

# Informed Consent Through Contracting for Supervision: Minimizing Risks, Enhancing Benefits

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Obtaining informed consent has become a routine part of both initiating and continuing clinical services. Psychologists are trained to anticipate the risks and benefits, identify alternatives, understand limits to privacy, explain these factors to prospective clients, and assist them in making decisions about their participation. Only in recent years have psychologists begun to more formally incorporate the principles of informed consent into their work with supervisees. Providing supervisees with relevant information at the outset helps to minimize risks for supervisors and supervisees and to maximize benefits for supervisees and their clients. This article addresses the objectives and benefits of obtaining informed consent to supervision, highlights relevant ethical standards and guidelines, and describes the elements of a supervisory informed consent document.

*Keywords:* supervision, ethics, informed consent, supervision contracts, ethical standards and guidelines for supervision

Informed consent has become a fundamental building block of the therapeutic relationship. Psychologists are routinely trained to anticipate the risks and benefits of treatment and assessment, identify alternatives, recognize the limits to privacy, explain these factors to prospective clients, and assist them in making decisions about their participation. Ethics codes for mental health professionals address the need for informed consent to assessment and treatment (American Association for Marriage and Family Therapy [AAMFT], 2001; American Counseling Association [ACA], 2005; American Psychiatric Association, 2006; American Psychological Association [APA], 2002; Canadian Psychological Association [CPA], 2000). Many authors have described the applications of these ethics codes for treatment (Fisher, 2003; Haas & Malouf, 2005; Herlihy & Corey, 1996; Knapp & VandeCreek, 2003, 2006; Nagy, 2005). However, fewer have addressed the issue as it specifically applies to supervision, even though the need to do so is discussed in many professional ethics codes and specialty guidelines (AAMFT, 2001; ACA, 2005; APA, 2002; Association for Counselor Education and Supervision [ACES], 1993; Association of State and Provincial Psychology Boards [ASPPB], 2003; National Board of Certified Counselors [NBCC], 2002). Only in recent years have authors begun to formally and specifically address not only the need for informed consent (Kaiser, 1997; Watkins, 1997) but also the mechanics of incorporating it into supervision (Barnett, 2000, 2005; Bernard & Goodyear, 2004; Borders & Brown, 2005; Campbell, 2000; Cobia & Boes, 2000; Falender & Shafranske, 2004; Fall & Sutton, 2004; Haynes, Corey, & Moulton, 2003; McCarthy et al., 1995; Osborn &

Davis, 1996; Prest, Schindler-Zimmerman, & Sporakowski, 1992; Sutter, McPherson, & Geeseman, 2002; Welfel, 2002).

## Applicability of Informed Consent to Supervision

Several of the issues addressed in an informed consent for treatment or assessment are also applicable to supervision: Anticipated length of service, limits to privacy, fees, risks and benefits, and maintenance and storage of records are examples. In much the same way that clients benefit from learning about the professional background, theoretical approach, and credentials of their psychotherapists, supervisees benefit from obtaining similar information about their supervisors.

To make sound decisions about whether to participate in psychotherapy, clients need to be given at least some information about the implications of agreeing to do so (Knapp & VandeCreek, 2006). Ethically, consent must be truly informed (the prospective client is provided with enough information to make a reasonable decision) and voluntary (not forced or coerced), and the individual must be competent to make a decision (Haas & Malouf, 2005). Haas and Malouf (2005) defined competency as “the ability to initiate a voluntary action and determine one’s choices with at least the degree of autonomy possessed by the average member of one’s culture or society” (p. 53).

These concepts are only partially applicable to supervision.<sup>1</sup> Consent for any psychological service—clinical or supervisory—

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<sup>1</sup> For the purposes of this article, the term *supervision* is used to describe an intervention provided by a senior member of the profession to a more junior member as part of the latter’s training or rehabilitation. The supervision is required by some outside entity, and the supervisor assumes legal responsibility and ultimate authority for all or a designated portion of the supervisee’s work. The external body determines the supervision’s nature and duration. Conversely, consultation is not generally required by an outside entity and may be provided by a member of the same or an allied profession who possesses the desired expertise. An individual may seek consultation to develop expertise in some new area of practice or as a strategy to enhance his or her professional development. The duration is determined by the needs of the consultee, and the ultimate responsibility for clinical decisions rests with the consultee.

must be informed: Consumers of both kinds of service should be provided with relevant information about factors that might reasonably influence their decisions. The other two components, voluntariness and competence to consent, however, apply differently to supervision.

Consumers of clinical services must be free to accept or decline without undue influence or coercion (legally mandated services notwithstanding). If, after reviewing informed consent materials, prospective clients are unwilling to participate, they may choose to seek services from another provider or a different type of professional. Alternatively, they may elect not to receive any services at all.

Conversely, supervisees' alternatives are necessarily restricted by the requirements of their graduate programs, licensing boards, APA, or other professional associations or entities whose requirements they are attempting to meet. Supervisors must be aware of these requirements, ensure that their policies and procedures do not conflict with them, and incorporate relevant portions into their informed consent materials. An individual supervisor will likely have additional requirements reflecting the idiosyncratic policies of the agency or institution as well as his or her theoretical orientation and supervisory style. Like psychotherapy clients, supervisees do not have the right to define the parameters of the supervisory relationship (e.g., determine the limits to their privacy) but do have the right to understand what these parameters are before agreeing to participate. When provided with all relevant information, supervisees can decide whether to apply for a particular graduate program, practicum, internship, license, certification, or job. Choosing to enter the profession, however, limits supervisees' options.

As discussed, consumers of clinical services must be deemed competent to evaluate the risks and benefits of the proposed relationship (Fisher, 2003; Haas & Malouf, 2005; Knapp & VandeCreek, 2006; Nagy, 2005). Mental or physical illness or cognitive impairment may compromise an individual's capacity to accomplish this task. Supervisees, conversely, are presumed to have the capacity to understand what they are agreeing to and to make reasonably informed decisions.

