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

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Approval of the Thesis

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Abstract

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

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The study adopted the Explanatory sequential design of mixed method to investigate the Knowledge, Attitudes and Practices among counsellors in Botswana. Study examined counsellors' knowledge of CS, their level of access to CS, attitudes, practices, ethical guiding principles of their clinical practice and determined possible strategies for improving the intervention. Despite clinical supervision (CS) being a mandatory requirement in counselling globally, Botswana's practice appears to lag.

Data was collected sequentially using a structured questionnaire followed by semi-structured interviews. Extensive literature from various sources was reviewed and revealed that; "psychological treatment requires psychological treatment supervision" and hence, CS is a mandatory requirement in mental health professions. However, local literature revealed very little evidence of CS implementation in Botswana regardless of the complex psychosocial challenges that led to the mushrooming of counselling centres. This status quo inspired the exploration of this phenomenon to empirically establish the knowledge, attitudes and practices of CS. Probability and non-probability sampling were used and respondents were practising counsellors of all genders aged 25 to 65 with more than 3 years of experience in counselling. Participants were drawn from five (5) districts and different environmental settings within the mental health professions of Botswana. Quantitative and qualitative methods were mixed, and data triangulation was adopted while data analysis was by SPSS, NVivo, thematic and basic qualitative content analysis.

The study findings established positive attitudes, poor access, limited knowledge and competencies, ineffective practices, lack of training and lack of national guiding principles. These findings have policy and practical implications for counselling services, counsellors' education and further research.

Keywords: Clinical supervision, Perceptions, Counsellor supervision, Access, Attitudes, Knowledge, Practice, Ethical Principles, Counselling, Botswana.

Declaration

I declare that this thesis on The Knowledge, Attitudes and Practices of Clinical Supervision Among Counsellors in Botswana was solely composed by myself Tshidi M Wyllie under the supervision of Prof. (Dr.) K O. Muraina. The work is my own except where explicitly stated in the text and scholarly cited. This work was not previously submitted to any institution for degree except as specified. Parts of this work are currently under consideration for publication.

AI Acknowledgment

Non-Use of AI

I acknowledge that I have not used any AI tools to create, proofread or produce any text or ideas related to any draft or final versions of the thesis. I acknowledge my use of Office Microsoft spell checker, for spelling and punctuation to proofread my thesis. This action was completed in July 2024.

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Dedication

This work is dedicated to my family, especially my husband Ian M Wyllie, my two boys Ricardo-Rick and Jason-Isaac for all their support, encouragement, prayers and love throughout the process. Not forgetting my grandkids Richard-Rich, Ryan and Erica for their love. I hope this work inspires my grandkids in the pursuit of their academic achievements. I also dedicate this work to my parents who raised me to become an enthusiast; thanks Mum and Dad (Mr & Mrs Botshelo Ramfatshe). Apart from Christ Jesus, you were my driving force, I love you and may God Bless you more!

Lastly, the thesis is dedicated to all counsellors and mental health practitioners across different environmental settings in Botswana.

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I thank God almighty and my Lord and Saviour Jesus Christ of Nazareth for the strength, grace, wisdom, motivation, inspiration and most importantly the breath of life because every breath I take is by the grace of God. I acknowledge the Holy Spirit who carried me through to the full completion of this project. Thank you, Lord, for my divine calling into the counselling ministry. Your will be done in earth as it is in heaven, and may this research impact lives and make a difference in the counselling field in my beloved country; “My Botswana, My Pride”.

My profound and sincere gratitude goes to my research supervisor, Prof. (Dr.) K.O. Muraina, for his unwavering academic guidance and mentorship throughout this study, especially for prompt feedback on submissions, which made a significant difference in the timely completion of this thesis; may you be forever blessed, Prof. (Dr.) Muraina.

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List of Abbreviations

ACA- American Counselling Association

ACA – Australian Counselling Association

AIDS-acquired immunodeficiency syndrome

APA- American Psychological Association

ASCA- American School Counsellor Association

BACP- British Association for Counselling and Psychotherapy

BAIS- Botswana AIDS Impact Survey

BAPR- Botswana Association for Psychosocial Rehabilitation

BAPsy- Botswana Association of Psychologists

BCA- Basic Content Analysis

BCA- Botswana Counselling Association

BGBV- Botswana Gender-Based Violence Prevention and Support

BGCA- Botswana Guidance and Counselling Association

BHPC- Botswana Health Professions Council

BMFC- Botswana Marriage and Family Counselling

BOCAIP- Botswana Christian AIDS Intervention Program

BOFWA- Botswana Family Welfare Association

BONASW- Botswana National Association of Social Workers

BONELA- Botswana Network on Ethics Law and HIV/AIDS

BOSASNET- Botswana Substance Abuse Network

BSPCP- Botswana Society of Professional Counsellors and Psychotherapists

CACREP- Council for Accreditation of Counselling and Related Educational Programs

CBT- Cognitive Behavioral Therapy

CHS- Counselling and Human Services

CIA- Central Intelligence Agency

CS- Clinical Supervision

CSE- Counsellor Self-efficacy

DEPRS- Department of Educational Planning and Research Services

DSE- Diploma in Secondary Education

FPC-B- Federation of Professional Counsellors Botswana

G&C- Guidance and Counselling

GCE- Cambridge General Education Certificate

GRFS- Goals, Roles, Function and Systems Model

HIV- Human Immunodeficiency Virus

HOD- Head of Department

ICA- Interpretive Content Analysis

ICCE- International Centre for Credentialing and Education of Addiction Professionals

IDM- Integrated Developmental Model

IPDSM- Integrative Psychological Developmental Supervision Model

KAP- Knowledge, Attitude and Practice

MFT- Marriage and Family Therapy

MOBE- Ministry of Basic Education

MOESD - Ministry of Education and Skills Development

NACA- National HIV and AIDS Coordinating Agency

NGOs- Non-governmental Organizations

PARM- Professional Assessment Response Model

PSCSM- Professional School Counsellor Supervision Model

PIC- Phronesis International College

QCA- Qualitative Content Analysis

RCSI- Rehabilitation Counsellor Supervision Inventory

RNPE- Revised National Policy on Education

SAATF- Support, Accessibility, Advocacy, Teamwork and Feedback

SAMHSA- Substance Abuse and Mental Health Services Administration

SARS-CoV2- Severe Acute Respiratory Syndrome Coronavirus

SAS- Systems Approach to Supervision Model

SCMCT- Social Cognitive Model of Counsellor Training

SCSM- School Counsellor Supervision Model

SHE- Safety, Health and Environmental

SPSM- Structured Peer Supervision Model

SPSS- Statistical Package for Social Sciences

SUD- substance use disorders

TPB- Theory of Planned Behaviour

TRA- Theory of Reasoned Action

UB- University of Botswana

UPR- Unconditional Positive Regard

UREC- Unicaf University Research and Ethics Committee

WHO- World Health Organization

YWCA- Botswana Young Women's' Christian Association

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CHAPTER 1: INTRODUCTION

Chapter Introduction

Extensive literature across peer-reviewed mental health journals describe what counselling is, many refer to it as a professional relationship between a client and a therapist to psychosocially empower clients to find options and solutions to their challenges. Most authors concur that counselling is a therapeutic helping relationship between a counsellor and a client with goals to help resolve personal issues and regain an emotional equilibrium and balanced functioning. Deduced from the definitions is that a helping paradigm underpins the counselling process and involves a facilitator and someone needing therapeutic assistance. Literature (Wosket, 2017; Stones,2002; Borders & Brown,2005; Carroll,2001) further underscores that counselling is a mental health service that provides help to individuals facing psychological challenges and struggling to cope with various mental health-related issues and has the Client-counsellor-clinical supervisor relationship process.

In the counselling profession, Clinical supervision (CS) is a quality assurance component provided by a more professionally experienced and qualified counsellor trained in clinical supervision. According to Wheeler and Richards (2007), it is a structured counsellor evaluation by experienced counsellor to ensure clinical and professional competency, quality counselling service and client safety. Wosket (2017,2016) also opine that it is a professional relationship to enhance counsellors' service provision, safeguard the wellbeing of clients and protect reputation of the counselling practice. Literature shows that clinical supervision (CS) enables clinical supervisors' to perform multiple roles of clinical coach, mentor, educator, consultant and pedagogical advisor. Stones (2002) asserts that CS has to do with "to direct, oversee"; watch over or "maintain order". Concurring with this view, Morgan and Sprenkle (2007, p.7) purport that:

> In a general sense, supervision seems to involve a structured relationship between a supervisor and supervisee with the goal to help the supervisee gain the attitudes, skills, and knowledge Needed to be a responsible and effective therapist.

Carroll (2001) argues that clinical supervision is essential for counsellors' mentorship and evaluation of professional development. Morgan and Sprenkle (2007) emphasise the critical regulating role of clinical supervision in counselling services by saying; "where there is lack of coordination every counsellor may do things their way". These convincing arguments show the reason why clinical supervision is mandatory and considered essential to the effectiveness of counselling services by different counselling regulating bodies throughout the world.

Given this, various countries have established regulating bodies and developed guiding principles or frameworks for the counselling profession to ensure professional conduct. Therefore, Clinical supervision has become a speciality within the counselling profession, hence it has its theoretical models and is conducted by qualified, licensed counsellors accredited in clinical supervision (Msimanga, & Moeti, 2018; Muchado, 2018). CS has become a norm in counselling and psychiatry to prevent harm to clients and ensure efficiency. Therefore, accessing CS is crucial for counsellors even in developing countries such as Botswana where the counselling profession is still relatively new.

This study sought to investigate Botswana counsellors' knowledge, attitudes and practices of clinical supervision to establish the status because, with limited knowledge, the practice may be negatively impacted. Similarly, despite the amount of knowledge counsellors may have, if the attitudes towards CS are negative, applying theory into practice may be challenged. Given this perspective, the significance of examining CS practices in the country cannot be overemphasised, as Benshoff (1988, p.ii) asserts:

> Although supervision is widely recognised as critical to the professional development of both practising counsellors and counsellor trainees, adequate clinical supervision may be more of an ideal than a reality for many counsellors due to a lack of supervisors who have the necessary expertise, time, interest, and willingness to provide regular, ongoing supervision.

In developing countries such as Botswana, clinical supervision is a scarce skill not easily embraced which is not surprising because according to Opondo et al. (2020) and WHO (2022), mental health research in

Botswana is lacking. It is worth noting that the emergence of Human Immune Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) heightened critical need for clinical supervision to support counsellors overwhelmed by providing counselling for complex psychosocial issues emanating from high prevalence and high transmission rate that led Botswana to be considered the most affected in the world (Msimanga & Moeti,2018; Muchado,2018). The situation led to an increase in mortality rate, a decrease in life expectancy, a massive increase in orphanhood, vulnerable and disadvantaged populations.

The complex psychosocial issues needed evidence-based support interventions, as a result, counselling became the major support service throughout the country leading to establishment of many counselling centres by individuals; many of which lacked relevant qualifications, skills and competencies. The counselling services provided, lacked proper coordination, regulation and theoretical framework. However, the nation faced a health crisis that created mental health crisis needing counsellors; consequently, lay counsellors providing counselling were overwhelmed due to lack of access to clinical supervision (Msimanga & Moeti,2018; Muchado,2018). Given this background, this study sought to investigate knowledge, attitudes and practices of clinical supervision among counsellors to create scientific knowledge, add to literature, inform practice and contribute towards clinical supervision development.

1.1 Statement of the Problem

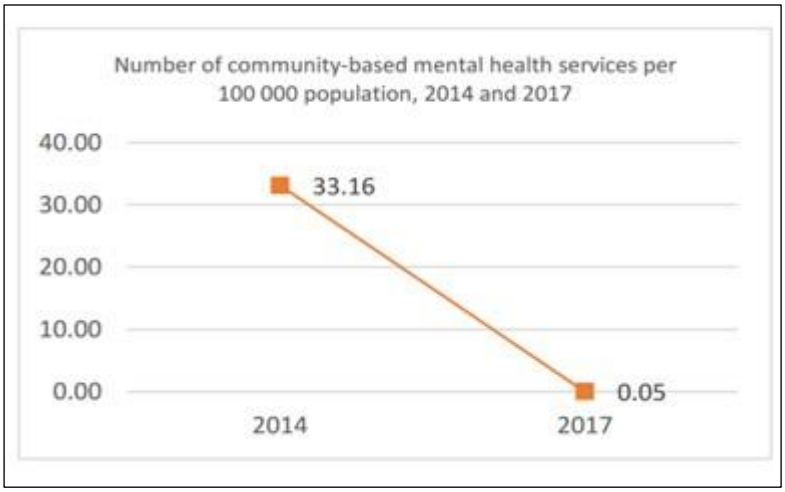
The problem investigated by the mixed methods research was the knowledge, attitudes and practices of clinical supervision among counsellors in Botswana. Contemporary counselling is a fairly new phenomenon in the country introduced in the early 80s as Career Guidance to prepare young people for the world of work (Muchado, 2018; Ministry of Education,1996; Onyewadume,2008).

