000; King & Wheeler, 2000; Ladany, Lehrman-Waterman, Molinaro et al., 1999; Navin, Beamish, & Johanson, 1997). We were interested in assessing a sample of the *next generation* of clinical supervisors (i.e., advanced doctoral students). We conducted a qualitative study, consisting of semi-structured telephone interviews (Range: 20-60 minutes) with seven female and three male students from APA-accredited counseling psychology programs in eight geographic regions.

The sample identified as White (n = 7), Biracial (n = 1), Other (n = 1), and one withheld identification. Eight completed a clinical supervision course, one was currently enrolled, and one had no supervision coursework. Four individuals completed a one-semester, supervision practicum, and one provided clinical supervision during a counseling practicum. Two had additional experience supervising master's students individually and/or in groups, and one conducted four years of clinical supervision research. All were student affiliates of APA and adhered to the APA (1992)[1] Ethics Code. One participant was a member of the National Career Development Association, and one belonged to the American Marriage and Family Therapy Association and the National Association for Social Work.

Participants responded to 18 questions regarding: supervision content in ethics codes; supervisor responsibilities and risks; use of informed consent in supervision; self-protection strategies; ways to address supervisee competence concerns; and ethical obligations to others. Using an inductive analysis procedure (Patton, 1990), the first author identified seven major themes (verified by the third author) concerning the depth and accuracy of participant knowledge. This paper summarizes these themes and offers training and research suggestions.

MAJOR THEMES

Theme 1: Participants Could Not Articulate How Ethics Codes Address Supervision

While nine participants said the APA (1992) Ethics Code includes supervision, they could not describe this content. One individual said the codes do not cover it specifically; another said the APA code inadequately addresses this topic; and two mentioned the ACES Ethical Guidelines for Counseling Supervisors (1990), but did not know how supervision was covered.

Theme 2: Participants Identified a Limited Number of Supervisor Responsibilities and Risks

Only two responsibilities were mentioned by a majority of the sample: legal and ethical mandates to protect supervisees' clients ($n = 7$); and monitoring quality of supervisee work through observation and relevant, timely feedback provision ($n = 6$). A few mentioned following APA (1992) Ethics Code ($n = 4$); promoting and monitoring supervisee competence ($n = 4$); and being a good role model/mentor ($n = 4$). Participants explicitly identified only two risks: legal liability for supervisee negligence ($n = 6$); and limited control over supervisee work ($n = 3$).

Theme 3: Participants Identified a Limited Number of Self-Protection Strategies

Documentation of supervision was the only prevalent self-protection strategy ($n = 5$). A few participants mentioned following APA (1992) Ethics Code ($n = 3$); discussing standards of conduct with supervisees ($n = 3$); maintaining malpractice insurance ($n = 2$); consulting with colleagues and supervisors ($n = 2$); using informed consent for supervision ($n = 1$); being supervised ($n = 1$); and knowing supervisee's work by observing sessions ($n = 1$). All indicated they would refuse to supervise someone either because of concern about ethical/legal risks ($n = 7$); inability to provide competent supervision ($n = 5$); incompatible supervisor-supervisee styles ($n = 4$); supervisee impairment ($n = 3$); and/or personality conflicts ($n = 1$).

Theme 4: Participants Were Uncertain About Informed Consent for Clinical Supervision

Nine participants defined informed consent as explaining supervision process (i.e., roles, expectations, confidentiality limits, and responsibilities) but expressed uncertainty about the accuracy of their definitions. One individual had never heard of informed consent for supervision. Most stated that they used informed consent in their clinical supervision and planned to use it in the future in order to outline expectations (n = 7); help protect themselves legally (n = 3); and/or set the stage for supervisor and supervisee responsibilities (n = 2). One individual did not plan to use informed consent, and one was uncertain about its use.

Theme 5: Participants Identified Few Ways to Address Concerns About Supervisee Competence

The only prevalent strategy to address supervisee competence concerns was developing a remediation plan (n = 8). A few participants reportedly would consult with a supervisor, colleagues, or person in charge (n = 4) and/or document their concerns and interventions (n = 3).

Theme 6: Participants Minimized Their Accountability to Certain Constituencies

When asked about their accountability to supervisees' clients; the person supervising their supervision provision; supervisees; a State Licensing Board; and professional psychological organizations, every participant indicated at least minimal accountability for all but professional organizations. Highest accountability was to supervisees (n = 8) and supervisee clients (n = 7). Only two participants indicated high accountability to their supervisor.

Theme 7: Participants Vaguely Differentiated Supervisor Legal and Ethical Responsibilities

Seven participants stated the two differ as follows: legal responsibilities are a minimum standard, while ethical responsibilities represent aspirational standards (n = 4); what is unethical is not necessarily illegal, and vice versa (n = 2); and, while different, they share a common

goal of providing the highest treatment quality ($n = 1$). Three participants made no distinctions.

TRAINING AND RESEARCH RECOMMENDATIONS

The participants' responses indicate a superficial knowledge and understanding of supervision ethics. None could articulate how ethics' codes address supervision, they were accurate but uncertain about informed consent for supervision, and most vaguely understood the differences between ethical and legal responsibilities. They failed to explicitly identify both the responsibility to serve as gatekeepers for the profession (Bernard & Goodyear, 1998) and the risk of providing harmful supervision (ACES, 1993), although several reportedly would not supervise if they lacked competence or time. Very few mentioned consultation and documentation either as self-protection strategies or as ways to address concerns about supervisee competence. Although recognizing that they had responsibility for client welfare and for supervisee development, participants were quite focused on their own vulnerability. They likely were in Watkins' (1994) *Role Shock* stage, characterized by confusion about role boundaries, anxiety, insecurity, and concerns about one's competence.

Given the sample's limited knowledge and understanding, we recommend that training programs emphasize the content of ethics' codes, the parties to whom supervisors are accountable, and the importance of informed consent for supervision (McCarthy Veach, 2001). Discussion, role playing, supervision practica, and post-degree supervision may further facilitate knowledge and understanding. Future research should include comparisons of students with and without formal supervision training, studies of in-vivo behaviors to determine how supervisors implement their ethics knowledge and understanding, and investigations of differences in knowledge and understanding as a function of experience and other personal characteristics.

NOTE

1. At the time of data collection, the 1992 APA Ethics Code had not been revised. The only change regarding clinical supervision in the 2000 Ethics Code is the new standard 7.07 which prohibits sexual relationships with all supervisees in a department, agency, or training center (Knapp & VandeCreek, 2003).

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