Bernard and Goodyear (1998) originally proposed three levels of informed consent to supervision. First, clients must consent to treatment with the supervisee, and, second, they must do so with the understanding that their case will be supervised. Finally, supervisees consent to supervision. Falvey (2002) has expanded on these levels of consent to include "supervisee consent to supervision with a given supervisor" (p. 71) and "institutional consent to comply with the clinical, ethical, and legal parameters of supervision for the discipline(s) involved" (p. 71). The primary focus of this article is on one of these levels: supervisees' informed consent to supervision. Building on earlier publications, this article addresses the objectives of obtaining informed consent to supervision, highlights related ethical standards and guidelines, and describes elements of a supervisory informed consent document. Information needed to develop informed consent contracts for specific types of supervision is included.

### Objectives of Informed Consent

Many authors have recommended an informed consent process for supervision (Barnett, 2000, 2005; Bernard & Goodyear, 1998, 2004; Borders & Brown, 2005; Bradley & Ladany, 2001; Cobia &

Boes, 2000; Falender & Shafranske, 2004; Fall & Sutton, 2004; Falvey, 2002; Guest & Dooley, 1999; Harrar, VandeCreek, & Knapp, 1990; Haynes et al., 2003; Kaiser, 1997; Keel & Brown, 1999; Knapp & VandeCreek, 1997, 2006; McCarthy et al., 1995; Osborn & Davis, 1996; Prest et al., 1992; Remley, 1993; Sutter et al., 2002; Welch, 2003). An effective informed consent affords many benefits for supervisors, supervisees, and, ultimately, clients. Particularly when communicated orally and in writing, informed consent improves the effectiveness of supervisor and supervisee (Guest & Dooley, 1999; Osborn & Davis, 1996) and enhances the satisfaction of both parties.

Cobia and Boes (2000) have identified three ways obtaining the informed consent of supervisees positively affects the process. They asserted that providing prospective supervisees with clear information will "increase the opportunities for learning the skills necessary for professional collaboration; establish an environment conducive to open, honest communication; and promote the development of rapport and trust in the supervisory relationship" (Cobia & Boes, 2000, p. 293). Furthermore, informed consent documents elucidate expectations and responsibilities of both parties (Fall & Sutton, 2004; Guest & Dooley, 1999; McCarthy et al., 1995; Osborn & Davis, 1996) and clarify the goals, methods, structure, and purposes of supervision (Barnett, 2000; Guest & Dooley, 1999; Prest et al., 1992; Teitelbaum, 1990; Welch, 2003). Such clarification establishes a clear professional boundary, sets the tone for the supervisory relationship, and provides a model for supervisees. Additionally, discussion of these parameters at the outset will increase accountability and decrease impasses, misunderstandings, and dissatisfaction. The open discussion of issues that could contribute to conflict establishes a precedent for efficiently addressing problems when they do occur (Prest et al., 1992). A clear agreement provides a mechanism for systematically ensuring that important issues are covered (Sutter et al., 2002).

Supervisors who go through the exercise of preparing informed consent materials are forced to think through and articulate exactly what they want from supervisees. Similarly, supervisors must identify what they have to offer and what they are committing to provide. Perhaps the most important goal of informed consent therefore is to enhance the quality of the supervision and the supervisory relationship.

### Is All of This Really Necessary?

Most of the time, supervisory relationships proceed uneventfully. Supervisors are reasonably pleased with supervisees' performance, and supervisees are generally satisfied with the supervision they receive. Learning problems and minor misunderstandings, when they do occur, are typically navigated effectively, and, in spite of inevitable moments of dissatisfaction, the experience concludes positively.

Imagine, however, a supervisory relationship that does not go exactly according to plan. Surprises are generally not welcome, and they may provide the seeds for eventual impasses between supervisor and supervisee. Any unanticipated circumstance, outcome, or action on the part of the supervisor may result in a misunderstanding or conflict that culminates in a painful ending, compromises the reputation of the supervisor, or develops into a licensing board complaint or lawsuit. Consider the following cases, which, at the outset, appeared to portend rewarding, satis-

fyng, and fruitful learning opportunities for the supervisee and gratifying mentoring and teaching opportunities for the supervisor but culminated in impasses. Three cases are described, and preventative strategies follow.

#### *Dr. Anderson and Ted—Supervisee Boundaries*

Dr. Anderson was assigned to work with Ted, a recent graduate who needed 1 year of supervision to qualify for licensure as a psychologist. Initially, Dr. Anderson was pleased with Ted's work. About 6 months into the supervision, however, she observed Ted in the hall telling his client about his plans for the weekend. Dr. Anderson expressed concern about what seemed to be a more personal rather than professional interaction. Ted seemed to understand.

Two months later, Dr. Anderson saw Ted put his arm around a client while walking to his office. Again, she addressed this and ultimately felt satisfied that Ted understood and would modify his behavior. About 2 weeks before the supervision concluded, Dr. Anderson walked into Ted's office just after an appointment ended and saw that he had been eating his lunch during the session. When questioned, Ted suggested that Dr. Anderson was micromanaging his clinical decisions. Begrudgingly, Ted agreed not to eat during sessions while he was working under her supervision.

At the conclusion of the supervision, Ted left a form for Dr. Anderson to sign for the board of psychology, verifying his completion of the required hours and endorsing him for licensure. Given her concerns about his boundaries, Dr. Anderson felt anxious about the endorsement. After much soul searching, she announced that she could not, in good conscience, sign the form without attaching a letter describing her reservations. Ted was furious and stated that Dr. Anderson was distorting a theoretical difference into an ethical issue. Three weeks after the supervision ended, Dr. Anderson received a letter from Ted's attorney threatening a malpractice suit if she did not sign the form.