Due to emerging and complex psychosocial issues in schools, the Ministry of Basic Education (MOBE) introduced a holistic Guidance and Counselling programme in 1996. However, teachers appointed to the position of Senior Teacher 1- Guidance and Counselling lacked training, qualifications and experience in counselling, yet were expected to provide school counselling (Muchado,2002; Muchado,2018; Navin,1985; Mutanyatta,1993; Shumba, et al.,2011).

Psychosocial issues did not only affect schools, communities were equally impacted as grandparents became instant caregivers whilst grieving the loss of their adult children who left infants, toddlers and teenagers orphans. Child-headed households emerged and struggled with not only economic issues but stigma and trauma as well. Counselling centres were established in communities by people with little or no qualifications to provide psychosocial support. The mushrooming of counselling centres in the country and the complexity of emerging psychosocial issues treated by counsellors necessitated CS to ensure professionalism, efficiency and prevention of malpractice. Wheeler and Richards (2007) and Msimanga and Moeti (2018) assert that clinical supervision is caregiving clinical support to empower counsellors with the confidence to provide effective counselling. The issue of clinical supervision of counsellors in Botswana is not an individual, organisational, or industry problem, but a cross-cutting issue affecting various levels and therefore a concern to mental health service provision in the country. Hence, local literature laments lack of CS and poor mental health services in the country (Opondo, et al.,2020; World Health Organization ([WHO],2022) as indicated in the Figure 1;

Figure1

Botswana Mental Health Services



WHO Mental Health Atlas (2020) Botswana Member State Profile (p.3)

The counselling programme was introduced at the University of Botswana and Molepolole College of Education for diploma and degree, it was only recently that Master's degree was introduced.

Graduates were posted mostly to schools and yet there was no evidence of clinical supervision offered and those in communities seemed not to be aware of clinical supervision.

Msimanga and Moeti (2018, p.51) decried the absence of a budget to support supervision as an impediment to enhancing effective and adequate supervision; "there is an extremely limited budget if any laid aside to support supervision endeavours. Funds are needed to support clinical supervision as needs emerge". This scenario of inadequate CS, lack of guiding principles and uncoordinated counselling services is echoed in a few other articles presented in symposiums and international conferences (Msimanga & Moeti (2018). Watkins (2014, p.252) opined that; "At the recent International Interdisciplinary Conference on Clinical Supervision that international flavour was also nicely displayed, with attention being given to supervision in Botswana, Bulgaria, Cyprus, Denmark, Germany, Greece….." and go on to state that; "Also noted was a virtual absence of any type of supervisor training experiences, and the sore need for more attention to providing such educational opportunities". Muchado (2018, p.743) concurs stating;

> The counselling profession in Botswana is at infancy.
> There are no regulatory standards of practices, national licensure
> bodies or accredited training programs. The services lack cohesive structures.
> Rapid growth of counselling is largely due to the epidemic resulting
> in widespread counselling and testing centres.

Given that most people providing counselling in the country appear to lack training, it was important to explore the knowledge, attitude and practices of CS to establish if there was CS in Botswana, as Watkins (2014, p.251) asserts; "where there is a psychological treatment, there is a need for psychological treatment supervision, as the practice of psychotherapy and counselling has become increasingly globalised".

American Counselling Association ([ACA],2014) and other global regulating bodies articulate codes of ethics in counselling and clinical supervision. Wosket (2017) states; "Supervision and accreditation are the ways we appear to have chosen to regulate counselling and raise it to the status of a profession".

However, despite global trends and standards, Botswana seems to lack evidence of clinical supervision practice; local literature indicates limited information on CS and mostly reveals concerns over a lack of

coordination of counselling services, poorly structured and non-existent CS intervention in both public service and private practice (Msimanga & Moeti,2018; Muchado,2018).

According to Muchado (2018), Botswana Counselling Association (BCA) was established in 2000 as a regulatory body; however, it still struggles to receive recognition in the country. Msimanga and Moeti (2018) also state that due to a lack of effective coordination, lack of licensure and accreditation, there is a lack of standardised ethical guiding principles and many counsellors in Botswana do not have access to CS. There is a limited number of qualified clinical supervisors in the country, and this is what inspired the need to explore this phenomenon to establish the extent of the problem; this study aimed to develop knowledge and empirically establish the status quo.

Benchmarks from some international counselling regulating agencies such as American (ACA), Australian (ACA), and British Association for Counselling and Psychotherapy (BACP) proved helpful to the study.

There is a concern regarding knowledge, attitudes and practices of clinical supervision and very little evidence of any research ever conducted in Botswana on this concept, available literature appeared to have focused mainly on the challenges facing the implementation of counselling.

1.2 Purpose of the Study

Mixed methods (quantitative and qualitative) research investigated the knowledge, attitudes and practices of clinical supervision among counsellors in Botswana with the intention to establish the level of access, determine knowledge, examine attitudes, determine practices, investigate ethical principles guiding the clinical practices, and examine possible strategies for improvement in the country as no such study has ever been ventured into. Establishing the status of CS was significant for building knowledge to inform practice, policy and influence development in this field.

Despite global trends, CS practice seems to be an unchartered territory in Botswana (Borders,2015; Msimanga & Moeti,2018; Ellis, 2017), which is not surprising as Muchado (2002), Msimanga and Moeti (2018) assert that counselling is still in its infancy stage in the country where mental health stigma is prevalent.

With the establishment of new counselling centres in communities and introduction of counselling in schools, study aimed to establish the clinical supervision practices of counsellors. The purpose was to create knowledge and more understanding of CS to influence practical change and bring transformation through a scientific knowledge resource.

Botswana has ten (10) geographical districts; study purposively recruited participants from only 5 of the districts. Respondents were male and female counsellors aged between twenty-five (25) and sixty-five (65) with 3 and more years of experience. Respondents were drawn from Central, Kgatleng, Southeast, Kweneng and South (Southern) districts. The study was not intentional in explicitly studying either gender, it was not gender-specific or attempting to create a gender-balanced sample, but allowed the data to reveal which gender was predominant (Bedi et al.,2016). Nonetheless, global literature shows that there are more females than males in the counselling and psychology field (APA,2022; Lin et al.,2015; Zauderer, 2023) and a local database does not exist (Opondo et al.,2020).

1.3 Aims and Objectives

To:

1. Establish the level of clinical supervision access by counsellors in Botswana
2. Determine the knowledge of counsellors towards clinical supervision in Botswana,
3. Examine the attitudes of counsellors towards clinical supervision in Botswana,
4. Determine practice of clinical supervision by counsellors in Botswana,
5. Investigate ethical principles that guide counsellors in Botswana,
6. Examine possible strategies for improvement of clinical supervision

1.4 Nature and Significance

Study used quantitative and qualitative methods, data was collected using the structured questionnaire and semi-structured interviews. The study sample was not gender-specific; practising counsellors of any gender were drawn from different counselling environmental settings. Clinical supervisors' voices were added through interviews using open-ended questions.

The study is grounded on three theories of social constructivism to provide a framework from the Knowledge, Attitudes and Practice (KAP) stance whilst the literature review was guided by theories of clinical supervision and psychotherapy.

1.4.2 Significance of the Study

According to Sano (2019), clinical supervision provides a safe forum for novice counsellors to receive mentorship, coaching and clinical support from experienced counsellors. Literature (Bernard & Goodyear,2014; Msimanga & Moeti,2018; Ellis,2017; Bland,2012; Walsh-Rock,2018) further reveal that CS is an important evaluative intervention for counsellors' psychological and professional development. This research was essential to provide empirical information on the existence of a knowledge gap between CS theory and practice. The study unearthed empirical information to help bridge the knowledge gap and help strengthen coordination, influence change in counsellor education and CS development in the country.

Despite the existing plethora of literature on clinical supervision internationally, little can be said about the intervention in Botswana despite Bland's (2012) argument that CS is a foundational training and development service for mental health professionals essential for development of professional counselling skills.

Local literature (Msimanga & Moeti,2018; Muchado,2018; Bhusumane et al.,2010) show that with counselling centres established in every corner of Botswana, there was a need for professionalisation of clinical supervision. The significance of CS service is echoed by various scholars (Borders,2015; Ellis,2017; Walsh-Rock,2018; Bland,2012), and yet since counselling is a new profession facing various challenges in Botswana such as lack of coordination, ineffective regulation, lack of accreditation and licensure, unqualified and limited research, little can be said about the existence of CS. Therefore, the situation has become a matter of concern requiring professional standards and empirical evidence to influence change. Msimanga and Moeti (2018); Muchado (2018), and Bhusumane et al. (2010) agree that lack of clinical supervision is one of the challenges hindering the development of counselling in Botswana.

Given this situation, the focus of this study on the knowledge, attitude and practices of CS among counsellors helped to establish the status quo and provide empirical knowledge and evidence as very little

research was done except for a few articles presented at international conferences raising alarm. Hence, Muchado (2018, p.746) opined:

> There is a growing concern about issues of standard of practice due to several paraprofessionals and untrained people offering counselling. Counselling practice in Botswana is not regulated therefore, this is a concern about the welfare of the clients and the quality of service provided. The problem of malpractice, supervision and misconduct by practising professionals will always be a great concern if there are no regulatory standards.

Therefore, this study aimed to contribute to knowledge resources for subsequent research and provide a new impetus for further scientific development and transformative practical change and development.

1.5 Questions

Q1. What is the level of clinical supervision access by counsellors in Botswana?

Q2. What is the knowledge of counsellors towards clinical supervision in Botswana?

Q3. What is the attitude of counsellors towards clinical supervision in Botswana?

Q4. What is the practice of counsellors towards clinical supervision in Botswana?

Q5. What are the ethical principles that guide counsellors in Botswana?

Q6. What are the strategies for improving clinical supervision in Botswana?

1.6 Purpose Statement

Mixed-method research investigated knowledge, attitude and practices of clinical supervision among counsellors. To do that, this next chapter attempted to extensively review available empirical literature related to the phenomenon. Eight main areas are discussed starting with a chapter introduction that gives a brief outline of what to expect from the literature review followed by a brief discussion of quantitative and qualitative research methods, theoretical framework, underpinning theories to the study and description of the counselling industry under which this research is conducted followed by definition of key concepts. With contemporary counselling being relatively new in Botswana, the historical background of counselling and the current status

of clinical supervision are briefly discussed based on available local and international literature to establish the amount of empirical work already done.

1.7 Limitations of the Study

This has some limitations synonymous with research studies; the research topic; “The knowledge, attitudes and practices of clinical supervision among counsellors in Botswana” was the first limitation of the field of study and professionals to be engaged; the scope, location and population parameters were equally limitations. The study specifically utilised mixed methods in which the explanatory sequential research design was deployed which was time-consuming. The study targeted only practising counsellors and clinical supervisors aged 25-65 with 3 and more years of experience drawn from only 5 geographical districts, therefore, the sampling of convenient districts from which respondents were drawn excluded inaccessible districts and remote-based counsellors. Similarly, the use of the self-developed questionnaire attracted validity and reliability issues that demanded pre-testing of the instrument. There were also complexities of having adopted the eclectic theoretical framework, triangulation of methods and data analysis techniques which demanded precision and skills. The greatest limitation was that data collection coincided with the COVID-19 lockdowns. The next chapter reviews literature related to clinical supervision to establish existing empirical information and research gaps.

CHAPTER 2: LITERATURE REVIEW

Chapter Introduction

Begins by reiterating main research purpose which was to investigate the knowledge, attitudes, practices of clinical supervision among counsellors in Botswana. Counselling is still at an infancy stage in the country with little evidence of the existence of CS. This section also describes the quantitative and qualitative research methods, literature review databases, search engines used, theoretical framework and a description of the counselling industry; these formed the first section. Second section defines key concepts, historical background of counselling, the current situation in Botswana, detailed discussion on models of clinical supervision, types, benefits, perceived negative side followed by cultural implications and summary. Literature review centred on these issues to unearth extensive body of information significant to this study.

