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THE KNOWLEDGE, ATTITUDES AND PRACTICES OF CLINICAL SUPERVISION AMONG COUNSELLORS IN BOTSWANA

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ABSTRACT

There is a dearth of literature on clinical supervision (CS) of counsellors in Botswana, where professional counselling remains a relatively new field. This mixed-methods study examined the knowledge, attitudes, and practices related to CS among practising counsellors. An explanatory sequential research design was used, combining quantitative and qualitative methods. A total of 248 participants were drawn from five purposefully selected districts, including practising counsellors aged 25 to 65. Quantitative data were collected through questionnaires completed by 210 counsellors, while qualitative data were obtained via semi-structured interviews with 38 clinical supervisors. The study was grounded in a theoretical triangulation approach, drawing from Social Constructivist Theory, the Theory of Reasoned Action (TRA), and the Theory of Planned Behaviour (TPB). The study aimed to assess counsellors' knowledge, access to CS, attitudes, current practices, guiding principles, and potential strategies for improving supervision practices. Findings from both data sets indicated insufficient knowledge, limited competencies, poor access, and a lack of local ethical frameworks. Despite these challenges, respondents expressed positive attitudes toward CS. The data revealed convergence across methods, reinforcing key concerns. Recommendations included making CS mandatory, developing national ethical guidelines, enhancing training, reviewing educational curricula, and promoting awareness. Most counsellors lacked affiliation with regulatory bodies and relied on foreign ethical standards. Quantitative data were analysed descriptively using IBM SPSS, while qualitative data were thematically analysed, with themes aligning closely with the quantitative results.

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1. INTRODUCTION

Clinical supervision is essential to counsellors' professional development and functions as a quality assurance instrument to ensure "no harm" befalls those accessing counselling (Falender & Shafranske,2004; Goodyear et al., 2017). Literature is replete with information on the benefits of clinical supervision, globally there seem to be massive support for it as an evidence-based intervention in counselling for ethical and effective clinical practice. Various scholars have contributed immensely towards existing scientific information that has helped to create an understanding of the clinical supervision processes, guiding models and possible harm (Allan et al.,2017; Bernard & Goodyear, 2019; Watkins Jr., 2020; Wyllie & Muraina,2024; Wyllie,2024). Similarly, various regulatory bodies have formulated ethical guidelines based on supervisory best practices upon which many counselling codes were underpinned (Borders et al., 2014; Ellis et al.,2014). However, despite extensive international literature, very little exists in the case of Botswana as evident from dearth of local literature that reveal that contemporary Western-oriented counselling is still fairly new and classified at "infancy stage" and lacking effective coordination (Msimanga & Moeti,2018; Muchado,2018; Wyllie,2024).

International literature show that CS is important for effectiveness, prevention of burnout, addressing counsellor compassion fatigue, transference, counter transference and imposter syndrome often faced by counsellors. It is evident from literature that the intervention has immense benefits and cannot be underemphasised. However, literature also reveal possible harm if ineffectively implemented (Bernard & Goodyear,2019; Ellis et al,2014; McMahon & Errity, 2014; Wyllie & Muraina,2024; Wyllie,2024). This study aimed to establish the level of access, determine counsellors' knowledge, attitudes held and examine CS practices.

To achieve these objectives, the study sampled 248 practising counsellors across different counselling environments in the country with the aim to create empirical knowledge development and contribute to improvement of the intervention (Wyllie,2024). 210 practising counsellors of all genders aged between 25 and 65 with three and more years of experience in counselling were recruited from 5 districts to respond to questionnaire and 38 supervisors to interviews. This mixed methods research used explanatory sequential research design where quantitative data was collected first, descriptively analysed and results used to inform qualitative semi-structured interviews whose data was thematically analysed, and metanalysis used to establish convergence.

a. Purpose of the Study

The interest was in establishing counsellors' knowledge of CS, attitudes and practices by having them respond to a questionnaire and supervisors to semi-structured open-ended questions anchored on six variables; examining level of access, counsellors' knowledge of CS, attitudes and clinical practices, investigating ethical principles guiding their practice and possible strategies for improvement of the practice. According to Ellis et al. (2015) counsellors often experience inadequate, ineffective or harmful CS which may contribute to lack of interest towards accessing the intervention despite code of ethics emphasising the importance of accessing it every 20 hrs of providing counselling.

To examined counsellors' knowledge of clinical supervision there was need to establish their training in CS, competencies and ability to apply theoretical knowledge and skills in real life situations in their practice, examine ethical principles guiding their practice, their attitude towards supervisors, format of CS they accessed, their ability to competently incorporate UPR in practice and solicit strategies for improving the practice.

b. The Significance

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This study aimed to add knowledge, inform the practice, stimulate the desire for development of national CS framework and provide a baseline for further research in efforts to develop the practice in Botswana.

c. Research Questions

Q1. What is the level of access to clinical supervision by Counsellors?
Q2. What is the knowledge of counsellors on clinical supervision in Botswana?
Q3. What is the attitude of counsellors to clinical supervision in Botswana?
Q4. What are clinical supervision practices of counsellors in Botswana?
Q5. What ethical principles are guiding counsellors in Botswana?
Q6. What are possible strategies for improving clinical supervision?

d. Theoretical Underpinnings

Methodology adopted for the study was anchored on social constructivist theories and primarily underpinned by TRA and TPB (Ajzen & Fishbein,1985). The study draws from two distinct paradigms; the quantitative positivist paradigm that perceives patterns of behaviour as objectively perceivable, quantifiable, numerically represented phenomenon explainable from detached scientific causal laws of objectivity (Fossey et al.,2002). The second phase of the study was approached from the narrative, subjective qualitative paradigm that adopted interpretive stance of deriving data from respondents' lived experiences understood from their perspective and not from pre-determined researcher's philosophical and phenomenological perspective (Brady & O'Regan, 2009; Wyllie & Muraina,2024; Wyllie,2024).