The problematic behavior—Ted's apparently unprofessional boundaries with his clients—was not obvious at the outset of the supervision. Dr. Anderson had made a point of requiring that Ted agree to follow the APA (2002) "Ethical Principles of Psychologists and Code of Conduct." However, the behaviors in question were not specifically prohibited by the code, and Ted maintained that he had no way of knowing that Dr. Anderson would perceive them as violations. Dr. Anderson thought she had been very clear and did not know how she could have anticipated this misunderstanding about her expectations.

Dr. Anderson might have more clearly informed Ted about the evaluation process and the gatekeeping aspect of her supervisory responsibilities. In particular, she might have stated that if she had reservations at the conclusion of the supervision, she would convey them in a letter and attach it to the signed form. Furthermore, informed consent is a process that begins at the outset or even before the supervision commences, and it continues through the duration. Dr. Anderson, then, might have used the first incident as an opportunity to more thoroughly review relevant portions of the APA (2002) ethics code. As the supervision continued, she could have clarified with Ted her expectations about his behavior with clients, made a point of more carefully monitoring his boundaries, and, finally, communicated to him the range of potential consequences of further errors.

#### *Dr. McLeod and Susan—Unanticipated Conflict*

Susan was a master's-prepared psychotherapist who, because she did not have a doctoral degree, was required by the state licensing board to have her practice supervised by a psychologist. The agency in which Susan worked, however, did not have a psychologist available, so she was assigned to a clinical social worker. Dr. McLeod, a psychologist in independent practice near the agency, agreed to help by providing the required supervision. Signed releases authorized the two supervisors to exchange information to coordinate Susan's supervision.

After several interactions between the supervisors, it became clear that their styles were markedly different. Dr. McLeod consulted with colleagues about her discomfort with the other supervisor and ultimately decided to withdraw from the supervision. Susan was initially disappointed and later angry. She said she had had no idea that this was a possibility and that the withdrawal meant she would have to discontinue working until she had arranged for another supervisor. Susan complained that the interruption would be harmful to her clients and to her own career.

The dilemma encountered by Dr. McLeod might have been difficult to anticipate. Susan had no reason to believe that the relationship could be terminated prematurely, and neither did Dr. McLeod. Nevertheless, informing Susan in advance of possible reasons for termination or at least indicating that there might be unforeseen circumstances that could occasion it would have alerted her to the possibility.

When an agency or institution is delegating or sharing supervisory responsibility, significant coordination is necessary. Without this coordination, the supervisee might, for example, receive conflicting directives from the on-site and off-site supervisors. Alternatively, the styles of the two supervisors may be so different as to cause confusion for the supervisee. Ideally, any conflict between the supervisors regarding a client or the supervisee should be resolved at that level, to ensure that the supervisee does not end up in the middle. Minimally, it must be determined which supervisor has ultimate responsibility and authority over the supervisee's clinical work. The problems that surfaced in this case might have been anticipated and minimized or avoided with a meeting between the agency supervisor and Dr. McLeod before the arrangement was finalized. Dr. McLeod might have declined to provide the supervision or attempted to establish clear parameters about who was responsible for what. If the relationship still seemed untenable, other arrangements could have been made.

#### *Dr. Lopez and Dan—Supervisee Privacy*

Dan was a doctoral practicum student at a veteran's hospital and was receiving supervision from Dr. Lopez. Dan reported in supervision that he was irritated with the irresponsible behavior of one of his clients, who, like Dan's father, was alcoholic and estranged from his family. They processed his countertransference during supervision, and it did not seem problematic in subsequent work.

At the end of the semester, Dr. Lopez completed his evaluation of Dan's performance. In it, he mentioned that being the child of an alcoholic had created some difficulties for Dan but that Dan had addressed them appropriately. The evaluation was sent to Dan's faculty supervisor.

After reviewing the evaluation, Dan said he was shocked that Dr. Lopez would disclose such personal information to a professor

in his academic program. Dan had believed that what he shared would remain private, and he felt betrayed. Dr. Lopez explained that he routinely consulted with academic supervisors and did not see any reason to withhold information he thought relevant. Furthermore, Dr. Lopez pointed out, the anecdote provided a useful illustration, augmenting a favorable appraisal.

This third case illustrates another potential problem that might have been addressed through informed consent: the precise limits of the supervisee's privacy. Most supervisors recognize their responsibility to protect the privacy of the supervisee's clients (APA, 2002). They might not, however, anticipate the complex issues involved with the supervisee's privacy. Had Dr. Lopez discussed these limitations at the outset, Dan could have made an informed decision about what personal information he shared in supervision. Dr. Lopez might have reviewed the evaluation with Dan prior to sharing it further. At that point, Dan would have had an opportunity to request that Dr. Lopez modify the written evaluation, deleting the personal information. Finally, Dr. Lopez could have provided essentially the same feedback in a more general way. He could have stated, for example, that "during supervision, Dan identified relevant personal issues that could potentially compromise his objectivity, and he appropriately managed related countertransference."

### *Lessons Learned in Retrospect*

The expectations of the supervisors and supervisees in each case differed. None of these perhaps foreseeable problems was discussed in advance. Of course, it is impossible to anticipate and discuss every eventuality with a prospective supervisee. Nevertheless, acknowledging that fact with supervisees and clarifying such issues in a timely fashion will minimize misunderstandings. In each of these cases, obtaining the clear informed consent of supervisees at the outset of supervision would have afforded opportunities to clarify the parameters of the relationship and to avoid or mitigate the misunderstandings that occurred.