The study findings from combined quantitative and qualitative research approaches used aimed at creating scientific knowledge to help find a solution to a prevailing clinical supervision phenomenon in Botswana. Therefore, it was necessary to briefly discuss the two methods in this literature review.

2.1 Quantitative and Qualitative Research

This study sequentially combined quantitative and qualitative methods to accumulate body of knowledge, therefore, a brief discussion of these two methods was deemed necessary. Combining methods and techniques gave depth and quality to data; Puzanova, Larina & Ignatova (2023, p.866) argue that “One of the ways to obtain representative data is the combination of several sociological techniques”.

2.1.1 Quantitative Research Method

To inform and improve socio-economic activities and social sciences requires evidence-based interventions and approaches based on scientific research to develop new interventions or improve existing ones. Therefore, in such instances, scientific methods are deployed to extract and accumulate scientific knowledge.

In this study, two scientific approaches and methods were utilised; the positivist and the interpretivist approaches through the quantitative and qualitative methods. These methods are informed by ontological and epistemological underpinnings (Antwi & Hamza,2015).

Antwi and Hamza (2015) purport that the quantitative is ontological philosophy of objectivism and epistemological assumption of positivism whilst the qualitative research approach is underpinned by the ontological construct of constructionism and epistemological assumptions of interpretivism. Furthermore, ontology is considered to be a branch of philosophy that is focused on articulating the nature and structure of the world in describing the form and nature of reality. There are two broad contrasting schools of thought or ontological positions; objectivism and constructionism; objectivism holds the belief that there is an objective, independent and measurable reality, whilst constructionism's perspective is that reality is the product of social influences and is constructed by individuals within their environmental settings (Neuman, 2007). In other words, according to objectivism, scientific knowledge has to be objective, quantifiable and divorced from human influence. Therefore, through positivistic thinking, researchers adopt scientific methods and systematise ways of generating knowledge through numeric quantification, hence assumed to improve the precision of the description and the relationship among the variables. Upon this perspective, Arghode (2012) and Onwuegbuzie and Daniel (2003) argue that positivism aims at unearthing “truth” and presenting empirical knowledge descriptively. Therefore, under the positivist philosophical assumptions, the quantitative research method was adopted and questionnaires utilised for data collection.

The positivist stance assumption is that scientific knowledge consists of facts as its ontology focuses on the reality assumed to be independent of social construction as researchers adopt an ‘objectivist’ perspective; a realist approach ensures that researchers maintain a detached epistemological stance (Elkatawneh, 2016; Addo & Eboh, 2013). Literature reveals that due to the detached stance, objectivity is assured and researcher bias and data bias are eliminated or reduced as experimental methods and quantitative instruments and measurements are used to test hypothetical generalizations to facilitate transferability and generalizability of findings to larger populations and different settings (Golafshani, 2003).

According to Neuman (2007), the quantitative approach combines deductive logic with precise empirical observations of behaviour such as CS to discover and confirm a set of probabilistic causal laws that can be used to predict general patterns of human activity.

The quantitative method therefore is perceived as an inquiry into an identified social phenomenon to test a theory on variables, and it is measured numerically to reach conclusions and the data collected is analyzed using descriptive statistics (Mack, 2005). The main goal of the quantitative method is to determine whether the predictive generalizations of hypotheses are true or false (Bashir et. Al.,2008). Daniel (2016) opines that quantitative research is based on deductive and logical thinking of cause-and-effect to test hypotheses and develop generalizations to facilitate a better scientific understanding of the phenomenon being investigated. Therefore, data collection techniques gather quantifiable information which can be statistically analysed and numerically represented; it is done through the application of statistical techniques (Bashir et.al, 2008; Bryman, 2007). However, it is possible to approach research not only from the positivist objectivist epistemological and ontological position but also from the interpretivism (constructivism) stance. Hence, a brief discussion on the qualitative method.

2.1.2 Qualitative Research Method

Unlike the quantitative method, the qualitative method hinges on the interpretive constructivism underpinnings explicitly aimed at explaining the phenomenon from the subjective reasoning based on participants' experiential knowledge, subjective opinions, lived realities, meanings, attitudes and motivations behind their social behaviour. Therefore, this approach provides insight into the phenomenon of investigation thereby giving in-depth information and understanding from respondents' perspective.

Daniel (2016) reiterates that, unlike quantitative research, qualitative research is based upon a qualitative process of inquiry aimed at gaining an understanding of a social phenomenon from various perspectives.

Given this understanding, qualitative research is best conducted in a natural setting for a holistic perspective of the phenomenon as experienced by the participants.

The approach gives respondents a voice, therefore, it is upon this understanding that qualitative research is said to be primarily inductive in logic and subjective rather than objectively detached. Hence, Elkatawneh (2016), Neuman (2007) and Golafshani (2003) argue that; unlike in the positivistic approach, interpretivists believe that social phenomenon is based on the assumption that reality is a human construct which is socially constructed by those who live it.

Given these perspectives, suffice it to say that interpretivism derives its construct from an in-depth investigation of the participants and the problem being investigated. Therefore, from the interpretivist assumption, knowledge and meanings are acts of the researcher's interpretation and the respondents' lived experiences. Interpretive researchers' access to reality is through social constructions and voices of those being studied. Similarly, from the interpretive paradigm interpretations are based on observations, interviews, case studies and open-ended questions about the phenomenon and the data collected is interpreted to make meaning and draw inferences (Neuman, 2007).

According to Onwuegbuzie and Daniel (2016), the interpretive paradigm is concerned with understanding the world as it is perceived and experienced by individuals, therefore, researchers use meaning, patterns and themes rather than measurement methodologies, and data is derived from interviewing respondents, observations and relies on respondents' subjective views, not researchers' detached stance. It is essential to note that interpretive research does not predefine dependent and independent variables but focuses on the full complexity of the human sense and therefore, it is inductive rather than deductive in approach.

Contrary to the positivistic approach, the interpretive philosophical perspective upon which qualitative research is based views the world as constructed, interpreted and experienced by people in their interactions with each other and with their environments. Based on this paradigm, the nature of inquiry is interpretive to gain an in-depth understanding of a particular problem (Pathak et. al., 2013).

Interpretive paradigm research is applied to real-life situations as they unfold, as such, the methods used are non-manipulative, non-controlling and unobtrusive (Onwuegbuzie & Daniel, 2003).

Antwi and Hamza (2015, p.221) opine that qualitative research "uses a naturalistic approach that seeks to understand phenomena in context-specific settings" and researchers focus on understanding meanings, and experiences to make sense of the phenomenon from the respondents' perspective. It is upon this view that literature underscores that qualitative research method is inductive because it aims to authentically, empathetically and genuinely discover respondents' lived truth. Given this understanding, Daniel (2016) and Elkatawneh (2016) state that the main concern for the qualitative approach is research problem in its unique context from the humanistic subjective perspective rather than from the deductive and numeric approach, hence open-ended interviews were deemed appropriate in the qualitative phase of this research, and data is narrative words that formed codes and themes that were thematically analysed to establish patterns and meanings.

Research methods have inherent differing limitations hence literature show some researchers prefer to use mixed methods or methodological triangulation to reduce systematic bias in the data and reduce researcher personal biases, that was the reasoning for mixing quantitative and qualitative in this study.

2.2 Databases and Search Engines

Literature review focused on critical databases; counselling books, peer-reviewed journal articles, seminal and international conference presentation materials in clinical supervision, counsellor education websites, counsellor supervision journals and articles on cultural and multicultural aspects and implications on clinical supervision, ethical standards; different counselling ethical codes; professional guidelines and principles, as well as any professional clinical articles published by counselling regulating bodies. Doctoral dissertations on clinical supervision, CS theories, CS models, controversies surrounding the intervention and the possible harm associated with the practice were also consulted. Search engines and databases utilised included Google Scholar, Google Books, seminal and conference presentations, dissertations, ERIC, PsychINFO, the ProQuest electronic Journal dissertation platform and various university websites. CS is a common phenomenon across mental health professions, therefore, search engines yielded extensive literature on clinical supervision related to Counselling, psychology, school counselling, Counselling Psychology,

Guidance and Counselling, Counsellor education, multicultural counselling, psychiatric nursing, Family and Marriage Therapy, Social work and spiritual counselling.

The search focused predominantly on journal publications between 2015 and 2023 purposefully centred on the variables of clinical supervision. However, the review was expanded to include older research due to a limited number of recently peer-reviewed journal articles due to CS being a fairly new concept with very little research done thus far.

Keyword search involved variations and a combination of words to locate specific literature relevant to clinical supervision and these included; counsellor supervision, counselling supervision, Counselling education, Counsellor supervisor, clinical supervisor, ethical principles, counselling mentorship, counselling ethics, counselling standards, counselling codes, code of ethics, counselling principles, counselling theories, supervision models, clinical models, supervision theories, theories of supervision, models of supervision, multi-cultural supervision, multicultural counselling, types of supervision, definitions of supervision, counsellor competency, counselling efficacy, harmful supervision, counselling ethical compliance, supervisor-supervisee relationship and ethical clinical practice.

To access information on the historical background and earlier contributions made in CS an exception was made to locate earlier work done in the field locally and globally.

2.3 Theoretical Framework and Industry Field

This section articulates the theories upon which this research was grounded, the section also discusses all other theories that were reviewed and considered for underpinning the study which were however not deemed suited and justification for the choices made. These included the Social Constructivist theory, Husserl's Phenomenological theory. Theory is an abstract concept and most practices and research are grounded on theory.

There is no doubt that theory plays a significant role in research by providing guidance, organization, structure or foundation for a better understanding of the phenomena being investigated.

Research hinges on theoretical grounding, hence the importance of theoretical understanding and theory building (Litoiu,2015; Cinotti,2014).

Theory helps to make sense of findings, on this basis, Wacker (1998,20080) and Glanz (2017) argue that theory is essential in providing a research framework to help with data analysis and presentation of the findings. Kivunja (2018) also opines that theory forms an intellectual base upon which research data analysis and interpretation are grounded. Since theory helps establish the relationships between variables and builds a theoretical framework for research, every researcher has to identify theories suited to the research topic (Grant & Onsanloo,2016).

Various theories of knowledge, attitude and practice (KAP) were reviewed for suitability, selecting an appropriate theoretical framework to form the basis for this study was not an easy task, daunting as it was, a selection had to be made based on assumed compatibility between theories and the research topic (Grant & Osanloo,2016).

The framework was considered as having potential to provide perspective and inform presentation. Not every theory is suited to underpinning research in human social behaviours. Grant and Onsaloo (2016) argue that a theoretical framework can be equated to a "blueprint" for the entire research process as it gives direction, foundation and structure upon which researchers are to support their inquiry. KAP theories were reviewed for underpinning and undergirding the researcher's thinking process in this study through social constructivist approach and triangulation of three theories (Denzin, 2007,2012).

2.3.1 Constructivist Theory

Constructivist theory was thought to align well with the purpose of this study as it hinges on the constructivist principles of learning, growth and development (Goodyear, 2014; Bernard &Goodyear,2014), and correlates well with clinical supervision developmental models such as the discrimination model as CS is a professional development intervention. According to various scholars (McLeod,2014; Liu & Matthews,2005; Kurt,2020; Vygotsky & Cole,1978), constructivism was popularised by scholars such as Dewey (1933-1998) who was considered the philosophical founder of this theory and Bruner (1915-2016), and Piaget (1896 -1980).

Kurt (2020) and Adom et al. (2016) share the same sentiments that Piaget was well-known for cognitive constructivism, whilst the social constructivist theory was pioneered by Vygotsky (1896 1934). Vygotsky's work was first published in Russian around the 1930s before he died in 1934, his work was later translated into English and published around 1978.

Theory of social constructivism being more rooted in psychology and philosophy, and clinical supervision being from the sociological and cultural perspective was considered a suitable (Liu & Matthews,2005; Alzahrani & Woodllard, 2013). The assumed suitability was based on the belief that it gives the much-needed insight into participants' experiential self-reported disclosures as practising counsellors to tell their stories through semi-structured interviews and construct meaning from their experiential understanding of clinical supervision.