Constructivist theory aligned perfectly with the purpose of the study as it hinges on principles of learning, growth and development and adequately undergirded the study because clinical supervision is a professional development intervention for counsellors (Bernard & Goodyear ,2019; Vygotsky & Cole,2018; Vyotsky,2011; Wyllie,2024). Eclectic theoretical framework approach allowed triangulation of KAP (Knowledge, Attitudes and Practice) theories; social constructivist theory; Theory of Reasoned Action (TRA) and Theory of Planned Behaviour (TPB). TRA and TPB assume behavioural intention is determined by attitude and social normative perceptions (Ajzen & Fishbein,2002,2005). The study investigated knowledge, attitudes and practices of CS therefore compatible with TRA and TPB' focus on constructs of attitudes, subjective norms and perceived control to explain behavioural intentions (Ajzen & Fishbein,2005; Wyllie,2024). Exploring the phenomenon from this theoretical lense helped explain concepts; especially the influence of perceived behavioural control (PBC) on ability to perform a planned behaviour like CS, and the influence on intention and motivation as without motivation counsellors are unlikely to participate in CS (Ajzen & Fishbein,2005). Figure 1 shows the framework as applicable to the phenomenon in this study

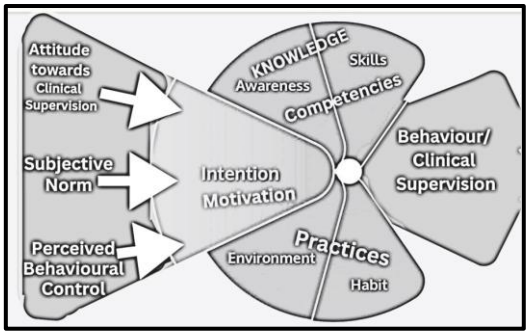

Figure 1. Showing TRA/TPB Model **(**Wyllie,2024, p.261)

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Extensive sources of information may influence how counsellors perceive and practice clinical supervision; knowledge, attitudes and practices may influence the ability to access and offer the intervention; policies, different environments and cultures may equally have negative or positive impact on CS implementation. Similarly, how it is perceived by counsellors and supervisors may affect the level of access; and environmental factors such as non-supportive environments, guiding principles, regulation and coordination may influence counsellors' perceptions towards CS.

Knowledge is an abstract concept that can only be inferred based on observable demonstration of skills, therefore, to the acquisition of knowledge has to be demonstrated through application of competencies and skills by counsellors and clinical supervisors in real-life situations (Wyllie & Muraina,2024; Wyllie,2024). Possessing knowledge and being competent is therefore crucial for effective CS practice. In counselling, CS process may be challenging if supervisors and counsellors do not have relevant knowledge and skills, such a scenario may lead to negative attitudes towards the practice and possible harm to beneficiaries. Therefore, knowledge is critical in performing a planned behaviour such as clinical supervision and should be accompanied by skills; hence, Bolisani and Bratianu (2018) opine that accumulated scientific theoretical knowledge should be accompanied by applied knowledge, skills and competencies.

Attitude refers to individuals' likes and dislikes toward certain things, behaviours or practices. It is also perceived as a psychological tendency to show preference towards certain things, behaviour or practices based on personal evaluation. Often personal preferences are expressed outwardly for others to understand (Wyllie & Muraina,2024). According to Bohner and Dickel (2010), attitude is an evaluation of an object of thought, attitude or object which may be abstract or concrete. It can be based on negative or positive evaluation individuals attach to a behaviour or practice which then influence their response towards it. According to Ajzen and Fishbein (2005), attitudes are learned predisposition to respond either favourably or unfavourably towards behaviour or a situation.

Practice refers to any action or omission by a counsellor of what is considered part of a counselling service, it may include actions that may cast doubt upon one's knowledge, competencies and ability to practice counselling. It may also be actions that may be considered harmful to professional credibility leading to the tarnishing of public image and trust in the profession (Australian Counselling Association [ACA], 2019). In juxtaposition; it could be an act of providing effective therapeutic help to those seeking it. In this study, practice refers to clinical supervision of counsellors grounded on clinical supervisors' knowledge, skills and experience based on cognitively acquired body of knowledge manifest in theoretical application of techniques, models and strategies in a therapeutic setting; evident from practical demonstration of skills (Banaji & Heiphetz,2010; Wyllie & Muraina,2024; Wyllie,2024). Literature is replete with information articulating the link between knowledge, attitudes and application of acquired knowledge that involves putting theory into practice, therefore, until CS knowledge is applied, it remains abstract construct to Botswana counselling setting. (Msimanga & Moeti,2018, Muchado, 2018; Wyllie & Muraina,2024; Wyllie,2024).

2. METHODS

The main goal for using mixed methods (quantitative and qualitative) was to obtain descriptive empirical information about the clinical supervision from practising counsellors and counsellor supervisors. From counsellors, quantitative (QUAN) data was gathered through questionnaire and qualitative data through interviews of supervisors to gain insight into the clinical supervision phenomenon and to explain numeric data. Participants came from different counselling environmental settings; from governmental and non-governmental institutions.

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Qualitative data was to corroborate and elucidate quantitative (QUAL) data findings. Data collection and analysis were done sequentially with quantitative data collected first and analysed to inform qualitative data collection process. This was to generate descriptive and explanatory scientific empirical information to add knowledge and inform the practice.

a. Recruitment Procedures

Practising counsellors and supervisors were recruited from governmental and non-governmental organizations. The study targeted counsellors aged between 25 and 65 years with 3 and more years of experience. Counsellors responded to questionnaires and supervisors to semi-structured interviews. Supervisors included centre managers, supervisors of school counsellors, district counsellor supervisors, counsellor educators and members of regulating bodies. Participants were recruited from 5 districts; 210 practising counsellors responded to questionnaires and 38 supervisors responded to interviews. Recruitment process was through emails and telephone calls due to COVID-19 restrictions and protocols. There was no monetary incentive for participation and the study was approved by Unicaf University Research Ethics Committee (UREC) and relevant national and local authorities in Botswana.