### Professional Ethical Standards and Guidelines

Most professional mental health organizations have ethical standards or guidelines that address informed consent, particularly as it relates to clinical and forensic services. A few have addressed, explicitly or implicitly, the need for informed consent to supervision. Relevant sections from eight sets of standards addressing informed consent in supervision are reviewed. Ethics codes promulgated by professional associations (AAMFT, 2001; ACA, 2005; APA, 2002; CPA, 2000) represent requirements for members. Guidelines developed specifically for clinical supervisors (ACES, 1993; ASPPB, 2003) are aspirational. A third category includes supervision requirements for particular certifications (AAMFT, 2002; NBCC, 2005).

The APA (2002) ethics code addresses informed consent in terms of consulting services (Section 3.10), which may be applicable to supervision. Psychologists must obtain informed consent from recipients of consulting services and "appropriately document written or oral consent, permission, and assent" (p. 1065). The ethics code further addresses required disclosure by students and supervisees:

7.04 Psychologists do not require students or supervisees to disclose personal information in course- or program-related activities, either orally or in writing, . . . except if (1) the program or training facility has clearly identified this requirement in its admissions and program materials. (APA, 2002, p. 1068)

Implicit in this statement is the assumption that having this information in advance may influence prospective students' decisions about whether to apply to a particular graduate program. Therefore, training program faculty members are required to inform students in advance of their matriculation. Supervisors who participate in the education of these students must be made aware of and required to comply with program policies regarding student and supervisee self-disclosure.

The APA (2002) ethics code (Section 7.06) further instructs supervisors to establish a clear evaluation process for students and supervisees and to inform them about it "at the beginning of supervision" (p. 1069). Supervisees are also required to inform their clients or patients about their status and the fact that they are being supervised. They also must protect their clients' identity in supervision or obtain authorization to reveal identifying information to supervisors.

Like the APA (2002) ethics code, the *ACA Code of Ethics* (ACA, 2005) includes specific protections regarding supervisees. The ACA (2005) indicates (Section F.4.a.) that "supervisors are responsible for incorporating into their supervision the principles of informed consent" (p. 14). Supervisors are further required to inform supervisees about policies and procedures to which they are bound and about due process options for addressing complaints about supervision. Also similar to APA's code, the ACA code of ethics addresses the rights of clients: Counselors must inform clients about their qualifications (Section F.1.b.) and protect clients' privacy in supervision (Section F.1.c.).

The *Canadian Code of Ethics for Psychologists* (CPA, 2000) addresses the issue in another way. The mandate (Section I.36) is to "be particularly cautious in establishing the freedom of consent of any person who is in a dependent relationship to the psychologist" (p. 12). This code specifically includes students, employees, and, by extrapolation, supervisees. The issues to be addressed as a part of this informed consent, however, are not specified.

The *AAMFT Code of Ethics* (AAMFT, 2001) specifically requires that informed consent be obtained from supervisees in two areas. First, when consulting with colleagues, marriage and family therapists are required (Section 2.6) to protect the privacy of clients and supervisees. They must avoid disclosing any information "unless they have obtained the prior written consent of the client, . . . , [or] supervisee" (p. 4). Second, Section 7.2 requires supervisors to talk with prospective supervisees in advance about charges for supervision and missed or canceled appointments, procedures for obtaining payment, and the possible use of collections agencies.

The NBCC (2005) is not a professional association but a certification board that has established an ethics code for counselors who hold that certification. The NBCC (2005) *Code of Ethics* is more specific, relative to other general ethics codes, in its treatment of supervision. Section C.b. states, for example, that supervisors are responsible for ensuring that their "super-

visees are informed of the supervisor's credentials and professional status as well as all conditions of supervision as defined/outlined by the supervisor's practice, agency, group, or organization" (p. 5). The NBCC (2005) *Code of Ethics* further specifies (Section C.d.) that supervisors must, as a part of informed consent, discuss the goals of supervision and their theoretical approach or paradigms. Next (Section C.e.), they must determine "agreed upon scheduled feedback as part of an established evaluation plan" (p. 5). The parameters of this requirement are clearly much broader than those delineated by the APA (2002), ACA (2005), and CPA (2000).

In addition to their general ethics codes, some professional associations have developed specialty guidelines for supervisors. ACES (1993), a division of ACA, has published a set of supervision guidelines that address informed consent. As guidelines, they are considered aspirational and are not enforceable. The "Ethical Guidelines for Counseling Supervisors" (ACES, 1993) recommend that supervisors "incorporate the principles of informed consent . . . into the policies and procedures of their institution, program, courses and individual supervisory relationships" (p. 3, Section 2.14). Specific topics that, according to ACES, should be incorporated into an informed consent agreement include "requirements, expectations, roles and rules" (p. 3, Section 2.14). Furthermore, "mechanisms for due process appeal of individual supervisory actions should be established and made available to all supervisees" (p. 3, Section 2.14).

Like the NBCC (2005) *Code of Ethics*, the ACES (1993) "Ethical Guidelines" recommend that supervisors inform supervisees about the "goals, policies, theoretical orientations toward counseling, training, and supervision model or approach on which the supervision is based" (p. 3). Supervisors are encouraged to communicate in writing, "in a timely manner" (p. 3), about required professional competencies and experiences. When supervision occurs in a university training program, ACES (1993) recommends that supervisors "establish and communicate specific policies and procedures regarding field placements of students. The respective roles of the student counselor, the university supervisor, and the field supervisor should be clearly differentiated in areas such as evaluation, requirements, and confidentiality" (p. 4).

The AAMFT (2002) has established education and training standards for association members who want to become approved supervisors. The *Approved Supervisor Designation Standards and Responsibilities Handbook* (AAMFT, 2002) delineates supervisor training requirements and responsibilities and offers tools for supervisors. AAMFT members providing supervision for the clinical membership or marriage and family therapist licensure are required to develop a supervision contract for obtaining informed consent to supervision. Contracts are to include information about "fees, hours, time and place of meetings, case responsibility, caseload review, handling of suicide threats, and other dangerous clinical situations" (AAMFT, 2002, p. 12). The *Handbook* lists other issues that may be addressed and includes a sample supervision contract.