Guiffrida (2015) postulates that; "Clinical supervision is central to the successful training and ongoing professional development of counsellors and psychotherapists", in that view; this theory was thought to be a perfect fit because of its principles of learning and development as the supervision practice is anchored on professional development; knowledge, attitudes and practices. Similarly, some scholars (Bowen,1976; Sano,2019) argue that theories of clinical supervision, psychotherapy and counsellor education are anchored on constructivism. The literature revealed that Constructivist theory has been used in several social sciences research studies to provide an understanding of social behaviours; knowledge, perceptions, attitudes and practices and hence its assumed suitability in this study.

Adom et al. (2016) assert that; the constructivist philosophical paradigm is an efficient tool that can yield many benefits when implemented in conducting research in diverse fields of study. Furthermore, Guiffrida (2015) and Sano (2019) postulate that research participants often prefer giving their side of the story based on their lived experiences. Therefore, the use of constructivist theory as a foundation to guide the exploration of counsellors' knowledge, attitudes and practices of CS from the social sciences' perspective was considered significant to underpin this research.

However, the nature of the data collection methods required such as ethnography demanded an extensive amount of time to spend with research participants, the implication of time inherent in constructivism led to

re-evaluation and ultimately weighing the benefits against the time factor, and only some aspects of the theory were adopted to allow participants to construct meaning of the phenomenon from their perspective but within the suited research time frame. As argued by Adom et al. (2016), researchers who need a "relatively shorter time in concluding cannot underpin their research entirely on the constructivist philosophical paradigm".

Since social construction is embedded in a phenomenological reinterpretation of the social sciences, Husserl's phenomenological theory was another possibility for grounding the research (Grand et al.,2015).

2.3.2 Husserl's Phenomenological Theory

Phenomenological theory was popularised by Husserl in 1928, who is a recognised pioneer and founder of phenomenology. The theory is considered "the science of the essence of consciousness" shared by people from personal lived experiences. It holds the view that understanding meaning can be explained by different types of experiences lived by individuals. The theory provides an opportunity for participants to understand and give meaning based on their attitudes, perceptions, imagination, and assessments to make conclusions based on their understanding and knowledge of the phenomenon (Giorgi,2009). According to Smith (2013), this theoretical approach is concerned with daily social human experiences and calls for direct interaction with those being studied to capture their experiences verbatim (Moustakas,1994; Smith,2013).

Concurring with this view are Zahavi (2003) and Cohen et al. (2009) who argue that Phenomenology advocates for the study of personal experiences, and views behaviour as influenced by the experienced phenomena and not by objectivity or independent assessment. Thus, implying the influence of subjectivity over objectivity as individuals construct their meaning. Reaching the same conclusion are Zahavi (2003) and Giorgi (2009) who argue that the intentionality of consciousness is not a result of an external influence only, but emanates from one's internal processing of experiences and assessment of the benefits against the risks which gives a better understanding of the phenomena in its given social context and social setting.

This theory's assumption hinges on the belief that people's actions and behaviours are influenced by the knowledge, attitudes and practices of those around them; those in their social settings; as such, the tendency is to adopt societal views and behaviours to fit the societal and cultural narrative and expectations (Cohen et al., 2009; Giorgi,2009; Smith,2013; Zahavi,2003).

A benchmark was done to establish any existing studies where the framework was successfully applied in mixed-method research; however, it appears to have been used extensively in grounding qualitative studies; for example; Gabarde (2020) used it in her qualitative research study titled "Phenomenological Study Exploring Emotional Intelligence and Mindfulness in the Workplace".

However, the theory did not seem to align well with the purpose of this study and according to Admon et al. (2016) perceptions (attitudes), knowledge and behaviours can be explored better through engaging theories of knowledge, attitudes and practice (KAP), hence third theory reviewed.

2.3.3 Theory of Reasoned Action (TRA)

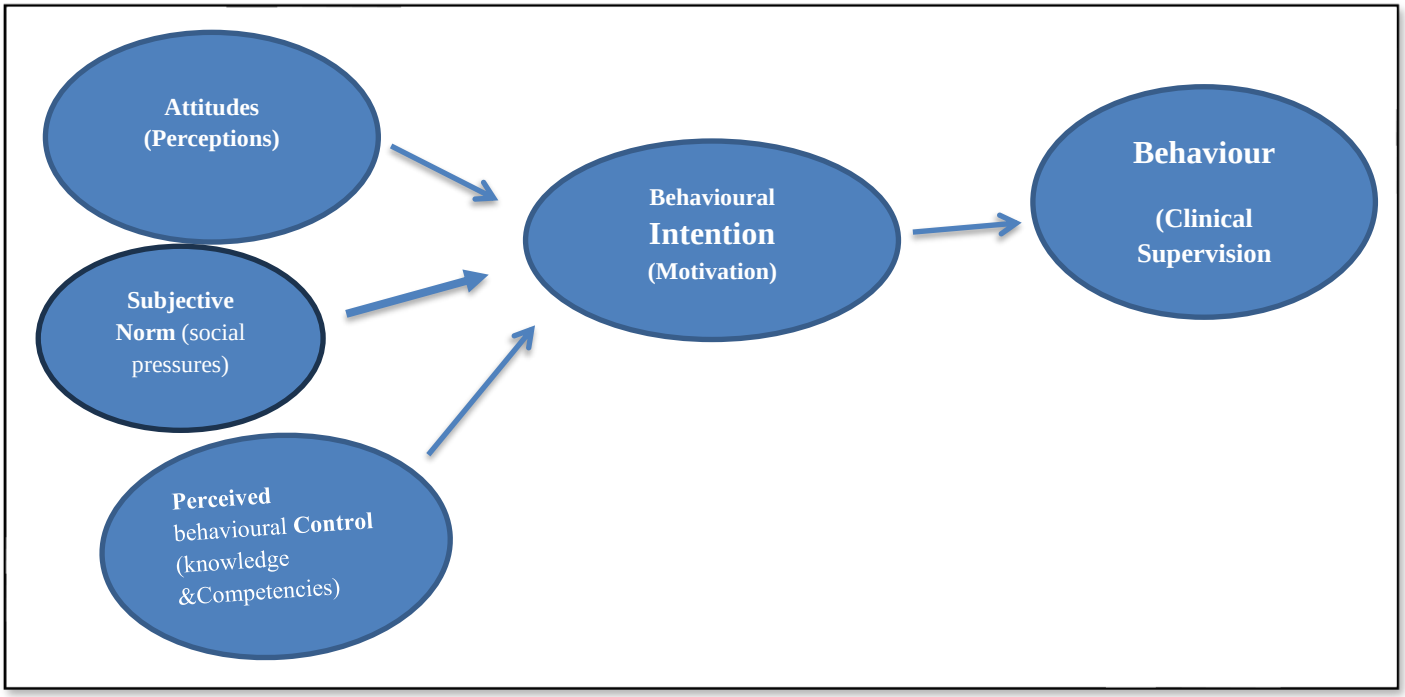
Literature reveals that in 1980s as an improvement of Anderson's Information Integration theory was done (Luenendonk,2019; Ajzen & Fishbein 1975, Ajzen & Fishbein 1988**).** According to Ryan and Carr (2010), it was upon this theory that TRA emerged and assumes that intentions of the individual reflect one's attitude and perceptions on the possibility of performing specific behaviours. Madden et al. (1992) assert that this theory has been widely used by scholars as a model for the prediction of behavioural intention. Moreover, Sheppard et al. (1988) argue that the model adequately predicts the behavioural intentions and behaviours to be deployed in informing behavioural modification strategies.

The theory is concerned with attitudes, subjective norms and intentions of individuals toward performing a particular behaviour, however, it also depends on whether positive behaviour is produced. This theory allowed for the exploration of knowledge towards clinical supervision (Madden et al.,1992; Ryan & Carr,2010).

Sheppard et al. (1988) assert that apart from attitude and subjective norms, whether or not individuals believe they have the knowledge and competencies to perform the behaviour plays a significant role in executing the behaviour; implying that the performance of the behaviour is linked to self-evaluation of abilities and potential benefits to be derived. Therefore, it can be inferred that behavioural intention alone may not necessarily lead to the execution of behaviour. Relating this theory to this research provided a conceptual understanding of attitudes practices among counsellors. Below are components as it links to this research topic (Hale et al.,2002).

Figure 2

Showing Components



Adapted from Hale et al. (2002, p.261). Basic Components of Theory of Reasoned Action

Since the research study could be grounded on a set of theories, the fourth theory that was considered was the Theory of Planned Behaviour (Grant & Onsanloo,2016).

2.3.4 Theory of Planned Behaviour (TPB)

Literature show that Fishbein developed the theory in the early eighties as a buildup of the theory of reasoned action (Luenendonk, 2019). This was considered suitable because this study focused on understanding the link between attitudes and behaviour. As a theoretical base, it helped explain the influence of attitudes on human social behaviour. It assumes that people are rational and their actions and behaviours are mostly influenced by their assessment of the implications and benefits of executing a behaviour (Ajzen & Fishbein, 2005; Fishbein & Ajzen,1977).

TPB helped examine the probability individuals may execute certain behaviour and entails beliefs. Consequently, the desire to perform certain behaviour is mostly influenced by the individual's attitudes towards that behaviour, therefore, the behavioural intention can be a determinant of one's willingness towards

performing specific behaviour (Madden et al.,1992; Ryan & Carr,2010). Individuals' attitudes towards performing a behaviour greatly influences their intention; for example; people are often inspired to perform the behaviour if there are perceived positive benefits.

Looking at this research through this theoretical lens enabled inferences to be made that counsellors may be inspired to access and conduct clinical supervision if there were perceived benefits. Subjective norms also play a significant role because often people are motivated by the social environment, trends, narratives, external and social influences or social pressures (Akpeh & Ezeoke, 2017; Luenendonk, 2019). TPB model assumes that an individual with a combination of a positive attitude, strong intentions, objectivity and positive perceived behavioural control is more likely to perform the behaviour than someone with a deficit of the same (Akpeh & Ezeoke, 2017; Fishbein & Ajzen,1977).

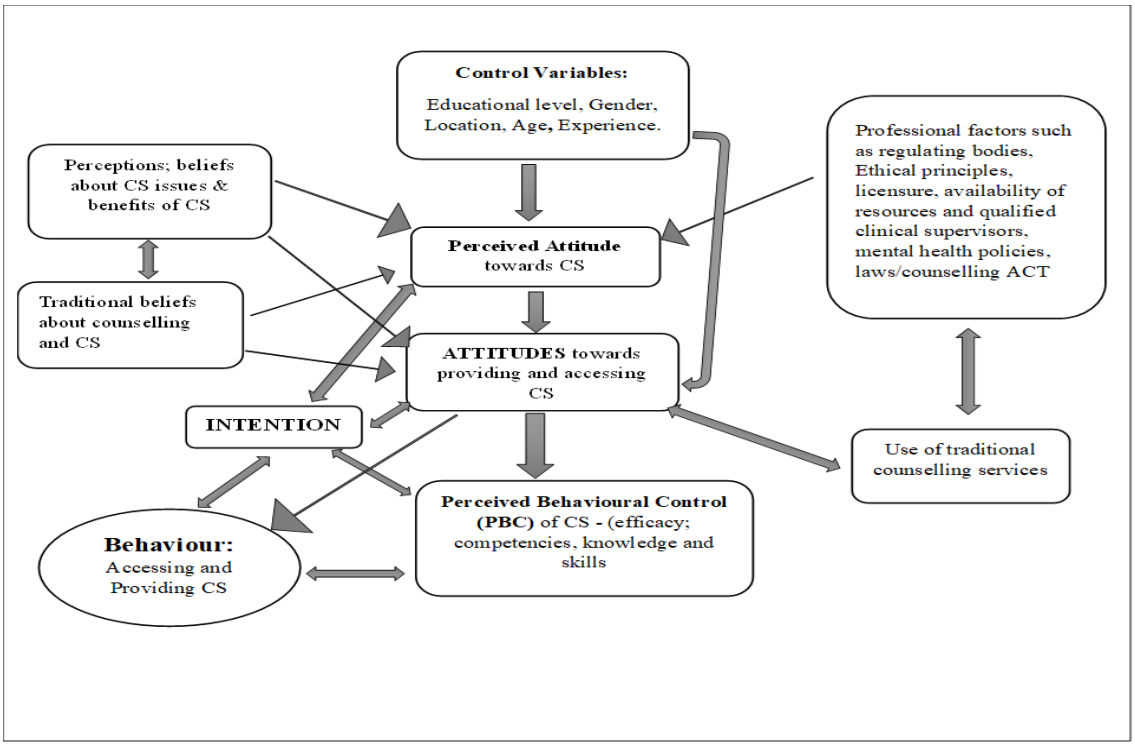
Based on these underpinnings, the assumptions were that the knowledge, attitudes and practices of CS among counsellors in Botswana could be impacted by a lack of competencies and confidence to conduct clinical supervision. The interaction between counsellors' normative beliefs, behavioural beliefs, perceived behavioural control, subjective norm, attitudes and knowledge and intentions may have had a significant role in the CS practice.

