Clinical Supervision of Psychotherapy: Essential Ethics Issues for Supervisors and Supervisees

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Clinical supervision is an essential aspect of every mental health professional's training. The importance of ensuring that supervision is provided competently, ethically, and legally is explained. The elements of the ethical practice of supervision are described and explained. Specific issues addressed include informed consent and the supervision contract, supervisor and supervisee competence, attention to issues of diversity and multicultural competence, boundaries and multiple relationships in the supervision relationship, documentation and record keeping by both supervisor and supervisee, evaluation and feedback, self-care and the ongoing promotion of wellness, emergency coverage, and the ending of the supervision relationship. Additionally, the role of clinical supervisor as mentor, professional role model, and gatekeeper for the profession are discussed. Specific recommendations are provided for ethically and effectively conducting the supervision relationship and for addressing commonly arising dilemmas that supervisors and supervisees may confront. © 2014 Wiley Periodicals, Inc. J. Clin. Psychol.: In Session 70:1051–1061, 2014.

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Clinical supervisors serve in a number of crucial roles in the clinical training and professional development of future mental health professionals. They teach, mentor, share their experience and wisdom, help guide supervisees' professional development, and serve as gatekeepers of the profession (Bernard & Goodyear, 2014). Their ultimate outcomes are to impart knowledge, help enhance skills, and help prepare the supervisee for success at the next level of training and practice. Because supervisees are providing direct clinical services to clients while often at very early stages of their training, supervisors maintain a significant responsibility to provide sufficient oversight and training to help ensure that clients receive the best services possible and to help minimize risks of harm to them (Falender & Shafranske, 2004).

Numerous ethical issues, challenges, and dilemmas may arise that are relevant to both the conduct of the supervisory relationship and the interactions between supervisees and their clients. Clinical supervision that integrates a focus on these ethics issues will hopefully help prevent many of the more commonly occurring challenges and dilemmas, and for those that do arise, it is hoped that they will be thoughtfully addressed and resolved in a timely manner consistent with the supervisee's and/or client's best interests (Barnett & Johnson, 2008; Vasquez, 1992). The major areas of ethics that pertain to clinical supervision and the provision of clinical services by supervisees are discussed and specific recommendations for proactively and effectively addressing them are provided. While no one article can address every possible challenge and dilemma that may arise, we do hope to provide a framework for addressing relevant ethics issues that are likely to occur.

Assessing the Supervisee's Training Needs

Tailoring the supervision provided to each individual supervisee's training needs is essential. Prior to even having the supervisee see clients, supervisors should determine the supervisee's strengths and weaknesses, areas that necessitate additional training before seeing clients, and areas where the need for more intensive supervision may be indicated (Barnett, 2011). Supervisors

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should consider a review of previous coursework and clinical experiences and engage in a discussion of the supervisee's relevant knowledge and experiences, such as how to conduct an interview, basic counseling skills, goals of treatment, assessment of treatment needs, and the like. The supervisor then can provide remediation as needed, assign clients as would be appropriate, and provide the type and intensity of clinical supervision indicated by the supervisee's level of training, knowledge, and skill (Barnett, 2011).

Some supervisees may be quite advanced in some areas of practice, yet may need additional training or even remediation in others. Thus, no one approach to clinical supervision can ever be appropriate for every supervisee and each supervisee's training needs may change over time, so modifications in how supervision is provided may need to be made (Barnett, 2011; Bernard & Goodyear, 2014).

Competence

It is essential that each clinical supervisor possess two types of competence: competence in the clinical areas to be supervised (e.g., child therapy, adult assessment, substance abuse treatment) as well as in the practice of clinical supervision (Barnett, 2011; Barnett & Johnson, 2008). This is consistent with Standard 2.01, Boundaries of Competence, of the American Psychological Association (APA) Ethics Code (APA, 2010), which states that before providing any professional services, psychologists ensure that they do so "with populations and in areas only within the boundaries of their competence based on their education, training, supervised experience, consultation, study, or professional experience" (p. 4). It is advised that those interested in providing clinical supervision to others first undergo formal training in clinical supervision that includes both didactic instruction and clinical training that involves supervision of the application of one's supervision skills (Falender et al., 2004).