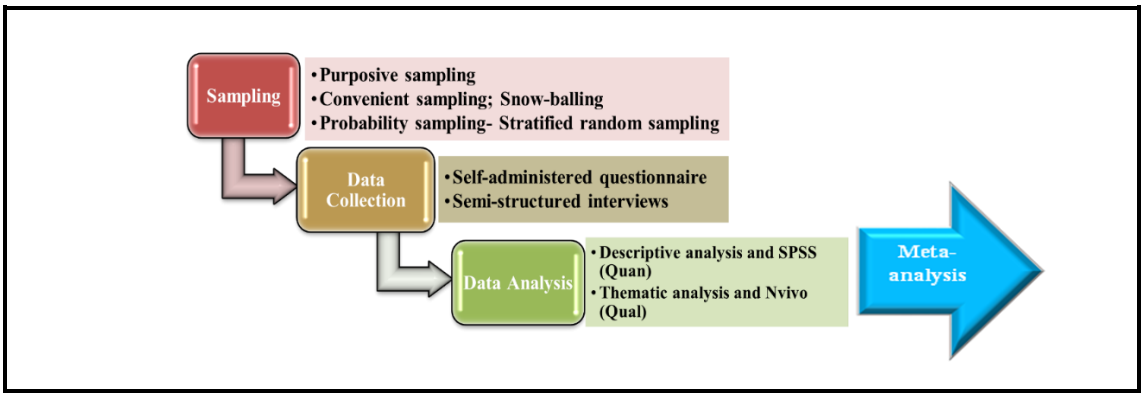

Figure 2. *Sampling, Data Collection and Analysis Process (Wyllie,2024, p.171)*

b. Instrumentation of Research Tools

Instrumentation for quantitative data collection was self-developed as none existed that could be adapted for the study. The development of the instrument was based on step-by-step guidelines for constructing a "Theory of Planned Behaviour questionnaire" and designing KAP (knowledge, Attitude and Practice) surveys and questionnaires (Ajzen,2006; Andrade et al.,2020). The study started with a deductive process followed by an inductive process of investigating knowledge, attitudes and practices of clinical supervision. The questionnaire comprised 36 items seeking information on six variables; Knowledge, Access, Attitudes, Practice, Ethical guiding principles and Strategies for improvement of CS and had 5 Likert scale responses from:

"Strongly Agree" = 5
"Agree" = 4
"Neutral" = 3
"Disagree" = 2
"Strongly Disagree" =1 (Wyllie & Muraina,2024; Wyllie,2024).

c. Validity and Reliability

Validity is the accuracy of an instrument in measuring what it is supposed to measure; it is important for an instrument not only to be reliable but give a valid measure as well (Drost,2011). Bashir et al. (2008) and Golafshani (2003) assert that validity is the accuracy of an assessment in measuring what it purports; it is about the extent of accuracy of the instrument in representing the concept it claims to measure. Similarly, reliability is the consistency of a

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particular test or questionnaire to produce similar results when administered under similar circumstances; the degree to which the instrument yields consistent results; encompasses internal consistency, test-retest and inter-rater reliabilities (Collins et al., 2007; Johnson,2014; Wyllie,2024). Therefore, to test the instrument, thirty-six (36) participants were randomly selected for piloting and the instrument was tested on IBM SPSS 26.0 using Cronbach's Alpha, the test indicated a relatively good internal consistency and was considered reliable based on the Alpha value for each variable as indicated in Table 2. Alpha is considered reliable indicator of the quality of an instrument (Taber,2016; Wyllie & Muraina,2024).

Respondents of the pilot phase were not included in the actual research population sample.

Table1. Showing Cronbach's Alpha for Testing Reliability and Validity of Questionnaire Items

Subscale	*N*	*Items*	*Cronbach's α*
Access	*36*	*6*	*.728*
Knowledge	*36*	*6*	*.871*
Attitude	*36*	*5*	*.860*
Practice	*36*	*6*	*.921*
Ethical	*36*	*5*	*.699*
Principles	*36*	*6*	*.924*
Strategies			

Adopted from Wyllie (2024, p.179)

d. Ethical Assurance

Permission was sought and received from Unicaf University Research Ethics Committee (UREC) and national and local authorities in Botswana. Respondents were debriefed on the significance of the study and consented to take part. The study posed no risks to the respondents. Participation was anonymous and responses could not be traced back to the respondents as identities were protected through data coding. Respondents were free to withdraw if they desired and their data excluded in such instances.

e. Qualitative (Clinical Supervisors)

Supervisors responded to open-ended questions and were equally recruited from diverse counselling environments from the 5 districts. These were individuals from governmental and non-governmental organizations who served as counselling centre managers, heads of private practice counselling clinics, supervisors of district counsellors, supervisors of school counsellors, leaders of regulating organizations and counsellor educators from both governmental and privately owned tertiary institutions. In some areas, supervisors were line managers.

3. RESULTS AND DISCUSSION

Quantitative Results

Descriptive statistical analysis was done in the first phase of the quantitative study for data gathered through the questionnaire. Data was cleaned, coded and scrutinized for missing values before analysis. The questionnaire started by gathering relevant background demographic data; gender, age, years of experience, level of education, professional field, district location and counselling environmental setting. This data was significant for contextual information on appropriateness of respondents and is presented in Figure 3 showing participants characteristics in frequencies and sample population (N=210).