The ASPPB has published a set of supervision guidelines (ASPPB, 2003) that may be helpful to psychologists supervising others in three contexts: doctoral-level candidates for licensure and credentialed and uncredentialed nondoctoral personnel providing psychological services. Guidelines for doctoral-level candidates

(Section I.B.) suggest that prospective supervisees be provided with

a written document specifying the rules and regulations of the program, as well as the roles, goals and objectives expected from both supervisees and supervisor. At the onset of training, the supervisor will be responsible for developing, along with the supervisees, a written individualized training plan. (ASPPB, 2003, p. 3)

The ASPPB (2003) *Supervision Guidelines* emphasize the need for written informed consent with regard to evaluation and specifically recommend having a written contract.

### Overview of Ethics Codes and Guidelines

Table 1 is a summary of topics that might be included in an informed consent to supervision, along with ethics codes and guidelines that address them. Many of these issues are considered in other sections of these codes (e.g., multiple relationships; APA, 2002), but not specifically as they relate to informed consent.

### Informed Consent Documents for Supervision

Obtaining the informed consent of supervisees at the outset of supervision is critical to minimizing risks and maximizing the benefits. Whether they are seeking supervision to meet academic, licensure, or certification requirements or to assist in rehabilitation following an ethical violation, supervisees all benefit from having clear information about that to which they are agreeing. Many authors and specialty guidelines recommend, and ethical standards require, that informed consent be obtained in writing. The format in which the information is presented will vary with the type of supervision, the context, and the preferences and theoretical orientation of the supervisor.

Cobia and Boes (2000) suggested two strategies for obtaining the informed consent of those receiving postdegree supervision: "professional disclosure statements" (p. 293) and "formal plans for supervision" (p. 293). The first, developed by the supervisor, describes the service being offered and addresses the "mutual rights and responsibilities of all parties, the parameters of supervision, methods of evaluation, desired outcomes, and potential risks and benefits" (Cobia & Boes, 2000, pp. 293–294). The second, the formal plan, is essentially an individualized learning contract—a corollary to the treatment plan used in psychotherapy (Barnett, 2005; Teitelbaum, 1990). This document, generally developed by the supervisee in collaboration with the supervisor, might incorporate learning goals, objectives, strategies, job responsibilities, criteria for evaluation, and other information unique to the individual. If any of these elements are not included in these documents, a form referencing them along with signature lines for each party provides an opportunity to obtain written verification that the information has been discussed (Bernard & Goodyear, 2004; Borders & Brown, 2005; Fall & Sutton, 2004; Haynes et al., 2003; McCarthy et al., 1995; Sacuzzo, 2003; Sutter et al., 2002). These three components of a supervision agreement—a professional disclosure statement, learning contract, and signature page—could be separated or combined into one or more documents. One advantage to separating the information is that this allows the supervisor to have a generic handout for use with all

Table 1  
*Supervisory Issues Addressed in Terms of Informed Consent*

Supervisory issue	Code of ethics or guidelines
Conditions of supervision (e.g., goals, roles, rules) Client privacy in supervision <sup>a</sup>	AAMFT (2002), ASPPB (2003), NBCC (2005) AAMFT (2001), ACA (2005), APA (2002), NBCC (2005)
Disclosure of trainee status <sup>a</sup>	ACA (2005), ACES (1993), APA (2002), CPA (2000), NBCC (2005)
Documentation of consent Due process for supervisees	APA (2002), ASPPB (2003) AAMFT (2001), ACA (2005), ACES (1993), ASPPB (2003), NBCC (2005)
Evaluation	ACES (1993), APA (2002), ASPPB (2003), NBCC (2005)
Job duties, required experiences Supervisee privacy Supervisor's credentials and theoretical orientation	ACES (1993) AAMFT (2001), ACES (1993), APA (2002) ACES (1993), NBCC (2005)
Supervision boundaries, multiple relationships, exploitation, power differentials Required self-disclosure and personal growth activities	ACA (2005), ACES (1993), APA (2002) ACES (1993), APA (2002)
Fees	AAMFT (2001), ASPPB (2003)

*Note.* AAMFT = American Association of Marriage and Family Therapy; ASPPB = Association of State and Provincial Psychology Boards; NBCC = National Board of Certified Counselors; ACA = American Counseling Association; APA = American Psychological Association; ACES = Association for Counselor Education and Supervision; CPA = Canadian Psychological Association.

<sup>a</sup> These items involve the informed consent that supervisees obtain from their clients or patients regarding their supervision.

supervisees in addition to a set of materials that address the unique needs of a particular supervisee.

### Components of a Supervision Contract

The following are examples of topics that might be addressed in an informed consent for supervision. The list is not exhaustive, and it is not intended to imply that all issues must be discussed in every contract. Rather, it is a menu of topics designed to help supervisors identify areas most pertinent to the types of supervision they provide. Because ethics codes, specialty guidelines, and certification and licensure requirements differ, the reader should consult the applicable documents for assistance in determining what to include and what to omit. If deemed more appropriate, some information could be communicated to supervisees orally.

### *Supervisor's Background*

Supervisees can make the best use of supervision when they know something about their supervisors' background. Such information can be particularly helpful when supervisees are able to choose a supervisor. Minimally, supervisees want to know their supervisors' academic degrees, certifications, and clinical specialties. When the supervision is needed for licensure or certification, specific credentials may be required, and related information should therefore be provided. Supervisees may also benefit from knowing something about their supervisors' theoretical approaches to both supervision and psychotherapy (ACES, 1993; NBCC, 2005).