As with all other types of clinical competence, supervision competence falls along a continuum; one is neither fully competent nor totally incompetent. Similarly, one may be competent in one aspect of one's role and not in others, and one may be competent at one point in time and not at others. It is thus important to take care in establishing and maintaining one's various competencies. Clinical supervisors should be active students of the art and science of clinical supervision, continually working to enhance their competence in this important area of practice. When unsure if one's particular competencies are sufficient and if they meet required standards, it is recommended that colleagues with experience and expertise in that particular area of professional practice be consulted.

Likewise, when a supervisee is treating a client whose clinical needs fall outside the supervisor's areas of competence, delegating supervision of that particular client to a colleague with the needed competence is recommended. Clinical supervisors should predict the potential for issues related to their competencies and discuss in the supervision contract appropriate courses of action for supervisees to take if such an issue was to arise.

Informed Consent

Just as with psychotherapy, assessment, and all other professional services mental health clinicians provide, and consistent with Standard 3.10, Informed Consent, of the APA Ethics Code (APA, 2010), it is essential that a thorough informed consent process be engaged in at the outset of the supervisory relationship (Bernard & Goodyear, 2014; Falender, 2011; Thomas, 2007, 2010). This can take the form of a supervisory contract or agreement that is signed by both parties (for sample supervision contracts, see Bernard & Goodyear, 2014; Falender, 2011; Thomas, 2007, 2010).

At a minimum, this agreement should include the following topics: expectations, responsibilities, and obligations of both supervisor and supervisee; any fees and financial arrangements relevant to the supervisory relationship; scheduling and emergency contact information; documentation and record keeping requirements; the use of any audio and video recording; evaluation and feedback to include the expectations and requirements for successful completion of the training experience; expectations for confidentiality and any reasonably anticipated limits to

confidentiality; legal requirements such as mandatory reporting requirements; expectations for use of the supervisor and when the supervisee should contact him or her; and information about how and when the supervisory relationship will be ended (Barnett, 2011; Bernard & Goodyear, 2014; Falender, 2011; Thomas, 2007, 2010).

As with any other informed consent agreement, it is important to ensure that consent by the supervisee is given voluntarily, that the supervisee is competent to give his or her own consent (e.g., is above the age of majority), that what the supervisee is agreeing to is understood by him or her, and that the consent is not only reviewed and explained verbally but also documented in writing (Barnett, Wise, Johnson-Greene, & Bucky, 2007). Additionally, it is important to keep in mind that informed consent is not a singular event, but rather an ongoing process (Barnett et al., 2007). As circumstances or situations change in the supervisory relationship (e.g., changes in the supervisee's responsibilities) the informed consent agreement should be updated.

A Developmental Approach to Clinical Supervision

Clinical supervision may be provided through varying means and intensities dependent on the supervisee's training needs (Barnett, 2011). As the supervisee progresses through stages of professional growth and development, his or her training needs and need for a particular type of supervision will change (Falender & Shafranske, 2004; Stoltenberg & McNeill, 2009). Thus, the clinical supervisor will likely take a rather active role in the beginning of the supervisory relationship, and then gradually reduce his or her involvement to allow the supervisee to take on greater autonomy and responsibility. For example, as the supervisee demonstrates the ability to competently handle increasing amounts of autonomous functioning, supervision can progress through the following continuum, noting that not every supervisee's training needs will necessitate the need for each of these types of supervision:

1. The supervisee observing the clinical supervisor providing a particular clinical service (e.g., having the trainee observe the supervisor conduct an intake interview or observe the supervisor administer a test).
2. The supervisor and supervisee engaging in a role-play of a particular clinical service during individual supervision.
3. If possible, the supervisor and supervisee providing the clinical service jointly (e.g., co-leading a group or conducting an intake interview together).
4. The supervisor observing the supervisee providing the clinical service and sharing feedback and suggestions in real time (e.g., using I-Supe to communicate directly during a session).
5. The supervisee video recording the provision of clinical services and providing the supervisor with the videos and with clinical documentation to review prior to the supervision session. The supervisor then integrating the review of the videos and documentation into their supervision sessions.
6. The supervisee audio recording the provision of clinical services and providing the supervisor with the recordings and with clinical documentation to review prior to the supervision session. The supervisor then integrating review of the recordings and documentation into their supervision sessions.
7. The supervisee audio and/or video recording selected cases for intensive review in clinical supervision, and for the remainder of cases providing the supervisor with documentation of the professional services provided.