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Participants Characteristics

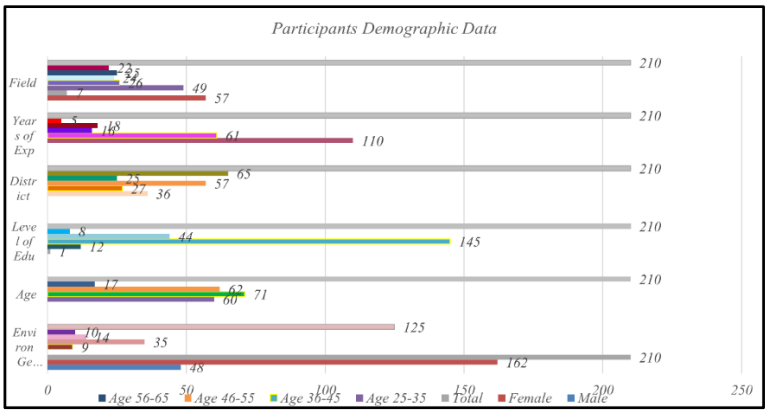

Figure 3. *Participants' Demographic Data (Wyllie, p.216)*

Figure 3 data show that (48,22.9%) were Male, (162,77.1%) female and (0%) for "other/prefer not to say" option. There were more female respondents than those who identified as male, none chose the third option of "other/choose not to say". Years of experience showed (110,52.4%) had 3-10, (61,29.0%) 11-15, (16,7.6%) 16-20, (18,8.6%) 21-30 years. The lowest participation was in the 31- 40 years-experience-bracket with (5,2.4%), majority were from 3–10-years' experience bracket with 52.4%. Participants' level of education ranged from Certificate, Diploma, Bachelor's, Master's and Doctorate degree. The lowest level of education was a certificate (1,.5%), highest was doctorate (8,3.8%) and majority had Bachelor's (145,69.0%) and Master's degree (44,21.0%).

Table 2. Showing the Districts from which the Sample was Drawn

District	N (%)
Central	*36(17.1)*
Kgatleng	*27(12.9)*
South-East	*57(27.1)*
Kweneng	*23(11.9)*
Southern/South	*65(31)*

Table 1 shows majority of respondents came from Southern (31%) and the least participation was from Kweneng district (11.9%).

Majority of respondents indicated publich school as their counselling environmental settings (125,59.5%), followed by non-governmental organizations (35,16.7%) and the least were from government departments (9,4.3%). Respondents' area of speciality included counselling (57,27.1%), Guidance and Counselling (49,23.3%), Psychology (25,11.9%) and Social work (22,10.5%). However, some indicated their areas of specialization as Early-Childhood-Education (7,3.3%), Humanities (26,12.4%) and Primary Education (24,11.4%).

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Based on this data, it can be concluded that majority of respondents were in the counselling and human services, Guidance and Counselling followed by Psychology.

The results are herein organized by research questions

Research Question 1: What is the Level of Access to Clinical Supervision by Counsellors?

This question sought to examine counsellors' level of access, annual frequency of ccess, the format of CS accessed between individual, groups and peer-to-peer, the length of CS session between 60 – 90 minutes. (91, 43.3%) participants chose to be neutral on this issue, (70,33.4%) indicated not having access to clinical supervision by choosing "strongly disagree", "disagree", and only *(49,23.3%)* counsellors confirmed having access to CS.

It was also crucial to establish the frequency of access, specifically annual access; majority (79,37.6%) "strongly disagreed" and (40,19%) "disagreed", (5,2.4%) strongly agreed, (5,2.4%) agreed to accessing CS once annually and (81,38.6%) were neutral. The issue of duration of CS session was also examined, and (99,44.3%) were neutral, (81,38.5%) disagreed whilst only *(36,17.1%)* confirmed accessing CS session lasting between 60-90 minutes.

Concerning the format accessed, (101,48.1%) "strongly disagreed", (46,21.9%) "disagreed" with accessing *Individual CS,* (35,16.7%) were neutral and *(28,13.3%)* agreed with accessing individual clinical supervision. On *Group supervision* format, (103,49.0%) "strongly disagreed", (57,27.1%) "disagreed" giving *(160,76.1%)* cumulative of those who reported not accessing CS group format whilst (18,8.6%) "strongly agreed", (9,4.3%) "agreed" and (32,15.2%) were neutral. Similarly, (41,19.5%) "strongly disagreed", (34,16.2%) "disagreed", (7,3.3%) "strongly agreed", (17,8.1%) "agreed", and (111,52.9%) were "neutral" to *Peer-to-peer* format. It can be concluded based on the data that there is low level of access and the most accessed mode is individual CS (13.3%) followed by Group (12.9%), and the least accessed is peer-to-peer (11.4%). This is consistent with literature that revealed that most frequently offered format is individual as a dyadic experience (Borders et al., 2014; Grant & Schofield, 2007; McMahon & Errity, 2014).

Research Question 2: What is the Knowledge of Counsellors on Clinical Supervision in Botswana?

This question examined counsellors' knowledge by interrogating their awareness of the intervention as a requirement in counselling, examined their training, their ability to apply CS theoretical knowledge to real-life situations, awareness of confidentiality, competency in addressing ethical dilemmas and the importance of building rapport or therapeutic alliance in clinical practice.

Respondents' knowledge of clinical supervision as a requirement in the counselling service responses showed (79,37.6%) "strongly agree", (36,17.1%) "agree", (19,9%) "strongly disagree" and (60,28.6%) disagree, whilst (16,7.6%) were "neutral".