The review benchmarked and established that this theoretical framework was successfully used by Akpeh and Ezeoke (2017) in their study entitled; "Knowledge, Attitude and Practice (KAP) Study of Diffusion of Flood Alert Campaign in Anambra". Having identified and adopted the eclecticism; theoretical triangulation purported by Denzin (2007,2012), this study was underpinned by three theories and adopted the conceptual framework model from Tanhan (2017) and Tanhan and Young (2021) as indicated in Figure 3;

Theoretical/Conceptual Framework

Figure 3

Showing Conceptual Framework



Adapted from Tanhan and Young (2021, p.1970)

2.3.5 Industry Field Description

Counselling falls in the mental health field, Mental health covers various professions such as psychotherapy, social work, psychiatry, Family and Marriage therapy, nursing, pastoral counselling and psychology. On these grounds, there are a variety of definitions of counselling and clinical supervision in each of these different professions (Allan et al.,2016).

Carroll (200l) perceives counselling as; “a process of helping” those in need of mental health services, some define it as a “helping professional relationship” between someone who needs mental health assistance and a therapist. Borders (2015) and Stones (2002) describe counselling as “a helping profession which therapeutically empowers a client to find alternatives to challenges”.

Similarly, Wosket (2017) assert that it is a "therapeutic relationship between a Counsellor and a client" intended to help the client process and find solutions to their personal, mental and social problems to ultimately regain emotional and mental equilibrium. Sheppard (2015, p.1) goes on to quote BACP (1986) definition;

> The skilled principled use of relationships to facilitate self-knowledge, emotional acceptance and growth and the optimal development of personal resources……. working through feelings of inner conflict or improving relationships with others.

However, the definition had a series of reviews over the years and currently is defined as; "A specialized way of listening, responding and building relationships based on therapeutic theory and expertise that is used to help clients or enhance their wellbeing" (BACP,2018-19, p.118). Olanrewaju and Suleiman (2019, p.31) stated that;

> Guidance and counselling are services that all human beings need at one point in their life. There is no human being that has never had a problem at one point or another…...

Similarly, in 1997 American Counselling Association (ACA) defined counselling as: "the application of mental health, psychological or human development principles, through cognitive, affective, behavioural or systemic interventions, strategies that address wellness, personal growth, or career development, as well as pathology". Today the same association defines counselling as; "a professional relationship that empowers diverse individuals, families and groups to accomplish mental health, wellness, education, and career goals" ([ACA],2014, p.20).

This study adopted American ([ACA],2014) definition due to its holistic approach to the Botswana Counselling situation. The counselling field has a quality assurance service achieved through clinical supervision conducted by more experienced and qualified counsellors who are also trained in clinical supervision.

Wheeler and Richards (2007) opine that clinical Supervision is a systematic review, assessment or monitoring and evaluation process with developmental intentions, not a fault-finding endeavour.

CS is not necessarily administrative but a clinical service that provides professional growth and clinical support to counsellors to ensure clinical competency and quality counselling service (Allan et al.,2016).

According to Wosket (2016), it is a professional relationship aimed at improving counsellors' competency aimed at ensuring client safety whilst protecting the integrity of the profession. A myriad of literature shows immense benefits of clinical supervision when it is well-structured and well-implemented in providing clinical support; debriefing, mentoring and coaching to less experienced therapists for professional growth and effectiveness of service (Carroll,2001). However, ensuring effective counselling as advocated for by Carroll (2001) can only be guaranteed through ensuring access and compliance to clinical supervision.

2.4. Definition of Key Concepts

In this section, concepts and terms relative to the present study were reviewed and comprehensive definitions articulated, these include; clinical supervision, perceptions, attitudes, knowledge and practice, supervisor, supervisee and ethics. Though clinical supervision was briefly defined under the field industry, there was a need to reiterate here.

2.4.1 Clinical Supervision

Clinical supervision entails supportive, developmental and educational activities aimed at improving the supervisee's counselling competencies, viz; knowledge, skills and techniques derived from the practice. Throughout this study clinical supervision, counsellor supervision and supervision are used interchangeably. A myriad of literature exists on clinical supervision, this section of the literature review attempted to adequately discuss the various existing definitions of clinical supervision. Since counselling is relatively new in Botswana, clinical supervision of counsellors is equally a new phenomenon.

Bernard and Goodyear (2004,1998) state that the field of supervision has expanded dramatically since 1992 through the formulation of theoretical frameworks and supervision models based on empirical research

"to inform the practice, and yet it is still a relatively new field of study". Glaes (2010) also posit that; "the current supervision models are still considered to be in their developmental stages".

It is again on this premise that Neill and Stoltenberg (2016, p.3) assert that clinical supervision blossomed or rather "exploded" in the early eighties;

> IDM as an approach to supervision has progressed for nearly 30 years….
> the influence of this initial presentation from a developmental perspective
> led to an "explosion" of developmental conceptualizations.

Clinical supervision practice is a well-regulated and well-defined intervention in counselling, psychiatry and nursing. In these professions, the activity is well laid out with a theoretical framework and underpinned by ethical codes as a requirement. It is upon this perspective that various mental health governing bodies act as gatekeepers to the professions and have developed ethical codes.

According to Levy (2004); Duncan et al. (2014) and Linton (2003) the importance of CS is undeniable as evident from counsellor education programmes, which is the reason why the practice has become an essential component of mental health training to "align knowledge, theory and practice", hence it has become a common practice across mental health professions and now a specialised field or profession. Based on this understanding, Johnson (2020) postulates that it is significant in counselling and an important instrument for ensuring effective and ethical counselling practice. Goodyear (2014); Australian Counselling Association ([ACA],2016,2019), Australian ([APS],2007); American ([APA],2014,2015) show that CS is a crucial service that facilitates learning.

Similarly, Feldstein (2000) argues that supervision is aimed at enhancing counsellors' clinical knowledge and skills in the counselling process. It is perceived as a means of coordinating, monitoring, directing or overseeing the counselling process (Johnson, 2020). Johnson (2020) goes on to say that it is a service intentionally designed to improve the practical application of counselling theories and techniques, therefore, has inherent educational and developmental functions provided by clinical supervisors through clinical support, mentorship, coaching, educational and facilitative approach to supervisees during the supervision process.

Literature portrays CS intervention as an instrument of quality assurance in counselling for the improvement of supervisees' competencies.

The word Counsellor in this study refers to anyone providing any service considered to be therapeutic such as "talk therapy", psychotherapy or Guidance and counselling. Whilst client (s) refers to an individual(s) who receive a therapeutic mental health service that includes counselling service and clinical supervision. Clients are usually individuals, couples, families or groups of people and sometimes specific organisations who access counselling such as schools and communities and in CS that could be a group of counsellors ([ACA], 2019).

Literature review unearthed myriad definitions all sharing themes, for example; many of the definitions of clinical supervision appear to be adaptations of Bernard and Goodyear's (2004) and Loganbill et al., (1982). Many counselling regulating bodies also appear to have adopted Bernard and Goodyear's (2004) definition. Definitions generally portray the clinical practice as an educational and developmental service critical for improvement of counselling competencies with the gatekeeping function and integrity of counselling.

Sampled in this literature review are a few of the many definitions of clinical supervision. Literature (Cook, 2008; Feldstein, 2000; Lyman, 2010; Glanz, 2020; Bernard & Goodyear, 2004; Milne,2007) show that definitions of clinical supervision changed over the years with many centred around Loganbill (1982) and Bernard and Goodyear (2014,2004) definitions with very little modifications; for example, Loganbill; "an intensive, interpersonally focused relationship in which one person is designated to facilitate the development of therapeutic competence in the other person". Bernard and Goodyear (2014, p.9,2004, p.8) improved on the same by adding hierarchical distinction involved in the process describing; "intervention provided by a more senior member of a profession to a more junior member(s) of that same profession".

Bernard and Goodyear (2004) went on to assert that supervision has the monitoring and evaluative aspect, and protection of those who receive the counselling service.

What followed seemed to be a trend of continued adoption of Bernard and Goodyear's definition by many scholars, with very few changes by most. Diverting slightly from this train of thinking is Falender and Shafranske (p2004, p.3) who view it as; "distinct professional activity in which education and training aimed

at developing science-informed practice is facilitated through a collaborative interpersonal process". It is worth noting that there is no hierarchical distinction in this definition, though echoing the same message.

Though Falender and Shafranske (2004,2008) define clinical supervision without hierarchical distinctions, the emphasis is in consistency and that it is facilitated by a trained and experienced counsellor; "regular, ongoing supervision of counselling skills provided by another trained and experienced professional". Benshoff (1988) also clarifies that clinical supervision should not be confused with administrative supervision which is a managerial function focusing on ethical issues, behaviours, professionalism, professional relationships time management and not on the therapeutic clinical counselling process.

Cook (2008) shares a similar view with Benshoff (1988) in pointing out that CS ensures quality counselling process during therapy, whilst the administrative supervision ensures that counsellors are ethically fulfilling their job requirements, job description and on time at work.

Walsh-Rock (2018, p.3) also defines clinical supervision as a "process that requires consistent supervision meetings, usually weekly, for supervisees to process their counselling experiences to bring a higher degree of attention to clinical skills and case conceptualization", whilst administrative supervision "focuses on job performance related to organizational goals".

Similarly, Cummings (2004) views clinical supervision as aimed at facilitating counsellor development and professional growth. Like many other scholars; Cummings (2004) acknowledges that it is intended to facilitate professional growth among supervisees.

The American Counselling Association ([ACA],2014) definition also appears to mirror Bernard and Goodyear's (2004) as it explicitly states the hierarchical aspect and views CS as a collaborative relationship between one offering supervision and the one accessing it. ACA (2014) further perceives it as a clinical process to facilitate counsellor competencies in their counselling process, this description encompasses the role played by the supervisor in the counselling service.

On the other hand, ([SAMHSA],2009, p.3) definition is more on functions without explicitly stipulating hierarchy or characteristics of the supervisor; “a disciplined, tutorial process wherein principles are transformed into practical skills, with four overlapping foci: administrative, evaluative, clinical, and supportive”.

This shows that the facilitator wears multiple “hats” and performs multiple functions as an evaluator, supervisor, teacher, consultant, mentor, coach and administrator depending on the setting. However, Blakely (2009) views it as process; “guiding a less experienced member of a profession with a contractual and formal process” and goes on to say that the professional nature intended is to enhance counselling performance. Additionally, Bland (2012) perceives it as “intervention provided by a more senior member of a profession to a more junior member of that same profession”, thus clearly highlighting aspect of hierarchy, goes on to elaborate saying that; “This relationship is evaluative, hierarchical, extends over time, and has simultaneous purposes meant to enhance the professional functioning of the more junior person(s)” through monitoring counselling service to clients. One can deduce that supervisors also perform the role of professional gatekeepers for those entering the profession and this corroborates Cook’s (2008) view on clinical supervision.

An observation made is that vast definitions mirror Bernard and Goodyear (2004); there are therefore very few differences between all these definitions to Bernard and Goodyear's (2004) which is embraced by many.

Almost all of these definitions perceive clinical supervision as evaluative process, provided or accessed over time to enhance counselling competencies and functioning of junior and less experienced counsellor(s) to ensure quality of counselling services offered (Milne,2007).

In this study, “Supervision” is interchangeably used with “clinical supervision” and “counsellor supervision” as referring to the intentional professional process for evaluation and monitoring of counselling competencies.

In Botswana school context, Guidance and counselling teacher (s) supervision will probably be an activity conducted by the school’s Guidance and Counselling department member with portfolio title of “Senior Teacher 1- Guidance and Counselling”; the equivalent of the school counsellor in other countries. In that context, the situation may differ from one setting to another and from school to another.