It is also important to keep in mind that numerous other approaches to clinical supervision exist and many clinical supervision strategies may prove useful. Factors such as the supervisor's theoretical orientation and a range of other factors may influence how clinical supervision is provided (Falender & Shafranske, 2004). Additionally, the strategies listed above do not represent a linear progression. It is possible that an advanced supervisee may receive a referral for a client whose treatment needs fall outside the supervisee's usual areas of clinical competence. In these situations, the supervisor and supervisee may jointly agree to move back to an earlier stage of this developmental progression for the supervision of this particular case, as a means of promoting both the development of clinical competence and the best interests of the client receiving the

clinical services, while simultaneously functioning at a higher developmental level of supervision for other clients' treatment.

Creating a Safe Holding Environment

Although there typically is an evaluative component to the supervisory relationship, for the supervisee to obtain maximum benefit from the clinical supervision, and thus for the clients treated to receive the best care possible, the supervisee must perceive the supervisory relationship to be sufficiently safe to be able to openly share thoughts, ideas, experiences, and feelings with the supervisor (Association for Counselor Education and Supervision [ACES], 2011; Winnicott, 1965). In fact, without experiencing trust, security, and safety in the supervisory relationship, supervisees may tend to censor what is shared with the supervisor for fear of negative feedback, criticism, or a negative evaluation, which greatly puts at risk the quality of supervision and the quality of the treatment provided to the supervisee's current and even future clients (Ladany, Hill, Corbett, & Nutt, 1996).

Although there is a need for feedback and recommendations for change and growth to foster the learning process, it is hoped that this can be done in a manner that promotes openness to the supervisory process. For this important learning to occur, it is vital that supervisees feel safe enough to experiment, try new things outside their comfort zone, and be able to report back to the supervisor on "failures," not just successes, to achieve maximum benefit from the supervision process (Moghe & Barnett, 2007; Worthen & McNeill, 1996). Similarly, clinical supervisors should actively seek out, and be open to receiving, feedback from supervisees about the supervisory relationship and process, and should actively demonstrate this openness during informed consent and within the supervision sessions.

Evaluation and the Feedback Process

Although the establishment and maintenance of a trusting relationship and safe environment are essential for clinical supervision to be successful, the supervisory relationship will typically be an evaluative one, with the supervisor providing feedback and evaluation to the supervisee as well as to his or her training program (Bernard & Goodyear, 2014). These requirements should always be discussed during the informed consent process. The supervisee should understand the criteria for evaluation, the expectations and standards to be met to successfully complete the training experience, and how and when the evaluation process will be conducted (Thomas, 2007).

Both formal and informal evaluations and feedback should be provided to supervisees (Bernard & Goodyear, 2014). Any formal evaluation rating form and criteria for success should be reviewed with the supervisee at the outset of the supervisory relationship to ensure understanding of all expectations and standards (Falender & Shafranske, 2004). Additionally, a schedule for formal evaluation should be agreed upon, and the supervisee should be informed of all individuals who may receive the results of these formal evaluations and how they may be used (Thomas, 2007). Additionally, informal feedback should be provided to the supervisee on an ongoing basis. Timely, helpful, and constructive feedback to the supervisee on an ongoing basis is an ethical imperative (ACES, 2011). Feedback and recommendations for improvement should be provided to supervisees with sufficient time and support for them to have the opportunity to engage in any needed remediation prior to receiving a final evaluation at the completion of the training experience (Falender & Shafranske, 2004).