### *Supervisory Methods*

Supervisors use a broad range of methods in their work. They might review audiotapes or videotapes, observe counseling ses-

sions and test administration, and evaluate clinical records and reports. Some supervisors conduct cotherapy with supervisees, do site visits (if the supervisee works off site), or in other ways monitor their supervisees' cases. Supervisees might also be required to submit a list of all clients and to update their supervisors about intakes and terminations. Whatever methods are used, supervisees will benefit from knowing about them in advance (ACES, 1993).

### *Supervisor's Responsibilities and Requirements*

Clinical supervisors are generally considered legally responsible for all of their supervisees' work (Falvey, 2002). There are circumstances, however, in which a supervisor might be charged with overseeing only a circumscribed area of the supervisee's practice (e.g., psychological testing, couples therapy). Such narrowly focused supervision may occur when the purpose is to obtain specialty certification or to remediate particular deficits. The supervision contract should, to clarify liability, state precisely which services the supervisor is agreeing to oversee.

Mental health emergencies generally require rapid, complex decision making (Falvey, 2002). The stakes are high, and the lives of clients or others may be at risk. Such situations are stressful and challenging even for the most seasoned psychologists, and consultation with colleagues, when possible, is standard procedure. Concern for the welfare of clients and supervisees as well as for supervisors' liability dictates that, to the extent possible, supervisees should not be required to navigate these situations alone. Supervisors are responsible to either be available to supervisees, particularly in crisis situations, or designate appropriately trained colleagues as substitutes when they are unavailable. Supervision contracts represent one mechanism for ensuring that supervisees know how and under what circumstances to seek assistance.

### *Supervisee's Responsibilities*

Supervisees are responsible to meet the requirements established by the employer; by the relevant ethics codes, rules, and laws; and by their supervisors. Job responsibilities are generally outlined in a job description or learning contract. Such documents can be incorporated into, attached to, or referenced in a supervision contract.

Assigning supervisees to review and prepare to discuss specified ethics codes, rules, and laws will likely convey the importance of this aspect of their responsibilities and provide an opportunity to ensure that these obligations are clearly understood. In the event of an ethical violation, supervisors may limit their liability by requiring supervisees to sign off on a statement indicating that they have reviewed related documents and policies governing trainees and employees and that they agree to abide by them.

It might be argued that compliance with ethics codes, rules, and laws can be assumed. Such regulations, however, are complex, and, in spite of academic course work, supervisees, particularly novices, may not thoroughly understand all of their applications and implications. Most would indicate, for example, that they would tell their supervisors about suspected child abuse. Precisely what constitutes abuse, however, may not be as obvious.

Because of this complexity and the fact that supervisors are legally liable for their supervisees' errors (Falvey, 2002; Harrar et al., 1990; Knapp & VandeCreek, 2006; Sacuzzo, 2003), it may be helpful for supervisors to provide their supervisees with guidelines regarding the types of events, personal experiences, and problems about which they want to be informed. The following are examples of situations in which supervisors would likely want to be consulted:

- disputes with clients or impasses in the therapy;
- allegations of unethical behavior by clients, colleagues, or others (e.g., a client's family members);
- threats of a complaint or lawsuit;
- mental health emergencies requiring immediate action;
- high-risk situations; cases in which clients evidence suicidal thoughts, gestures, or attempts or a significant history of attempts; or cases in which clients present with a history of, propensity for, or threats of violence;
  - contemplated departures from standards of practice or exceptions to general rules, standards, policies, or practices;
  - suspected or known clinical or ethical errors and related countertransference;
  - contact with clients outside the context of treatment;
  - legal issues, such as possible reporting obligations related to suspected abuse of a child or vulnerable adult or ethical violations by other professionals.

Supervisors may want to require that, in addition to keeping them informed, supervisees agree to implement or revisit any directives given by the supervisor. The following is an example of a related statement that could be signed by the supervisee:

I agree to keep my supervisor informed about all aspects of my clinical work (as specified above) and to implement all supervisory directives. If, after a course of action has been agreed to, additional information becomes available or changes in circumstances cause me to believe that reconsideration is warranted, I will revisit the issue with the supervisor in a timely manner.

In the case of a lawsuit or a board complaint about the supervisee's behavior, if he or she failed to follow any of the provisions of the supervisory contract (e.g., did not inform the supervisor about circumstances when clearly required to do so, did not follow specified procedures), the supervisor's culpability might be limited.

### *Potential Supplemental Requirements*

As supervision progresses, problems not evident at the outset might develop or become apparent. A supervisee's behavior may, for example, suggest possible impairment. The supervisor might, at that point, believe that a medical, mental health, or substance abuse assessment is indicated. In other cases, the cause of the impairment might become obvious or be disclosed by the supervisee, and a direct referral for treatment might be appropriate. Similarly, basic skill deficits or ethical incompetence might manifest as the supervisee assumes new responsibilities, and remedial education might be necessary, either concurrently with or prior to continuation of clinical work.

When unforeseen difficulties develop and supervisors want to impose additional requirements, supervisees need to be informed in advance (ACA, 2005; APA, 2002; Whiston & Emerson, 1989). Bernard and Goodyear (2004) have recommended that "if there is a possibility that personal counseling will be recommended for any trainees in a given program, all trainees should be cognizant of this practice upon entering the program" (p. 55). Underscoring this point, Knapp and VandeCreek (2006) provided a vignette about an intern whose arrest for soliciting a prostitute was published in the newspaper. The supervisor required that the supervisee participate in a mental health assessment.

Fortunately, this setting had the authority to order the evaluation and treatment because the program had made it explicit at the outset of the supervision that it could require psychological or medical evaluations and therapy for any intern who appeared to have a condition likely to impair [his or her] ability to perform [his or her] professional duties competently. (Knapp & VandeCreek, 2006, p. 226)

Although these authors (Bernard & Goodyear, 2004; Knapp & VandeCreek, 2006) focused on students, the potential for conflict is decreased when any supervisee who might be required to undergo an assessment or treatment is informed about that possibility in advance.