Therefore, organizational policies, educational policies and general set-up may have a bearing on the dynamics of the construct of clinical supervision (Luke, 2007). It has become apparent that there are so many definitions of supervision and most of the definitions seem to have borrowed from Bernard and Goodyear (2004), hence Cinotti (2013) postulates that; "the most widely utilized definition of CS is Bernard and Goodyear (2004)'s that points out supervision as an activity centred around the professional relationship between a more experienced member of a profession, and a less experienced one with intentions to inculcate "knowledge, skills and attitudes" to the less experienced practitioner.

The definition clearly describes the nature of the professional relationship as being maintained over a prolonged period with evaluative, monitoring and clinical support functions offered to the less experienced counsellor(s) to enhance relevant competencies for effective provision of psychotherapy.

Supervision is therefore viewed as an instrument of quality assurance; hence supervisors are often perceived as gatekeepers of the profession because they seem to also regulate the licensure, professionalism, and protection of clients and the profession itself. Through this supervisor-supervisee collaborative relationship, the less experienced and those new in the profession gain the competencies and skills necessary to build the confidence required to operate as fully-fledged practitioners. Therefore, clinical supervision has inherent in it the aspect of counsellor('s) self-efficacy which may influence the practice and the desire to access clinical supervision.

Theory of Reasoned Action (TRA) and Theory of Planned Behaviour (TPB) explain this correlation better; on how practising any specific behaviour has something to do with the issue of self-efficacy/behavioural control; the belief one has on their ability to perform a specific behaviour (Glanz,2017; Ajzen,2002; Ajzen & Fishbein,1975,2005).

The concept of self-efficacy was popularized by Bandura (1977) through social learning/cognitive theory that postulated that one's self-efficacy; the belief in their ability to successfully execute a given task has significance on the individual's actual performance of the task, therefore, literature reveals that clinical supervision is essential towards enhancing self-efficacy among counsellors (Bernard & Goodyear, 1998,2005; Glanz,2017; Falender & Shafranske,2008; Falender & Shafranske,2021; Goodyear et al.,2009).

This view links well with Lyman's (2010) views that clinical supervision is a "tutorial and mentoring" type of intervention in which a supervisor monitors the counsellor(s) or counsellor-trainee to facilitate the learning and development of counselling skills. This places more emphasis on the aspect of monitoring and evaluation of the clinical work of the counsellor to ensure the quality of the service offered to clients.

Like many other scholars, Glaes (2010) and Bland (2012) perceive clinical supervision as an intervention provided by a more senior member (s) of a profession to a junior member(s) of the same profession. This aligns with Bernard and Goodyear's definition because it goes on to describe the nature of the professional relationship as being evaluative, hierarchical, and maintained over time whilst simultaneously performing other functions intended to improve professional competencies among junior counsellor(s).

Clinical supervision is considered essential to the development of clinical competencies in the counselling profession, that's why Bernard and Goodyear (2009, p.7) opine that experience alone is insufficient for counsellor(s)'s professional development without regular mentorship, feedback, coaching, clinical guidance and reflection on clinical work through clinical supervision provided by more experienced clinicians and gurus in the field. The clinical relationship, therefore, has an aspect of seniority coupled with relevant qualifications to be able to supervise other counsellors in the field. This view is shared by Glaes (2010) who asserts that clinical supervision is typically provided by experienced and licensed counsellor supervisors. Glaes (2010) goes on to say that supervision is similar to teaching and consultation as it involves the sharing of knowledge, skills and evaluation.

Clinical supervision is meant to improve supervisee's professional performance to subsequently benefit their clients, that is why extensive literature (Barnett, Cornish, Goodyear & Lichtenberg, 2007; Goodyear et al.,2009; Bland,2012) shows that it is important to be conducted over a prolonged time; not just during the training of student counsellors to prepare them for their professional world of work, but for continued effective counselling.

Based on this observation, it can be inferred that Bernard and Goodyear's (2004,1998) definition appears to have influenced not just individual scholars, but counselling regulating bodies worldwide as well; American ACA (2014, p.21) defines clinical supervision as;

> a process in which one individual, usually a senior member of a given profession designated as the supervisor engages in a collaborative relationship with another individual or group, usually a junior member(s) of a given profession designated as the supervisee(s) in order to promote the growth and development of the supervisee(s), protect the welfare of the clients seen by the supervisee(s), and evaluate the performance of the supervisee(s)".

With that in mind; it is worth looking at Bernard and Goodyear's (2014, p.9),

> An intervention provided by a more senior member of a profession to a more junior colleague or colleagues who typically (but not always) are members of that same profession. This relationship is evaluative and hierarchical, extends over time, and has simultaneous purposes of enhancing the professional functioning of the more junior person (s), monitoring the quality of professional services offered to the clients….

This exact same is adopted by Milne & Watkins (2014, p.21). However, this study adopted the American ([ACA],2014) definition with some few modifications and exclusions, and herein defines clinical supervision as a professional relationship of providing clinical expertise, mentorship and coaching to a less experienced professional by a qualified and experienced professional, thereby ensuring the effective delivery of counselling service through an evaluative and monitoring process to safeguard the welfare of clients and the credibility of the profession. This broad definition has inherently encompassed all aspects of supervision and points out the tripartite fact that supervision also indirectly cascades down to benefit the supervisee's clients (Linton, 2003; Bland,2012).

2.4.2 Concept of Perceptions

People often use perceptions and attitudes interchangeably, Pickens (2005) defines perceptions according to Allport's 1935 work as "a mental or neural state of readiness, organized through experience, exerting a dynamic influence on the individual's response to objects and situations to which it may be related".

Pickens (2005) goes on to say that usually, people refer to a person's attitude as perceptions in trying to explain their behaviour. Attitudes may be perceived as a complex construct as often it is a manifestation of a combination of attributes that include one's personality, beliefs, values, behaviours and motivations.

It is common for people to deduce one's perceptions from observing and assessing their actions or behaviour, hence, when someone tends to lack commitment towards work or a particular practice it is often interpreted by many as having to do with their perception towards that particular practice, action or behaviour. According to Ajzen and Fishbein (2005), perceptions and attitudes play a significant role in human social behaviour. Similarly, McLean (2003); Pickens (2005); and Oskamps and Schultz (2005) argue that perceptions and attitudes are three-dimensional; there is the affect(feelings), cognition (belief, thought or mental aspect) and behaviour (action/acting) involved. To this effect, Pickens (2005) posits that perceptions are closely related to attitudes and sometimes not easy to differentiate.

Ajzen and Fishbein (2005) postulate that; "the performance of specific behaviours can be best explained by considering the proximal attitude toward the behaviour rather than the more distal attitude toward the object at which the behaviour is directed". However, many scholars seem to have adopted Lindsay and Norman's (1977) definition of perception as the process by which organisms interpret and organise sensation to produce a meaningful experience of the world; implying a process through which people make sense and cognitively arrange sensations to produce a meaningful experience of the world.

The word perception is said to have emerged from the Latin word *percipio*, which could mean a collection of different words such as; conceive, observe, understand, notice, collect, organise and apprehend with the mind or with one's senses. This implies that perception develops when an individual is confronted with a situation, and their way of making sense of the situation; interpreting the stimuli in most cases is influenced by their past experiences of dealing with a similar situation. Similarly, how one's perceptions are formed is influenced by how one had successfully or unsuccessfully addressed the situation during previous encounters. This implies that past experiences may shape people's perceptions and contribute to the formation of certain attitudes towards certain situations.

Pickens (2005) asserts that how an individual interprets or perceives may be different from reality; perceptions about situations could be inaccurate, but remain true to those holding them despite lacking reality. Glanz (2017) argues that perceptions individuals hold about a particular behaviour are usually influenced by beliefs, past experiences, gains, losses and personality.

What's striking in Pickens' (2005) view is that the development of perceptions is a process that involves four stages of stimulation, registration, organization, and interpretation; this seems to indicate that a person's awareness and acceptance of the stimuli is a process significant to perceptions.

Moreover, how receptive one is to the stimuli may be influenced by their personality and pre-existing attitudes, beliefs, knowledge and motivation; therefore, it is common for people to be selective and attracted to the stimuli they perceive as having more gains and ignore those they perceive as having the potential to bring the opposite negative effects such as possibly triggering psychological distress (Quarto,2003).

This understanding of what perceptions and attitudes are creates an awareness of the existing interlinkage between the concepts and behaviour. Therefore, inferences can be made that attitudes and perceptions people have concerning certain activities can influence their practices and the probability of participating or not participating in a behaviour depending on attitudes held towards it which may largely be influenced by knowledge held. Literature (Ajzen & Fishbein 2005; Bernard & Goodyear,2004; Glanz,2017; Quarto,2003) show that there is a link between knowledge, attitudes and behaviour or practice.

2.4.3 Concept of Knowledge

It is possible that possessed knowledge, feelings, attitudes, perceptions and practices of clinical supervision could lead to a negative or positive evaluation and perception of the practice and result in either positive or negative behaviour towards the practice.

Hunt (2003, p.100) asserts that "knowledge is often defined as a belief that is true and justified". This definition has led to the measurement of knowledge as either someone is correct or incorrect in answers and in the interpretation that either someone knows or does not know something. Based on the available literature, the concept of knowledge hasn't been explicitly defined despite its significance in human existence.

Therefore, an inference made in the case of clinical supervision based on the definition of viewing knowledge as "a belief that is true and justified" is that either counsellors believe clinical supervision is "true and justified" or they don't. If the latter, then they may not engage in CS practice depending on their belief and knowledge which may influence their attitudes, perceptions and practices.

According to Hunt (2003), knowledge creates the ability to be orderly, effective and well-structured in achieving things, hence it is possible that with adequate knowledge of clinical supervision and proper skills, the CS could be orderly implemented. People's perceptions are based on the information acquired and knowledge retained through different senses, experiences and situations encountered. How the acquired data is interpreted may equally be influenced by held perceptions.

Therefore, according to Hunt (2003, p.101), "the process of acquiring and retaining knowledge and beliefs in memory is called learning and is a product of all the experiences of a person from the beginning of life to the moment at hand".

Hunt (2003) believes that behaviour change comes as a result of acquired knowledge and the application of acquired information, and that; "with learning traditionally, learning has the concept of knowledge being defined as the relatively permanent modification of the behavioural potential of an organism which accompanies practice". Suffice it to say that knowledge has the potential to influence behaviour.

Biggam (2001) holds similar views that knowledge is an abstract concept that cannot be directly observed but can be inferred from observing people's behaviours and practices. Therefore, with that in mind, one can infer that in clinical supervision practice, the acquired theory and knowledge can be evident in the application of clinical supervision skills, and be considered indicators of acquired theoretical and applied scientific knowledge. Biggam, (2001) goes on to argue that knowledge is an "awareness or familiarity gained by experience" and further asserts that knowledge must meet three criteria; it must be true, the perceiver must believe it to be true, and the perceiver must know it to be the case. However, there should be a difference between knowledge and blind belief or mere opinion about something to count as knowledge.

Nonetheless, Bolisani and Bratianu (2018) postulate that despite knowledge being a critical abstract concept, it has not been clearly and adequately defined by many, therefore; it has been elusive. However, goes on to opine that the concept of knowledge comes from the word knowing, implying the ability for individuals to inquire, learn, accumulate or gain new information, skills and competencies through various ways to be considered to know a particular concept or possess knowledge.

In this perspective, knowledge could be perceived as acquired information that influences one's beliefs, attitudes, perceptions, practices and actions or behaviour.

2.4.4 Concept of Attitude

Issues about knowledge, attitudes and practice constructs are complex as there are various factors involved. According to Bohner and Dickel (2010, p.392), "An attitude is an evaluation of an object of thought, attitude objects comprise of anything a person may hold in mind, ranging from the mundane to abstract things, including people, groups and ideas". Schwarz and Bohner (2001), borrowing from Allport (1935) view attitude as; "a mental and neural state of readiness, organized through experience, exerting a directive and dynamic influence upon the individual's response to all objects and situations with which it is related", implying cognitive assessment and held perceptions toward objects and situations.

The definition seems to have evolved over the years; for example, Schwarz and Bohner (2001) also reviewed Krech and Crutchfield's (1948) definition that perceived attitude as; "an enduring organization of motivational, emotional, perceptual, and cognitive processes concerning some aspect of the individual's world". However, most people consider attitude simply as likes and dislikes towards things, objects or people, whilst others consider it to be a psychological tendency for people to express their likes or dislikes towards things based on their evaluation and preferences. Usually, when that is the case, people outwardly demonstrate their attitudes towards such situations/objects/behaviours to show their like or dislike, favour or disfavour towards the issue or object of concern.