Clinical Supervisor as Gatekeeper to the Profession

Despite the positive roles of clinical supervisor described above, ultimately each clinical supervisor has the responsibility to ensure that those who are not suited for independent practice in the mental health professions are not authorized to do so (Bernard & Goodyear, 2014). At times it may be tempting to take a "wait and see" approach, but if a series of consecutive supervisors take this approach, a supervisee with inadequate clinical skills or who does not possess the

needed personality attributes or disposition may be passed along like a "hot potato" (Johnson et al., 2008), to the likely detriment of that individual's future clients and to the detriment of the profession.

Although at times it may be uncomfortable to implement this role, it is essential that clinical supervisors take this obligation seriously by providing opportunities for remediation to supervisees who display problems with professional competence, and taking necessary action to prevent continued progression toward independent practice in the profession if remediation is not successful, consistent with requirements for evaluation and the provision of feedback to the supervisee's training program that are addressed and agreed upon in the supervision contract. Standards for successful completion of the training experience should be clearly articulated to the supervisee at the outset of the supervisory relationship and progress toward achieving them (or lack thereof) should be reviewed periodically throughout the training experience (Bernard & Goodyear, 2014; Falender & Shafranske, 2004; Thomas, 2007).

Clinical Supervisor as Professional Role Model

In addition to all the teaching that clinical supervisors provide, they also serve the important function of professional role model (Barnett, 2011). More than what clinical supervisors say to their supervisees, how they interact with the supervisee and how they act toward others may have a greater effect on impressionable supervisees who are in the process of forming and developing their professional identity (Vasquez, 1992). For example, a clinical supervisor who speaks at length with the supervisee about the importance of respecting and maintaining each client's confidentiality, but who also leaves his or her clients' records on their desk for the supervisee to see the clients' names and who casually discusses clients by name and shares sensitive information about them in the hallway with a colleague, will likely affect the supervisee's view of what a mental health professional is and does by these actions. The same will be true with regard to how the supervisor safeguards sensitive information the supervisee shares about him or herself in supervision sessions.

Finally, how the clinical supervisor conducts him or herself in supervision sessions with the supervisee will likely have a significant affect on how the supervisee functions as a professional as well. If the supervisor is warm, empathic, and understanding (or cold, emotionally distant, and unsupportive, for that matter) with the supervisee, the supervisee may internalize these qualities and emulate them in relationships with clients, both now and in the future, as well as with their future supervisees.

Clinical Supervisor as Mentor

In addition to serving as instructors and role models, clinical supervisors can serve in the very important role of mentor. The role of mentor goes beyond that of clinical supervisor in that the mentor takes a personal interest in the mentee's overall professional growth and development (Johnson, 2007). Mentors may focus discussions on career planning, balancing work and family, establishing one's career, addressing finances, getting involved in the profession, becoming engaged in scholarship, and the like. In fact, the mentor may invite the mentee to join him or her at professional meetings and conferences, introducing the mentee to the mentor's colleagues, assisting with professional networking activities, and working to help promote the mentee's career. Mentor and mentee may work jointly on research and writing projects or may serve on professional organization committees together, with the mentor helping to integrate the mentee into the profession.

An important aspect of the mentoring done by effective supervisors is to assist their mentees to better understand and navigate the administrative structure and political dynamics of the training setting. Experienced supervisors have much to share with neophyte clinicians on how to work effectively in a particular training environment.

A Focus on Diversity–Cultural Competence

Issues of diversity in all its forms should be given active attention in all aspects of the supervision process as well as within the supervisory relationship. It is important for supervisors to address issues of diversity between the supervisor and supervisee within supervision as well as to foster the development of cultural competence for supervisees in their work with clients (Barnett, 2011; Barnett & Johnson, 2008; Vasquez, 1992). Effective clinical supervisors will model how to thoughtfully and sensitively address issues of diversity in how they attend to differences between the supervisor and supervisee (e.g., gender, gender identity, age, race, culture, ethnicity, language, sexual orientation, socioeconomic status, disability; Vasquez, 1992). Thoughtful supervisors will also push supervisees to consider and address how these factors may be affecting the supervisees in their clinical work with clients. It is essential that cultural competence (really, diversity competence) is considered an essential aspect of clinical competence and is integrated into all aspects of the supervisee's clinical work as well as into all aspects of clinical supervision as is relevant (APA, 2010; Vasquez, 1992).