Regarding training; (112,53.3%) "strongly disagreed", (16,7.6%) "disagreed" with being trained in CS giving a significant cumulative (128,60.9%) of counsellors who reported being untrained. (22,10.5%) were neutral, (33,15.7%) agreed and (27,12.9%) strongly agreed giving a cumulative *(28.6%)* of respondents who reported being trained. (74,35.2%) "strongly disagreed", (33,15.7%) "disagreed" giving a cumulative (50.9%) of respondents indicating inability to apply theoretical knowledge to real-life practical situations. (41,19.5%) chose to be neutral, (33,15.7%) "strongly agreed" and (29,13.8%) "agreed", therefore; only (29.5%) agreed with the statement. Thus, based on this data, only a small percent of respondents indicated competency in theoretical application.

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Concerning awareness of confidentiality**,** (6,2.9%) "strongly disagreed", (5,2.3%) "disagreed", (79,37.6%) were neutral, (44,21%) "agreed" and (76,36.1%) "strongly agreed". Therefore, data show a significant *(57.1%)* reported awareness of confidentiality. Based on data, it can be concluded that majority of counsellors are aware of the importance of confidentiality in clinical practice. Data further showed that (61,29%) strongly disagreed, (44,20.9%) disagreed with ability to address ethical dilemmas, (31,14.8%) were neutral, (34,16.2%) strongly agreed and (40,19.0%) agreed. Therefore, only (74,35.2%) indicated having relevant competencies to handle ethical dilemmas. Counsellors' knowledge of the importance of building rapport was also probed and (41,19.5%) agreed, (64,30.5%) strongly agreed; therefore, half of respondents (105,50.0%) reported being aware of the importance of rapport building, (46,21.9%) were neutral whilst (56,26.7) strongly disagreed and (3,1.4%) disagreed. It can be concluded therefore from data that there is awareness of rapport building among counsellors.

Research Question 3: What is the Attitude of Counsellors to CS in Botswana?

This question established counsellors' attitudes to CS by looking at six aspects; counsellors perceptions and beliefs on CS benefits as an intervention for enhancing counselling skills, their interest to learn more about it, their feelings about attending CS sessions, how comfortable they were with their clinical supervisor and whether or not they enjoyed attending clinical supervision sessions.

Data showed that majority (144,68.5%) believe CS enhances counselling, (64,30.5%) were neutral, and (2,1.0%) "strongly disagreed". Only a small percentage (1.0%) did not perceive clinical supervision as enhancing counselling skills; this percentage was insignificant.

Majority (205,97.7%) agreed to having interest in learning more about CS, (3,1.4%) strongly disagreed and (2,1.0%) were "neutral". Based on data, it can be concluded that an overwhelming percentage (97.7%) of counsellors were interested to learn more about clinical supervision. This interest shows positive attitude towards the intervention and desire for improvement. Data also showed that a significant number (150,71.5%) believe CS is a good intervention, (28.1%) chose to be neutral and (.5%) disagreed. Based on this data, it can be concluded that there is positive perception towards CS.

It was important to also establish whether or not counsellors enjoyed attending CS session; (94,44.8%) agreed and strongly agreed to the statement, (72,34.2%) disagreed and strongly disagreed whilst (44,21.0%) were neutral. Therefore, it can be concluded that respondents do not enjoy CS sessions. There may be explanation for counsellors not enjoying CS, so it was necessary to examine the working alliance between them and their supervisors; (111,53.1%) reported not being comfortable with their clinical supervisors as (76,36.4%) chose "strongly disagree", (35,16.7%) "disagree", (32,15.2%) "neutral" and only (66,31.6%) agreed with being comfortable.

Similarly, an overwhelming (196,93.3%) of counsellors did not agree with the statement on disliking CS, (5,2.4%) were neutral and only (9,4.3%) agreed to disliking clinical supervision. The conclusion made based on the data is that counsellors in Botswana do not dislike CS. Therefore, inference made is that there are positive attitudes towards clinical supervision among counsellors based on the 93.3% of disagreement.

Research Question 4: What are Clinical Supervision Practices of Counsellors in Botswana?

The question sought to establish respondents' confidence in providing CS, availability of CS skills, perceptions on the importance of empathy, rapport building, ability to use CS skills

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within ethical and legal boundaries, ability to maintain eye contact, maintaining open body posture and practicing confidentiality.

Data revealed that (54.2%) respondents indicated not being confident, (31,14.7%) were neutral and only (65,31.0%) agreed with being confident in their clinical practice. More than half (110,52.4%) agreed to having relevant rapport building skills, (34,16.2%) disagreed, and (66,31.4%) were neutral. On the importance of empathy and working alliance, more than half (108,51.4%) believe that empathy and working alliance are important in CS, (90,42.9%) were neutral and (12,5.7%) disagreed with the statement.

Data further shows (95,45.2%) disagreed with having the ability to use skills within ethical and legal boundaries, (32,15.2%) was neutral and (83,39.5%) agreed with having the ability to operate within the confides of ethical and legal practice. Based on data, it can be concluded that a significant number of respondents lacked skills to operate within ethical and legal boundaries.

Ability to maintain eye contact and open body posture was also examined and (117,55.7%) indicated ability, (83,39.5%) chose neutrality, (10,4.8%) reported not having specific skills to maintain eye contact and open body posture in sessions. Therefore, it can be concluded that (55.7%) is significant for counsellors with the skill.

Similarly, data showed that less than half (103,49.0%) agreed with the ability to articulate and practice confidentiality, (73,34.8%) disagreed and (33,15.7%) were "neutral". Therefeor, it can be concluded that there are questionable and ineffective clinical practices among counsellors due to significant reported lack of confidence and limited skills to function within ethical and legal boundaries as only a small number indicated ability to articulate and practice confidentiality, maintain eye contact, body posture and rapport building skills.

Research Question 5: What Ethical Principles are Guiding Counsellors in Botswana?