According to Zanin et al. (2017), an attitude is a negative or positive evaluation individuals make of an object, action, behaviour or practice which in turn influences their behaviour towards the object, practice or behaviour. Similarly, Fishbein (2004) perceives it as a "learned predisposition to respond favourably or unfavourably towards people, an idea, an object or situation". Consequently, attitude is formed based on an evaluation made either positively or negatively, and such a mindset may positively or negatively influence a person towards that particular object or situation. Literature further reveals that the concept of attitude is three dimensional with cognitive, affect and behavioural aspects.

This implies that there is the issue of knowledge and ideas (cognitive) individuals hold about the object/activity which has the potential to influence the emotional (affect) aspect, and subsequently influence the behaviour towards the situation, person, activity or practice positively or negatively (Zanna & Rempel,2008; Zanna,1990). As Ajzen and Cote (2008) and Ajzen and Fishbein (2005) point out, this also has to do with the level of intention one has. However, the level of intention alone may not adequately help predict behaviour, therefore, knowledge and Skills play a critical role; if the level of control or the ability to successfully perform the behaviour is low, chances are that it may manifest itself in a form of dislike, unfavourable evaluation and failure to perform the expected behaviour (Ajzen & Fishbein,2005; McLean,2003; Schwarz & Bohner,2001). Vogel and Wanke (2016, p.8) share similar views in defining attitudes as; "a summary evaluation of an object of thought, an attitude object can be anything a person discriminates or holds in mind; an object may be concrete or abstract".

2.4.5 Concept of Practice

Practice in this study refers to any action or omission by a counsellor that another may reasonably consider part of a counselling service or "that which could cast doubt upon the ability and competence to practice as a counsellor(s), and outside counselling that which harms public trust in the discipline or the profession of counselling and in the capacity as members of the Association" (ACA, 2019, p.6). It can also be used to refer to the action or service of offering effective therapeutic help to an individual (s) who voluntarily seeks such a service which entails the integration of knowledge, skill and experience, that could be accessed individually, as a family or group.

One cannot practice that which they do not know, hence it is worth reiterating herein that knowledge does not only refer to the cognitively acquired body of information but includes theoretical knowledge application of techniques, models and strategies in a therapeutic setting, and a practical demonstration of skills and knowledge which were acquired over time through hours of practice, internship, practicum or lived experiential learning (Levy,2004; Banaji & Heiphetz,2010).

Pickens (2005) opines that attitude provides internal cognitions, beliefs and thoughts about people and objects and stimulates people to act or behave in a certain way towards certain things, objects, behaviour and

people. Myriads of information (Ajzen & Fishbein,2005; Bernard & Goodyear,2004; Levy,2004; Oskamps & Schultz,2005) show that attitudes are learnt behaviours easily formed through the modelling process, and from personal experiences through interactions with people and situations in life. Literature further reveals that attitudes influence decision-making, behaviours and the choices people make to like or dislike something, someone or a practice (Ajzen,1988; Pickens,2005; Zanna & Rempel,2008; Zanna,1990).

Practice is about actions taken, behaviours portrayed or application of knowledge. It is about putting theory into practice and it is mostly influenced by knowledge and attitudes. To this, Kutscha, et al. (2020) state that; "*Theoria* (theory) refers to sciences and activities concerned with knowing, whereas *praxis* (practice) has to do with doing". Therefore, counselling and CS could be perceived as abstract until they are practised, and application is determined by knowledge and skills. Hence, attitudes and knowledge could influence the ability to practice the clinical supervision construct. Therefore, it is upon this view that scholars often talk of theory and applied theory, and consider Counselling, Psychology and Clinical Supervision as applied theory.

TRA and TPB assume that the best predictor of a behaviour is the behavioural intention determined by attitude toward the behaviour and social normative perceptions regarding it. TPB is an extension of the TRA and includes an additional construct of perceived control (Ajzen & Fishbein,2005; Ajzen,1985; Kutscha, et al.,2020). TRA and TPB focus on the constructs explaining variance as a predictor of several different behaviours. Ajzen and Fishbein (1991,1980,1975) attempted to explicitly show that attitudes toward a certain behaviour such as clinical supervision are a better predictor of the probability of performing the behaviour, their work defined the underlying beliefs such as behavioural and normative beliefs, intentions and influence in the potential for one to perform the behaviour.

Thus, an individual with strong beliefs of positive gains will develop positive attitude towards behaviour and performing it, whereas, a person with strong negative beliefs of possible negative results from performing the behaviour will equally have negative attitudes towards the behaviour and performing it, hence resulting in inaction or non-performance of the said behaviour.

Kutscha et al. (2020) also opine that an individual's subjective norm is influenced by their normative beliefs, coupled with level of motivation or lack thereof, on whether or not to perform the behaviour.

Similarly, if the belief is that certain people approve of the behaviour, the individual may be inspired to meet their expectations and view the behaviour positively and perform it.

When speaking of perceptions, knowledge, attitudes and practice in CS, TRA and TBP theories helped to explain these concepts. A "person's perception of the ease or difficulty of performing the behaviour" has the potential to influence their behavioural intention. Behavioural intention is equally linked to motivation and without motivation, a person is unlikely to carry out a specified behaviour. Suffice it to say, strong intention, motivation, knowledge and skills are essential to the behaviour. Therefore, TRA and TPB provided a framework for understanding behavioural, normative and control beliefs linked to attitudes, perceptions and knowledge relevance to this study (Ajzen & Fishbein,2005; Kutscha et al., 2020).

2.4.6 The Influence of Perceptions on Behaviour

How behaviour is perceived and managed can influence the actions; practice and participation in a specific behaviour, therefore, the perceptions that counsellors have towards clinical supervision can influence their desire to take part in clinical supervision.

Perceptions, attitudes and knowledge possessed on clinical supervision practice can influence whether or not counsellor(s) engage in the practice (Johansen et al.,2011). Johansen et al. (2011) go on to state that several variables within an activity "have the potential to influence the likelihood of a behaviour occurring or not occurring, increasing or decreasing", being acted out or disregarded and being valued or undermined.

Ajzen and Fishbein (1975) in the Bayes' theorem explain that a person's attitude and behaviour are influenced by their beliefs and revision of their beliefs as influenced by new information received. Ajzen and Fishbein (1975) went on to argue that an individual's disposition is based on the perceived desirability of behaviour; if behaviour is desirably perceived and believed to be of benefit, then it could be predicted that it could influence the intention to act it out. This view underscores the link between perception, attitudes, knowledge, behaviour and practice (Ajzen,2002).

2.4. 7 Transference and Counter-transference

According to Sumerel (1994), transference and countertransference are covert behaviours and identifying their occurrence requires an ongoing awareness of one's issues that may interfere with the counselling process and this requires being authentic and aware of the possible triggers of the concerned issues. Sumerel (1994) goes on to say that awareness alone is not enough, it's only the beginning because having established the issues, one has to seek clinical supervision or counselling to address such issues.

Transference and counter-transference are perceived as phenomenon in psychoanalysis characterised by the unconscious redirection of feelings from one person to another, in the case of counselling, it could be feelings transfer or projection from the therapist to client and vice -versa. Both phenomena are based on the human ability to recognise the inside and the outside world of emotions.

Often this occurrence happens when the current client's issue brought into therapy possibly triggers certain feelings and behaviours that the supervisee/counsellor may have experienced in the past. This is why clinical supervision helps to address the phenomenon (Borders,2015; Norcross & Lambert,2011). Prasko et al. (2010) share similar views in saying that transference and countertransference sometimes happen during therapy between client(s) and counsellor(s) where a situation presents itself in which there may be strong emotional reactions to each other, and go further to say transference and counter-transference happen in therapeutic relationships that develop between the client and the counsellor and vice-versa, and may impair the therapeutic process if not addressed because due to the potential to derail the professional relationship.

Prasko et al. (2010) reiterate that "the occurrence has the potential to harm the counselling process and professional relationship if not averted". On the other hand, the therapist has to pay attention to negative or positive reactions towards him/herself from the client, such are not to be ignored but should be processed when they emerge. Supervisees are to be vigilant and alert to notice signs of strong negative emotions such as disappointment, anger, frustration or love projected into the therapeutic relationship by the client.

Attention also has to be paid towards heightened positive emotions of attachment and possible dependency that may manifest in the form of extreme liking or love, idolising and over-board idealization of the counsellor.

Similarly, counter-transference requires the counsellor(s) to be aware of schemas that may apply to them, and guard against personal feelings that may interfere with the counselling process and seek supervision if such a situation emerges or go for counselling if it is a counselling issue (Cutcliffe & Sloan,2014; Wheeler & Richards,2007).

This does not only apply to inexperienced counsellor(s), even experienced counsellor(s) may encounter countertransference, hence the importance of accessing CS by counsellors. This phenomenon is usually loaded with messages that need processing, for example, it could be signalling an issue the counsellor has to either take to counselling or clinical supervision. It may reveal an old unresolved issue from the counsellor's personal life that requires counselling to prevent the potential risk of interfering with the counselling process. To this fact, Prasko et al. (2010) assert that transference and countertransference feelings, behaviours and reactions are valuable sources of information concerning the client-counsellor professional relationship and the therapeutic alliance because both the inner and outer world of the client and counsellor(s) have to be monitored, evaluated and processed not to derail the clinical work.

2.4.8 Supervisor in Clinical Supervision

Clinical supervisors (Counsellor supervisors) in the counselling profession have several responsibilities including being a teacher, monitoring agent, evaluating, consultant, expert mentor, coach and gatekeeper to the profession. In some cases, their role could be both administrative and clinical depending on the setting, hence Linton (2003) states that; whilst many may conduct administrative and clinical, others focus only on the clinical role.

According to Linton (2003), Supervisors are professional counsellors appointed by respective institutions and accrediting bodies for clinical work with less qualified, less experienced counsellors and those new in the profession. Depending on the setting, policies and laws in different countries, they may also be professionals who play the gatekeeping role of ensuring that new people entering the profession are the right people with relevant qualifications and licensure.

American Counselling Association ([ACA],2014) defines supervisors as counsellors qualified to provide professional clinical development to less qualified counsellors.

Supervisor in the context of this research refers to someone qualified in counselling and clinical supervision and experienced in facilitating professional growth and learning to the counsellor who is less qualified, less competent or still new in the field and needing mentorship, coaching and professional guidance to gain more confidence and competence in the Counselling process. This is why Goodyear (2014, p.94) states that supervisor(s) "facilitate supervisee learning through several particular strategies".

Competence in this case refers to appropriate skills deployed during the counselling process and the clinical supervision process. It is the ability to adequately and efficiently execute the actual clinical supervision and counselling process.

According to Cummings (2004, p.22), to be a supervisor requires "concrete skills and techniques required to implement treatment plans and the ability to apply intellectual knowledge gained from coursework and seminars into effective actions that will promote growth and change in the client". In the same breath, Johnson (2020) argues that supervision is a clinical practice that is encouraged throughout the counsellor(s)' career life to ensure ethical practice and safeguard client well-being. The supervisor (s)'s major role is very significant, they don't only perform the clinical role, but sometimes the administrative role as well, depending on the setting and this is done to ensure adherence to ethical standards.

In their administrative role, they deal with issues of counsellor staffing, referral of clients and case escalation, scheduling, case management and communications to the public, key stakeholders and clients.

Supervisors enhance counsellors' professional counselling skills (Bernard & Goodyear, 2014; Stoltenberg,2008). ACA (2014) defines supervisors as counsellors qualified for supervision of counsellors' clinical work and possibly students of counselling (counsellor(s)-in-training). Clinical supervisors' responsibility is also to protect the counselling profession and safeguard the integrity of the profession through their gatekeeping function of vetting newly qualified counsellors for admission into the profession and licensing (Linton, 2003).

Supervisors may also assist supervisees in assessing their behaviours, thoughts, feelings, values, and beliefs not to be projected into the counselling sessions. Hence the function of the clinical supervision process

is to facilitate supervisee growth crucial for effective delivery of the counselling process and the credibility of the counselling profession.

Supervision must not be confused with counselling; it serves the teaching, evaluative and monitoring functions to enhance effectiveness of counselling process. Therefore, supervisor's role is mostly to determine whether supervisee(s) are adequately prepared to engage in the counselling practice.