A Focus on Ethics and Legal Issues

A focus on ethics and legal issues should occur both by modeling them throughout the supervisory relationship and through didactic discussions (Barnett, 2011; Vasquez, 1992). As educators and role models, clinical supervisors should endeavor to inculcate in their supervisees a focus on ethical and legal practice (Barnett & Johnson, 2008). This focus should go beyond merely meeting minimal standards of the profession to developing a lifelong focus on aspiring to achieve the highest ethical ideals of our profession in all we do professionally. These aspirational ideals (Beauchamp & Childress, 2008) form the basis of each mental health profession's code of ethics and include:

1. Beneficence—the obligation to help others and do good through all our professional decisions and actions.
2. Nonmaleficence—the need to avoid exploitation and harm of others in our professional activities and relationships.
3. Fidelity—our obligations to others that can be explicit such as are articulated in the informed consent agreement, and implicit obligations of all mental health professionals such as to be honest and caring.
4. Autonomy—to promote each client or supervisee's independent functioning over time and to not engage in actions that will promote their dependence on us.
5. Justice—the fair and equitable treatment of all and providing all individuals with equal opportunities for and access to needed care.
6. Self-care—the need to take adequate care of ourselves on an ongoing basis to help prevent burnout and resultant problems with professional competence while promoting psychological wellness (needed to be able to effectively implement the first five ethical ideals).

It is additionally important that supervisees develop a sophisticated approach to addressing ethical challenges and dilemmas that involves the application of a process of ethical decision making rather than looking for "the right answer." Clinical supervisors can model this approach throughout supervision by guiding the supervisee though a series of questions based on the ethical ideals listed above that will promote a thoughtful approach to ethical decision making. Examples include: Will engaging in this behavior be in my client's best interest? Will acting in this way be consistent with my obligations to this individual? Will this action possibly result in harm to this other individual? A number of models of ethical decision making are available and can be shared with supervisees for their use (see Cottone & Claus, 2000, for a review of many available decision-making models).

A Focus on Self-Care and Psychological Wellness

Practicing in the mental health profession, whether as a clinical supervisor or as a supervisee, brings with it numerous challenges and stresses. Issues such as clients who may relapse or not improve, meeting administrative requirements, dealing with decreased funding and lower reimbursement rates, having clients engage in dangerous and threatening behaviors, and a host of others make this a very challenging profession. For supervisors, the stress of being responsible for all services provided by supervisees, and at times needing to provide negative feedback, can be quite stressful and challenging. For supervisees, the challenges of meeting with clients without a supervisor present, being evaluated, and having one's clinical work regularly scrutinized can each be distressing.

Additionally, all mental health professionals must address and deal with the many challenges in their personal lives, which can include relationship, financial, health, and other difficulties. Taken together these stressors can result in distress (i.e., the subjective emotional response to the stressors in our lives), which if not adequately addressed can develop into burnout and problems with professional competence (Baker, 2003).

Ethical supervisors will promote their own psychological wellness by actively practicing self-care strategies, and working to keep a balance between various professional obligations and between their professional and personal lives. Doing so will not only help ensure their ongoing competence but also model these ethical practices for supervisees. Similarly, ethical supervisors should regularly address issues of psychological wellness, self-care, distress, burnout, and problems with professional competence in supervision to help ensure supervisees are proactively addressing these issues, both at present and to develop career-long habits and behaviors (Bernard & Goodyear, 2014). Further, should any challenges or problems be present that may adversely affect the supervisee's professional competence, addressing them prior to a negative effect developing is desirable.