Investigating ethical principles guiding counsellors in their clinical practice was relevant to understanding the phenomenon; data showed that a significant number (204,97.1%) agreed with valuing clients' confidentiality and privacy of records in their clinical practice, (2,1.0%) were neutral and (4,1.9%) disagreed. (144,68.5%) admitted practising unconditional positive regard (UPR), (60,28.6%) chose to be neutral and (6,2.9%) disagreed with the statement**.**

We cannot talk about ethical principles without examining counsellors affiliation to a regulating body. More than half (116,55.2%) indicated no affiliation to a local regulating body, (32,15.2%) were neutral on the issue, and only (62,29.5%) admitted affiliation. This was followed up by determining whether counsellors used Botswana Counselling Association (BCA) ethical principles, (128, 60.9%) reported not using BCA ethical principles, (30,14.3%) were neutral and (52,24.8%) admitted using BCA principles.

With only a small percentage of reported use of BCA principles, it was necessary to find out if there were any other local principles utilised, (83,39.5%) disagreed with using principles for a different regulating association, (25,11.9%) were neutral and (102,48.6%) agreed. Therefore, if local ethical principles were not utilised, there was need to investigate what principles respondents used; (48.6%) agreed to using other principles either than those from local regulating bodies, (136,64.7%) disagreed with the statement about not knowing any ethical principles, (58,27.6%) chose neutrality, and (16,7.6%) agreed with not being aware of any ethical guiding principles. It can be concluded that there is limited awareness and non-utilisation of local ethical guiding principles in clinical practice in Botswana.

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Research Question 6: What are Possible Strategies for Improving Clinical Supervision?

Table 3. Suggested Strategies for Improving CS Intervention

Strategies	***Agree***	***Neutral***	***Disagree***
1. Training Counsellors in CS	*119 (56.7%)*	*84 (40.0 %)*	*7(3.4%)*
2. Making CS Mandatory	*201(95.7%)*	*7(3.3%)*	*2(1.0%)*
3. Establishing Accreditation and Licensure	*133(63.3%)*	*74(35.2%)*	*3(1.5%)*
4. Having regular Planned CS sessions	*152(72.3%)*	*56(26.7%)*	*2(1.0%)*
5. Creating Awareness of CS	*204(97.1%)*	*4(1.9%)*	*2(1.0%)*
6. Instilling a good practice of documenting, ethical and legal compliance	*157(74.7%)*	*52(24.8%)*	*1(0.5%)*

Table 3 show that more respondents believe creating awareness of CS (97.1%), making CS mandatory (95.7%), instilling a good practice of documentation, ethical and legal compliance (157,74.7%), having regular planned CS sessions (72.3%), establishing accreditation and licensing body (63.3%), and training counsellors in CS (56.7%) were necessary for improvement of the practice in the country.

Without the voices of the supervisors, the results of quantitative data alone did not give a complete picture of the status of clinical supervision, therefore, there was follow-up through interviews of supervisors for corroboration, validation and explanation of numeric data, hence, presentation of semi-structured interview findings.

Qualitative Results

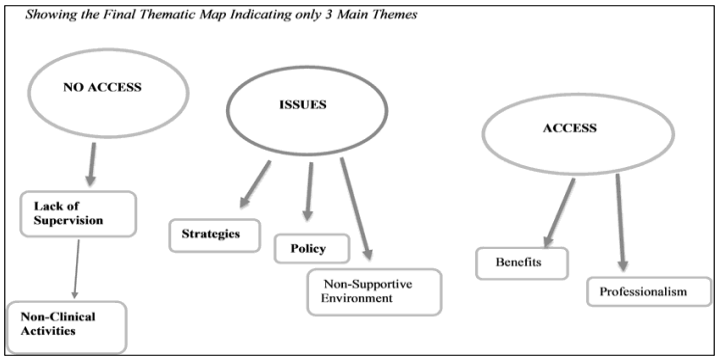

Figure 4. Showing three main themes identified (Wyllie,2024, p.236)

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As can be seen from Figure 4, three main themes emerged from supervisors' interviews ; "Access", "No Access" and "Issues". This corroborated, validated and explained the quantitative data findings. Few supervisors disclosed access to CS by few counsellors and stated the benefits such as ethical clinical practice, counsellors efficacy and professionalism. contratingly, some reported poor access and further elaborated that counsellors are exposed to non-clinical activities due impediments such as policy; lack of guiding principles, working in non-supportive environments and lack of qualified experienced supervisors. However, a few who reported being qualified and experienced in CS, decried underutilisation as counsellors do not access their services due to a few issues such as; lack of funds to pay for sessions, CS not being a mandatory requirement and hence majority of counsellors did not feel compelled to access it and stated that many lacked knowledge about its significance in enhancing their counselling skills. Supervisors suggested strategies such as making CS mandatory and developing guiding principles. However, many indicated not being aware of any ethical principles, and not affiliated with any local regulating body. Majority said they preferred using ethical principles from international organizations such as American Counselling Association, Australian Counselling Association and from other foreign countries where they acquired their professional qualifications. These themes were consistent with QUAN data.

Clinical Supervisors are counsellors who do not only provide CS but access it as well due to their counselling and clinical supervision service they provide, hence their interview results presented in Table 4

Table 4. Qualitative Content Analysis Results of Supervisors' Interviews by Variables

(N=38)

Responses	***Access*** ***N (%)***	***Knowledge*** ***N (%)***	***Attitudes*** ***N (%)***	***Practice*** ***N (%)***	***Ethical Principles*** ***N (%)***
Yes	*13 (34.2)*	*29 (76.3)*	*35(92.1)*	*35(92.1)*	*27(71.1)*
Neutral	*3(7.9)*	*0(0)*	*3 (7.9)*	*3(7.9)*	*0(0)*
No	*22 (57.9)*	*9(23.7)*	*0 (0)*	*0(0)*	*11(28.9)*
N= 38 (100%)	*38 (100)*	*38(100)*	*38 (100)*	*38(100)*	*38(100)*

Wyllie (2024, p.251)

There was need to merge,connect and identify areas of convergence in the study findings between quantitative and qualitative data. Table 5 show significant convergence.