### *Confidentiality Policies*

Supervisees are entitled, as are their clients, to privacy. The precise limits of that privacy, however, are dependent on variables including state or provincial law; policies of the academic program, training site, or employer; relevant professional ethics codes; and the specific policies established by the supervisor. The APA (2002) ethics code, like the codes of other professional associations (AAMFT, 2001; ACA, 2005; CPA, 2000), includes privacy protections that extend to supervisees either directly or implicitly. APA (2002, Section 4.02), for example, requires that "psychologists discuss with persons . . . with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities" (p. 1066). To

comply with these standards, supervisors must communicate the circumstances under which they are obligated to breach supervisees' confidentiality to report, for example, unethical behavior. Beyond reporting obligations, supervisors should inform supervisees about who will have access to information about them. Whenever multiple supervisors are involved, for example, coordination of services is advisable, if not essential, to ensure continuity and minimize confusion. Agreement to such communication may be established as a condition of the supervision. Disclosures of information beyond those outlined in the initial informed consent require the supervisee's authorization. Any special limitations to the privacy of clients or supervisees could also be elucidated. Conducting online supervision, for example, carries the risk that transmitted information could be accessed by others (Kanz, 2001). The APA (2002) ethics code therefore requires that supervisees be informed about who (e.g., academic or site supervisor, employer, licensing board) will have access to information about their work performance, their personal disclosures, and their supervisor's assessments and what types of records will be kept regarding the supervision.

### *Documentation of Supervision*

Many authors have recommended that supervision be documented, and they have described various formats for doing so (Bridge & Bascue, 1990; Falvey, 2002; Glenn & Serovich, 1994; Haynes et al., 2003; Luepker, 2003; Monahan, 1993; Munson, 1993; Weiner & Wettstein, 1993). Falvey, Caldwell, and Cohen (2002) have published a comprehensive set of documentation materials for use by supervisors. These include forms for recording narrative descriptions of supervision sessions, a log of hours and meeting dates, evaluation forms, and so forth. Whatever format is chosen to document supervision, supervisees should be informed about it. In particular, they should be apprised of the types of records that will be created and maintained regarding their supervision. An informed consent to supervision should specify exactly who, including the supervisee, will have access to that documentation; how and under what conditions it may be accessed; how long the documentation will be maintained; and how it will be secured.

### *Financial Policies*

The AAMFT (2001) code of ethics requires, and the ASPPB (2003) supervisory guidelines recommend, that supervisees be informed about all charges for which they are responsible. Practicum and internship students are not charged for supervision, in part because they typically contribute a service from which the agency benefits financially. Postgraduates and professionals required to receive supervision for rehabilitation or to obtain further credentials, however, may have to pay for supervision. Fees may be charged for various related services, such as supervisory sessions, report preparation, phone contact, document or tape reviews, and missed appointments. To avoid misunderstandings, supervisors should clarify all financial obligations with supervisees at the outset.

### *Risks and Benefits*

Supervisees are more likely to make informed decisions about their participation in supervision when they are made aware of the

potential risks and benefits. One risk involves the emotional discomfort associated with being scrutinized. Supervisees are encouraged to candidly discuss their work, including their mistakes. Doing so, however, creates the possibility that their disclosures will appear in a performance evaluation, may be disclosed to academic program faculty, or may result in a report of unethical conduct to an outside authority (Thomas, 1994). A negative evaluation has the potential to impact supervisees' ability to obtain a degree, their current or future licensure status, their potential for certification, whether they are allowed to pass their practicum or internship, or their employment status. Although supervisees may be required to abide by the APA (2002) ethics code, as discussed, they may lack a thorough understanding and therefore may not realize when they are admitting to an ethical error.

Highlighting the potential benefits of supervision as part of an informed consent, like informing them about risks, is advantageous to supervisees. Although many psychologists wisely seek consultation (see Footnote 1) throughout their careers, opportunities to receive frequent, critical feedback and to have one's work examined so closely following training are rare. Supervision has the potential to increase supervisees' understanding of the ways their personality, life experiences, and unique vulnerabilities may impact their work—both positively and negatively—and thereby increase their clinical effectiveness. Exposing one's work to the scrutiny of an experienced supervisor also helps to guard against ethical and legal errors. Finally, supervisees will likely generalize what they have learned to novel situations and therefore continue to realize benefits well after the supervision has concluded.

### *Evaluation*

Evaluation of job performance is an integral aspect of supervision. Apprising supervisees about this process in advance is required by many professional ethics codes (AAMFT, 2001; ACA, 2005; APA, 2002) and recommended by supervisory guidelines (AAMFT, 2002; ACES, 1993; ASPPB, 2003). Doing so increases the likelihood of supervisee compliance with expectations. Supervisees benefit when supervisors elucidate potential evaluation methods (oral, written form, narrative, self-evaluation) and describe the particular skills and responsibilities on which the individual will be evaluated. In some cases, these methods and requirements will evolve over time, and revisions will be necessary. Nevertheless, when possible, having copies of forms that will be used for evaluation lets supervisees know what is required for success. Establishing a schedule for evaluation is also beneficial. According to Keith-Spiegel and Koocher (1998), a lack of timely feedback is the subject of many ethics complaints filed against supervisors.

### *Complaint Procedures and Due Process*

Supervisees might, at some point in the process, feel dissatisfied with their supervision. They may disagree with an evaluation or find a particular supervisory intervention to be offensive, intrusive, or harmful. Acknowledging the possibility of dissatisfaction at the outset and instructing supervisees about how to address such dissatisfaction may prevent a misunderstanding from developing into a serious impasse or complaint. Due process procedures can be described in a consent document, or, if they are contained in a



student handbook or human resource policy manual, they can be referenced (Bernard & Goodyear, 2004; Disney & Stephens, 1994; Forrest, Elman, Gizara, & Vacha-Haase, 1999).