Documentation and Record Keeping

Clinical documentation is required in each mental health profession's code of ethics, laws and regulations, practice guidelines, and institutional policies (e.g., APA, 2007, 2010). Timely, thorough, and effective documentation of the services provided by mental health practitioners can serve a number of important purposes (Falender & Shafranske, 2004). These include:

1. To help the busy clinician remember important information about the client's treatment from session to session, promoting the provision of high quality mental health services.
2. To provide information to members of a treatment team to assist each of them in coordinating the services provided in light of each other's treatment efforts and the results seen.
3. To help assure continuity of care should a client leave treatment at one point in time and then return for additional treatment at a later date, whether with this clinician or with another.
4. As a risk management strategy to create a tangible record of all services provided, any use of colleagues for consultation, the clinician's decision-making process, the client's role in treatment, and outcomes achieved.
5. Because each mental health profession's code of ethics requires it.
6. Because laws, regulations, and institutional policies require it.

While all clinical supervisors will be familiar with the requirement to document all direct clinical services (assessment, treatment, telephone calls in between sessions, etc.), some may not be aware of the value and importance of both the supervisor and supervisee documenting each supervision session. This documentation can (a) help reduce the chance of misunderstandings occurring, (b) help increase accountability on the part of the supervisee, (c) be an excellent aide for both parties when reviewing it to track progress both of the supervisee's clients and the supervisee's professional development, and (d) serve an important risk management role in providing a tangible record of what has transpired in supervision and the supervisor's reasonable good faith efforts to provide high-quality clinical supervision (Falender & Shafranske, 2004).

Boundaries and Multiple Relationships

Boundaries are the ground rules of all professional relationships (Smith & Fitzpatrick, 1995). They include touch, self-disclosure, gifts, time, interpersonal space, and location. Each boundary can be avoided, crossed, or violated. Boundary crossings may be clinically appropriate and even necessary at times, and boundary violations by definition are harmful and unethical (Gutheil & Gabbard, 1993). Attention to boundary issues, both as elements of the supervision of the supervisee's treatment of clients and within the supervisory relationship, is equally important.

In addition to raising supervisees' awareness of boundary issues in their work with clients, supervisors should be ethical role models for supervisees regarding the appropriate management of boundaries (Barnett & Johnson, 2008). Thus, for example, supervisors may appropriately utilize self-disclosure in supervision to enhance the value of the learning experience for the supervisee. As with all boundaries, crossings are defined by their clinical relevance, conformity with prevailing professional standards, being welcomed by the recipient, and being motivated by a desire to meet the other individual's clinical or supervisory needs, not by one's own personal needs or motivations.

Additionally, decisions about boundaries should be made with sensitivity to individual differences to include diversity differences as a behavior may be viewed as an appropriate and even necessary boundary crossing by some individuals and as an unwelcomed and inappropriate boundary violation by others (Smith & Fitzpatrick, 1995).

Multiple relationships are present when a mental health professional is engaged in a secondary relationship with an individual with whom one has a professional relationship. Thus, a clinical supervisor might have a personal, social, business, financial, or other similar type of multiple relationship with a supervisee or a supervisee might have such relationships with a client. As it is explained in Standard 3.05, Multiple Relationships, of the APA Ethics Code (APA, 2010), all multiple relationships are not patently forbidden, but those that hold the potential for exploitation of or harm to the supervisee or client should be avoided. Also, if being in a multiple relationship with a supervisee or client would likely impair one's objectivity and judgment, it should be avoided (APA, 2010).

Although some multiple relationships are unavoidable, such as in rural settings and certain other "closed" communities (Campbell & Gordon, 2003), all multiple relationships that are exploitative such as sexually intimate relationships, should always be avoided (APA, 2010). They are always unethical and demonstrate a clear abuse of the imbalance of power in the professional relationship.

It is also important to note that multiple relationships may be beneficial to the supervisee (Thomas, 2010). For example, a supervisor who has evaluative authority and who maintains responsibility for monitoring his or her supervisee's clinical activity may be simultaneously working with the supervisee on a research project or presenting at a conference with the supervisee. Thus, multiple relationships between clinical supervisors and supervisees can be beneficial so long as they appropriately foster the supervisee's professional development and are not exploitative in nature (Thomas, 2010).