Meta-Analysis

Table 5. Convergence of Data Findings

METHOD:	**Quantitative**	**Qualitative**
DATA COLLECTION	***Questionnaire***	***Semi-Structured Interview***

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RESEARCH QUESTION 1:		***What is the Level of Access to Clinical Supervision by Counsellors in Botswana?***	
		I have access to clinical supervision at my workplace (SA, A, N, D, SD)	How would you describe access to CS; tell me more about the intervention in the country?
Findings	*Overall, there is not much access to clinical supervision in Botswana. However, there is a significant level of uncertainty about whether what is being accessed is clinical supervision or administrative supervision.*	*Only (23.3%) "strongly agree" and "agree" to access, (33.4%) "strongly disagree" and "disagree" and (43.3%) remained neutral; were non-committal.*	The majority of interviewees reported No access to CS; *"There is no access to clinical supervision, only performance-related supervision during quarterly reviews."* *"I do not have access to CS at my workplace…. our regular meetings are administrative in nature"* *"I have been providing supervision for 10 years, but not many counsellors access my services".*
RESEARCH QUESTION 2:		***What is the knowledge of Counsellors on Clinical Supervision in Botswana?***	
		I am trained in clinical supervision. (SA, A, N, D, SD)	What would you say about your knowledge of CS and that of counsellors you work with?
Findings	*Overall, it is evident that there is awareness of what clinical supervision is but there is no knowledge in terms of training.*	*Only (28.6%) "strongly agree" and "agree", (60.9%) of the sample population "strongly disagree" and "disagree" and (10.5%) remained neutral.*	Significant number of interviewees reported knowing very little about CS, not trained or qualified to offer it, whilst others said they were merely aware and a few trained; *"I am not trained…. I know very little about clinical supervision…".* *"I have awareness, but I wouldn't say I am knowledgeable and competent to provide clinical supervision."* *"Never heard of my colleagues talking about accessing or providing clinical supervisor."*

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RESEARCH QUESTION 3:		***What is the Attitude of Counsellors to Clinical Supervision in Botswana?***	
		I believe clinical supervision is a good intervention (SA, A, N, D, SD)	What are your feelings and thoughts about clinical supervision?
Findings	*There is a positive attitude towards clinical supervision despite significant level of neutrality which emanating from insufficient knowledge and lack of training in CS.*	*(71.4%) of the population sample "strongly agreed" and "agreed", (0.5%) "strongly disagreed" and disagreed and (28.1%) remained neutral.*	Significant number of respondents had positive attitude towards CS: *"I value clinical supervision. I always feel refreshed and less stressed…. I find it very beneficial"* *"It is beneficial for counsellor growth,I wish every counsellor had access to it.* *"I enjoy CS; it helps me evaluate my service, competencies, address dilemmas, know how best I can improve. As a supervisor, I also get supervision on the clinical supervision I provide..."*
RESEARCH QUESTION 4:		***What are Clinical Supervision Practices of Counsellors in Botswana?***	
		I am confident in providing clinical supervision (SA, A, N, D, SD)	How would you describe clinical supervision practice in Botswana?
Finding	*There is some awareness about CS information but it is not being practised.*	*Only (32 %) of the population sample are confident in providing CS; they "strongly agreed" and "agreed", (52.7%) "strongly disagreed" and "disagreed" and (15.3%) were neutral.*	Most interviewees stated they have information on CS as a practice despite it not being part of their practice: *"Honestly, in our country, it's not done. Some of us think it's just for clinical psychologists and does not apply to us".* *"I do not offer it, and I don't access it, though I wish I could, I think it's safe to say that*

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			it is non-existent in practice, that's all".
RESEARCH QUESTION 5:		***What Ethical Principles are Guiding Counsellors in Botswana?***	
		I am affiliated with a Counselling Regulating body/Association (SA, A, N, D, SD)	Tell me about your affiliation with regulating bodies and counsellors' guiding principles
Finding	*There is no regulating body and ethical guiding principles, many participants are not affiliated with any regulating organization, whilst many uses ethical principles from international bodies to guide their practice.*	*(29.5%) "strongly agreed" and "agreed", (55.2%) "disagreed", and "strongly disagreed" while (15.2%) chose to be neutral.*	Majority of interviewees reported having awareness of guiding ethical principles but not affiliated with any local regulating body, and a few reported using ethical principles from foreign countries*: "I have never seen any in this country, I refer to the ones I used during my studies as a university student".* *"I am comfortable using the ACA (Australia) alongside the ACA(America)codes."* *"I am not a member of any regulating body; I function according to government protocols".*
RESEARCH QUESTION 6:		**What are Possible Strategies for Improving Clinical Supervision?**	
		Making clinical supervision mandatory is a good strategy to	What strategies would you suggest for improving

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		enhance the clinical supervision practice (SA, A, N, D, SD)	clinical supervision in Botswana?
Findings	*Strategies suggested included mandatory CS, establishing effective regulating body, licensing, training counsellors in clinical supervision, including CS in counsellor education curriculum and creating awareness of the importance of CS in counselling.*	*(95.7%) of the population sample "strongly agreed" and "agreed", (1%) "strongly disagreed" and "disagreed" and (3.3%) remained neutral*	Most interviewees suggested establishing an active regulating body to provide screening and licensing of qualified counsellors, and making clinical supervision mandatory for all practising counsellors: *"It should start with counsellor training institutions."* *"It's important to have effective national regulating body to ensure adherence to counselling principles, and for only qualified people to provide such service…"* *"It should be made mandatory for every practising counsellor, and that can only happen if there is a licensing body.*

Source: Wyllie (2024, p.272-275)

4. DISCUSSION

The findings of the current study add to the small body of literature on supervision of counsellors focusing on level of access, knowledge, attitudes and practice. In so doing, the study provides additional insight into Botswana Counsellors' clinical practice.