Generally, the first step for a dissatisfied supervisee is to attempt a resolution by talking directly with the supervisor. To encourage such attempts, supervisors may want to provide both formal and informal opportunities for supervisees to discuss what they are finding helpful as well as any aspects of the supervision with which they are dissatisfied. When these efforts do not produce satisfactory results or if the nature of the problem makes it untenable or unsafe to address with the supervisor directly (e.g., sexual harassment by the supervisor), alternatives can be provided.

### *Professional Development Goals*

A broad goal of all supervision is professional development. Supervisees may, however, have more specific learning goals beyond those implied in their job descriptions. Supervisory goals could, if appropriate, be incorporated into the supervision contract or, minimally, discussed as part of the informed consent process. The following are examples of goals that might be addressed in this context:

- specific skills and techniques that the supervisee wants to learn (e.g., to administer, score, and interpret particular psychological tests);
- particular deficits that the supervisee wants or needs to ameliorate (e.g., a tendency to avoid interventions or topics that might cause discomfort, difficulty setting appropriate limits with clients, or problems with staying current with documentation of clinical work);
- short- and long-term goals, such as developing expertise with specified clinical populations or enhancing knowledge of a particular theoretical orientation.

### *Endorsement*

Supervisors typically provide verification of hours worked and time spent in supervision. As gatekeepers for the profession, supervisors may also be expected to endorse supervisees for licensure or certification. The supervisor may feel uncomfortable about endorsing a supervisee because of concerns about competence, impairment, boundaries with clients, or other ethical issues that become apparent during supervision. Although APA (2002) is silent on the issue of endorsement, the *ACA Code of Ethics* (ACA, 2005) requires that, “regardless of qualifications, supervisors do not endorse supervisees whom they believe to be impaired in any way that would interfere with the performance of the duties associated with the endorsement” (p. 14). Of course, supervisors should bring these concerns to the attention of the supervisee in a timely fashion, but doing so may not be enough to eliminate the problem.

Sometimes, despite efforts to address such issues throughout the supervision, they may not be satisfactorily resolved. Therefore, supervisors may want to address this possibility in a supervision contract. Stating what they will do if they become concerned about the individual’s professional functioning and obtaining the supervisee’s agreement to participate in supervision with this understanding will prepare the supervisee and may offer some legal protection for the supervisor should the supervisee later object.

Supervisors may indicate, for example, that they will certainly verify that the supervisee participated in the supervision and the hours worked but that if concerns persist, they will also attach a letter describing those concerns. Informing supervisees about the nature and importance of the supervisor’s gatekeeping function will minimize related misunderstandings.

### *Duration and Termination of the Supervision Contract*

Often, the duration of supervision is predetermined. Supervision undertaken to meet the requirements for internship, practicum, licensure, or certification is an example. When the supervision is part of a disciplinary measure, termination may depend on the supervisor’s determination that supervisory goals have been met and on an employer or licensing board’s decision to lift sanctions on the basis of that recommendation.

Although most supervisory relationships continue for the planned duration, there are circumstances that may result in a premature termination. The supervisor’s unanticipated absence because of illness, incapacitation, family crisis, or changes in employment is an example. An untenable conflict between the supervisor and another individual responsible for the supervisee’s welfare could also result in an early termination. Other possible precipitants involve the supervisee’s behavior. Supervisors may want to identify for their prospective supervisees examples of circumstances that might lead to discontinuation of the supervision, such as supervisees’

- noncompliance with supervisory directives,
- concealment or misrepresentation of relevant information about themselves or clients,
- violations of ethical standards or laws,
- frequent tardiness or absences, or
- inability to practice with reasonable skill and safety.

Supervisors who have reservations about supervising a particular individual can possibly avoid the problem of having to initiate an early termination by offering a shorter duration contract or probationary period, with an option to extend it.

When supervisors elect to discontinue supervision prematurely, the consequences for supervisees may be significant. Supervisees should therefore be given as much notice as is reasonable, given the circumstances. The *ACA Ethics Code* (ACA, 2005) requires that both supervisors and supervisees give “adequate notice” (p. 14) and describe their reasons for withdrawal to the other party. Because of the gravity of supervisor-initiated terminations, it is helpful to inform supervisees in advance about the possibility and potential consequences. Although every conceivable reason need not be detailed, informing prospective supervisees about the general parameters will enable them to make informed decisions about their supervision.

### *An Ounce of Prevention*

Obtaining informed consent at the outset of supervision means securing the supervisee’s agreement to participate in light of all relevant factors. The setting, purpose, supervisor preferences, supervisee needs, and other such factors will determine what specific information is included in a supervision agreement, contract, or other informed consent document. Many authors have recommended the use of contracts for informed consent in supervision

(Todd & Storm, 1997; Walker & Jacobs, 2004; Welfel, 2002), and others have also provided sample supervision contracts that include some of the elements described above (AAMFT, 2002; Bernard & Goodyear, 2004; Campbell, 2000; Disney & Stephens, 1994; Falender & Shafranske, 2004; Fall & Sutton, 2004; Falvey, 2002; Haynes et al., 2003; Luepker, 2003; McCarthy et al., 1995; Osborn & Davis, 1996; Prest et al., 1992; Sacuzzo, 2003; Sutter et al., 2002; Teitelbaum, 1990). Clearly, the standard of practice is evolving rapidly, and the incorporation of informed consent into clinical supervision is becoming increasingly common and expected.

When supervisors prepare clear informed consent materials for supervisees addressing these issues at the outset, both orally and in writing, all parties benefit. Supervisors articulate and thereby fortify their commitments to supervisees. Supervisees learn what to expect, what will be expected of them, and what they must do to succeed. Both parties are likely to function more effectively, encounter fewer misunderstandings, and experience more satisfaction in their respective roles.

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