One multiple relationship dilemma often present in the supervision relationship involves the boundary between providing supervision and providing psychotherapy. Although most supervisors would know that one should not serve in both of these roles simultaneously, there always exists the possibility that a supervisor may slowly over time shift from the role of supervisor into the role of psychotherapist. The risk of this boundary transgression occurring may be greatest when supervision is provided from a psychodynamic orientation, which will often involve an examination of the supervisee's countertransference reactions to his or her clients, although it may occur whenever supervisors and supervisees address the supervisee's underlying emotional responses, issues, and conflicts.

This exploration of the supervisee's emotional responses and reactions to the client may involve a focus on the supervisee's unresolved issues and emotional conflicts, and can easily develop into providing psychotherapy to supervisees if care is not taken. In these situations, supervisors should remain aware of the potential to enter into a psychotherapist role. When this

appears imminent and when addressing these issues is in the supervisee's best interests, a referral to another competent professional for psychotherapy is recommended.

Emergency Coverage and Avoiding Abandonment

Clinical supervision is a significant responsibility and a sizeable commitment on the part of the supervisor. Merely being attentive and available during regularly scheduled supervision sessions is insufficient. Each supervisor has an obligation to make emergency coverage arrangements and ensure that supervisees know under what circumstances to contact the supervisor and how to do so (ACES, 2011; Bernard & Goodyear, 2014). Such issues should be openly discussed as part of the informed consent process and updated over time as is needed (Bernard & Goodyear, 2014; Falender & Shafranske, 2004; Thomas, 2007).

Supervisees should never be practicing independently and without adequate support and oversight from their supervisor (Barnett, 2011). The clinical supervisor's availability will affect the training experience of the supervisee and may have a direct effect on the quality of services provided to the supervisee's clients, and it may also have a significant modeling effect on supervisees as they are developing their professional identity.

Should a clinical supervisor be away from the office or otherwise unavailable due to illness, vacation, attending a professional conference, or the like, it is essential that this be discussed in advance (if possible) and alternative supervision arrangements should be made so that the supervisee does not experience any lapse in clinical supervision coverage. Because some potential interruptions in the supervisor's availability may be unanticipated and unplanned for, such as an accident or illness, it is best that emergency or back up coverage arrangements be made in advance and discussed as part of the initial informed consent process (ACES, 2011; Bernard & Goodyear, 2014).

Termination and Ending the Professional Relationship(s)

The supervisory relationship, just like the supervisee's treatment relationships with clients, at some point in time will come to an end. At times these endings are planned for and anticipated; at other times they may be forced on us or come as a surprise. Regardless, the issue of the ending of the professional relationship is one that should be discussed openly throughout the relationship beginning during the informed consent process (Barnett, 2011; Bernard & Goodyear, 2014; Falender & Shafranske, 2004; Thomas, 2007). A clinical supervisor may be planning for a leave of absence or may be transferring to another employment setting. A supervisee may be working at a particular agency for one semester or one academic year and then moving on to another training site. Supervisors should address these issues with their supervisees to help ensure the best possible training experience, but also because of the effect of modeling of professional behavior.

Additionally, the supervisee should be actively and openly addressing these issues with each client, as described above (Bernard & Goodyear, 2014). If a supervisee will need additional supervision after the clinical supervisor leaves a practice setting and if a client is in need of continued treatment after the supervisee's time at that setting ends, these issues should be discussed well in advance of these endings and advanced arrangements for a new clinical supervisor or psychotherapist should be made so that no significant lapse in professional services provided occurs.

Conclusions

Clinical supervisors play a vital and essential role in the training and professional development of students and junior colleagues. But how supervision is conducted can significantly affect the quality of the learning process for the supervisee and can greatly affect outcomes such as the quality of clinical services provided by supervisees to their clients. Attention to the ethical issues reviewed in this article is essential for supervisees and their clients to achieve maximum benefit. Although this article can only serve as an introduction to the topic, and attention to

relevant ethics codes, laws, regulations, and institutional policies are essential as well, it is hoped that readers will use the information and recommendations shared in this article to begin a lifelong process of a focus on ethics in all aspects of their roles as both clinical supervisors and supervisees.

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