Study findings have been consistent in showing that majority of counsellors in the country do not access CS, have limited knowledge and competencies, lack of national guiding principles, and both counsellors and supervisors yearn for structure, regulation, effective coordination and training. Evident desire for CS development was indicated by both quantitative and qualitative data in this study. Concerning the level of training of counsellors, there is an evident exisiting gap between theory and practice. Hence, one of the themes was the need for incorporation of CS in counsellor education curriculum, training of counsellors and making CS a mandatory requirement for all practising counsellors, and this is in unison with literature findings (McMahon & Errity, 2014; Msimanga & Moeti,2018, Watkins, 2020).

Lack of guiding ethical guidelines creates an ethical area of concern, and the issue of poor access is another as ethical practice in counselling is crucial for professionalism, intergrity, prevention of unethical practices, safety of clients, checks and balances for transference and countertransference, prevention of legal action for malpractice and ensuring quality of clinical service.

This study revealed both counsellors and supervisors used ethical guidelines from foreign countries due to lack of national guiding principles. Majority reported being involved in administrative supervision rather than clinical, and some supervisors reported not being

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qualified in CS and using government policies unrelated to CS. This implies that majority of counsellors are supervised by line managers with little knowledge of CS who focus on non-clinical activities. Therefore, counsellors may not grow professionally and conflict may be frequent as line managers are not knowledgeable in CS; this may impact supervisee-supervisor professional relationship and consequently expose counsellors to harm (Boswell et al.,2017; McMahon & Errity, 2014; McMahon,2014; Tromski-Klingshirn & Davis, 2007).

In school settings, counsellors reported being supervised by school heads who lacked training in counselling, in such situations boundaries often get blurred and the importance of CS remains vague creating ineffective service provision as the school head can only operate from the administrative hat of a "school boss", not as clinical supervisor for provision of clinical support for professional development; One said: "I know nothing about Counselling, my background is Human Resource Management and I follow government protocols and procedures". Majority of counsellors stated that the only supervision they received was administrative as performance review focused on annual performance development plans (PDPs), balanced scorecards and achievement of organizational targets not related to clinical supervision or what goes on in the therapy room during counselling process.

Whilst international regulating bodies have ethical guiding principles for CS and counselling, counsellors in Botswana reported not having national ethical guiding principles and ethical standards for counselling service providers. Yet, literature show that one of the functions of CS is to ensure counsellor effectiveness and professionalism as it serves as an instrument for quality assurance crucial for addressing counsellor fatigue, counsellor burnout, imposter syndrome and thus enhances counsellor skills and competencies (Lane et al.,2016).

Themes from the qualitative data findings converged with the quantitative findings indicating that majority of respondents do not have access to CS and have limited knowledge despite positive attitudes. Themes centred around access unearthed issues affecting access, knowledge, attitudes and practices and revealing "non-supportive environments" and "non-clinical activities". However, there were expressed desire for training, mandatory CS and review of counsellor-education programmes. Consequently, positive attitudes to CS were consistent themes from interviews that correlated with quantitative findings and consistent with literature (Goodyear & Nicolas,2020; McMahon & Errity,2014; McMahon,2014).

These findings adequately connected to underpinning theories on the influence of perceived behavioural control (PBC) to level of access and provision of the service by clinical supervisors who reported lacking training and hence CS does not form part of their clinical practice. Majority of respondents reported being knowledgeable about CS, but on probing further, it turned out that they were "aware" but lacked competencies and skills to provide the service; one said; "I have awareness, but I wouldn't say I am knowledgeable and competent to provide clinical supervision." Hence, without positive perceived behavioural control(PBC) perfoming CS becomes challenging.

5. CONCLUSION

Implications for Practice

The study provides knowledge to limited literature on clinical supervision of counsellors in Botswana; it is valuable addition to descriptive information about counsellors and supervisors' lived experiences on access, knowledge, attitude and practices to influence change in clinical practice.

Suggestions for Future Research

The findings are consistent with literature findings and there is convergence between the two data sets.

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1. Future studies could consider replication using focus group discussion (FGD) from a gender-balanced approach as the limitation was more females than males participation in this study. FGD creates opportunity for richer qualitative data (Puzanova et al.,2023)
2. Further research on this phenomenon from experimental observational research approach with control groups is worth considering in relation to counsellor efficacy.
3. It would be interesting to establish the reasons behind limited access despite positive attitudes to CS from counsellors.
4. Reported inadequate supervision has implications for policy and practice; counsellor training, standard of practice, quality of service and safety of beneficiaries.
5. Future studies could consider CS and technology; exploring telehealth or tele-counselling based on lessons learnt from COVID-19.

Conclusion

The study revealed limited knowledge, lack of access, ineffective practices, yet unearthed positive attitudes towards CS. Study findings and literature are in unison regarding CS service being underdeveloped in Botswana as evident from limited knowledge, poor access, ineffective practices, lack of regulation, none-affiliation to regulating bodies and non-existent guiding principles. These findings and recommendations are an addition to literature to create knowledge, build awareness, stimulate dialogue, challenge the status quo and encourage further research in CS. This information is to influence policy to help apply scientific knowledge to transform the practice and addressed all key variables centered on level of access, knowledge, attitudes and practices of clinical supervision to stimulate responsiveness and willingness to know more about CS to shape the trajectory of counsellors and counselling in the country.

6. AUTHORS' NOTE

The authors declare that there is no conflict of interest regarding the publication of this article. Authors confirmed that the paper was free of plagiarism.

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