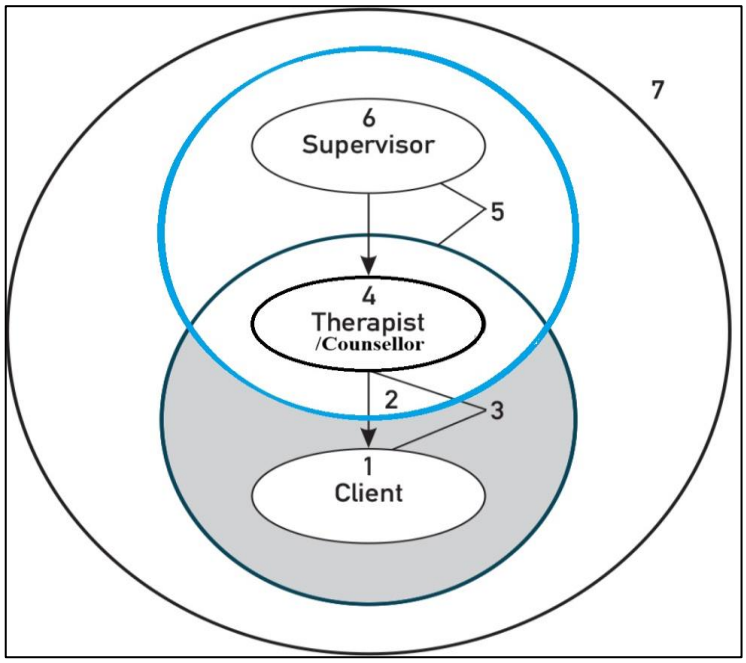
The concept of "clinical supervisor" therefore refers to a skilled and experienced counsellor(s) who use their expertise, competency and experience to create a therapeutic clinical alliance; beneficial relationship to facilitate the effectiveness of counsellors under their clinical mentorship (Linton,2003). American ([ACA],2014) describes a supervisor as a professional counsellor involved in professional development of another counsellor or a counsellor-trainee' for professional growth and goes on to articulate the roles of clinical supervisor(s) differentiating them from those of a counsellor and an administrator; for example; supervisor as a teacher, coach, consultant, mentor, evaluator and administrator. Moreover, the supervisor(s) core existence is centred on the provision of clinical support, encouragement and empowerment of counsellors.

Supervisors address a myriad of counselling work-related issues; such as multicultural sensitivities, ethical dilemmas, issues of spirituality, interpersonal and psychological dilemmas as well as issues about the supervisee's clients (case review); they enhance clinical counselling for the benefit of clients. Supervisors exist to ensure continued counsellor(s) skills development for effective treatment of clients, the quality of the service offered and clients' satisfaction feedback that authenticates the credibility of the profession (Cutcliffe & Sloan,2014; SAMHSA,2009).

Clinical supervisors assume multiple roles and wear several "hats" of teacher, evaluator, coach, overseer and gatekeeper to the profession. They facilitate the integration of counsellor self-awareness, theoretical grounding and the development of clinical knowledge and skills for counsellors' improved functional skills and professional practices. These supervisors' roles overlap and put the supervisor in a unique tripartite position of not only protecting the counselling profession, and the counsellor but indirectly protecting clients as well. Their roles ensure supervisees' adherence to professional standards by identifying and addressing any blind spots, discrepancies, impairments and possible malpractice (Milne & Watkins,2014).

Figure 4

The Model Showing the Tripartite Function of the Supervisor



Adopted from Hawkins (2018, p.387,389). The Seven Eyed Model

2.4. 9 Concept of Supervisee in Clinical Supervision

Supervisees are counsellors who work with clients in different settings within the mental health professions, some may be newly graduated counsellors with little counselling experience or they may have been in the field for some time but still inexperienced despite their academic knowledge. Such individuals therefore benefit immensely from accessing clinical supervision. However, this does not in any way imply that those with longer years of field service do not need clinical supervision.

The word supervisee in this study refers to any person who accesses supervision from a qualified and experienced professional counsellor holding the relevant qualification in clinical supervision. Supervisee accesses CS for professional growth to enhance competencies and effectiveness in counselling. In counselling, clinical supervision has become a requirement in most countries and is prescribed in the professional code of ethics. In some countries supervisees have to undergo supervision to obtain licensure, however as stated earlier, the rest of qualified counsellors are expected to access supervision as a requirement demanded by ethical codes and deemed necessary as they encounter some ethical dilemmas and complex clients issues,

it is also critical for the prevention of counsellor fatigue and possible burnout (Levy, 2004; Linton, 2003). ACA (2014, p.21) defines a Supervisee as "a professional counsellor or counsellor-in-training whose counselling work or clinical skill development is being overseen in a formal supervisory relationship by a qualified trained professional".

According to Bland (2012), in an educational institution, a counselling graduate student who receives regular, systematic supervision from a university supervisor in the counselling faculty is also referred to as a supervisee. Levy (2004) opines that an experienced counsellor or "counsellor trainee with more than three months of experience performing counselling duties in a counselling setting as an employee, volunteer, or intern" is also referred to as a supervisee.

ACA's (2014) definition is hereby adopted for this study with minor modifications to read as "any professional counsellor whose clinical counselling work is evaluated and monitored by a qualified and experienced counsellor for the development of counselling skills and effectiveness of the therapeutic process through regular professional supervisory relationship".

2.4.9.1 Ethics in Clinical Supervision

Ethics deals with the right or wrong aspect of behaviour; it is all about the morality of human behaviour or acceptable conduct. In a professional setting, ethics refer to professionally acceptable principles guiding professionals in the respective field or profession in a way that does not discredit the profession or harm clients. Counselling ethics refer to guiding principles, otherwise known as ethical codes of conduct that provide a framework for the counselling practice and regulate counsellors' professional conduct and behaviour to safeguard the clients, the practice and the integrity of the profession. Knowing and adhering to ethical counselling codes is an important requirement expected of every practising counsellor; therefore, ignorance of ethics does not recuse a therapist from being charged for misconduct or malpractice; "Lack of knowledge or misunderstanding of an ethical responsibility is not a defence against a charge of unethical conduct" ([ACA],2014, p.19).

It is worth reiterating herein that ethics involve ethical decision-making, navigating ethical dilemmas, and doing what is right and just for the benefit of the client and the profession; therefore, the nonmaleficence; "do no harm", confidentiality, privacy, consenting and contracting as well as justice principle all come into play when talking about ethics. On these grounds, counsellors are expected to be knowledgeable of the counselling ethics stipulated by their governing bodies in their respective countries of practice, and use them as a guiding framework, for example; American ([ACA],2014) and other regulating bodies like the Australian Counselling Association, ([ACA],2016,2019), APS (2007), and the American ([APA],2014,2015) have stipulated that professional counsellors are to behave ethically, legally and professionally with the awareness that the safety and welfare of their clients and integrity of the profession are dependent on their professionalism. Similarly, counsellors are to hold their colleagues in the counselling profession to the same ethical standards of practice and professionalism and ensure that ethical standards are maintained within the profession and this is done through clinical supervision and licensure.

Therefore, aligning knowledge, attitudes, ethics and practice to create an in-sync between theory and practice to achieve professional credibility is important for counsellors (Mauthner et al., 2002; Walsh,2015).

Velasquez et al. (2022) define ethics as guiding principles or standards used to provide a professional framework or morals of conduct; the way individuals are expected to behave within a profession, also perceived as the acceptable norm within a profession. Ethics, root "ethos", refers to the set standards of what is accepted as right or considered as wrong, the prescribed and acceptable human way of behaving; what one can or cannot do in terms of rights, justice, fairness and no harm to others (Velasquez et al.,2022). Misra (2021) views ethics as standards that impose reasonable obligations, retraining, controlling, guiding and preventing certain behaviours to safeguard people from being unethical, causing harm to others, taking advantage of clients' vulnerabilities, physically or emotionally harming clients, becoming too personal or unprofessional, not observing the professional boundaries and limitations, dishonesty, slander, fraud and many others ways. Singer (2021) shares similar views that ethics are standards related to issues of authenticity, truthfulness, trustworthiness, genuineness, congruency, honesty, fairness, empathy and compassion,

In general, ethical standards are centred around basic human rights that every individual is entitled to enjoy, such as life, freedom from harm and privacy among others. Counselling standards may have been derived from the basic human rights to ground the professional counselling ethics for the protection of clients and the profession.

Ethics influence people's professional behaviour; in this case, counsellors' behaviour because they must protect the clients who entrust them with their emotional issues and personal information from malpractice or harm by providing professional, ethical services, and behaving in ways that are not detrimental to clients and to the counselling profession. It is in this light that counselling regulating bodies and supervisors function as gatekeepers of the practice, and have clearly formulated ethical standards to guide the practice.

Ethics consist of standards of behaviour perceived to be acceptable and professional conduct as stipulated by mental health principles and counselling codes stipulated by regulating bodies in respective countries (Walsh,2015; Neill,2016).

According to Koocher and Keith-Spiegel (2008), ethics may also be referred to as the moral philosophy that deals with what is morally good and right to prevent professionals from doing what is considered bad, morally wrong or harmful. Therefore, ethics serve as the moral campus for humanity in different professions and are similarly applicable in counselling and clinical supervision.

Koocher and Keith-Spiegel (2008) further state that "the term is also applied to any system or theory of moral values or principles". Ethics appear to involve fundamental issues of practical ethical decision-making and a proactive way of avoiding complications in the event of the emergence of ethical dilemmas. Therefore, the major purpose of ethics is on the essence of value addition to the credibility of the profession through regulating standards upon which counsellors' actions and behaviours are underpinned; upon which they can be judged on whether they are right or wrong, acceptable or unacceptable, ethical or unethical in the mental health professions.

2.5 Historical Background of Counselling in Botswana

2.5.1 Brief History of Botswana

According to Modie-Moroka (2016); “history plays a significant part in any country”. Literature shows that colonial rule played a significant role in shaping the current socio-economic situation in Botswana and other African countries.

Literature concerning contemporary counselling history in Botswana before and during the colonial period is limited. People with mental health conditions or mental illness were considered “insane”, “lunatics”, and “crazy” and were either chained, locked up in family houses, kept in prison for public safety or taken to traditional healers (Modie-Moraka,2016). It is on this premise that Modie-Moroka (2016) opines that; “it is hard to trace the history of mental health services under the pre-colonial”. This is not surprising, as many Batswana could not read and write hence little is documented until the arrival of the missionaries and the introduction of reading and writing though only the children of wealthy families could afford to access the education system. Similarly, during the colonial rule, Britain did not invest in Bechuanaland social services or any form of infrastructure largely because the country was a land-locked semi-desert and considered to be severely poor compared to other African countries that had an abundance of minerals resources (Tlou & Campbell,1984,1997).

Botswana, previously a British colony called Bechuanaland Protectorate attained independence in 1966. The country covers 581,730 square kilometres in size and is said to be the same size as Madagascar or France and has a relatively small population estimated at 2,411,000 million (Parsons, 2022) and previously estimated at 2,292,000 in 2011 according to the 2011 population census (Botswana Government,2021; Central Intelligence Agency [CIA],2022; Hull,2019; Mupedziswa et al.,2021).

Poverty-stricken at the time of independence and considered a landlocked barren desert due to its location in the Kalahari Desert, the country strategically chose to focus on human resource development following independence to achieve rapid economic growth rather than give higher priority to investing in the military

like most of the African countries. Her major priority was building educated and trained human resources to drive the economy of the country. Hence, the country was not inundated with civil wars, coups or political instability.

According to Lewis (2020, June 18), the country became a shining example of democracy; he calls it "the African Exception", whilst Ojo and Duyile (2020) refer to it as; "the giant of Africa" and "Africa's success story." Democracy was and still is a concept engrained in Batswana's culture and traditions as Ojo and Duyile (2020) assert; there has always been a democratic process and tribal unity through the "kgotla" systems led by Dikgosi (chiefs) therefore, it is not surprising that Duyile (2020) goes on to refer to Botswana as "Africa's oldest continuous democracy".

Lewis (2020 opined that; "Botswana's successes in political and economic development reflect the extension of some important aspects of traditional culture, together with modifications pushed by the leadership that emerged in the years before independence". The country's cultural traditions were underpinned by a democratic approach in day-to-day decision-making, national consultations and transparency were grounded on the same principles of "Botho" (Ubuntu); "I am because we are" (Motho-ke-motho-ka-batho); which allows for freedom of speech "Mmua lebe o bua la gagwe" (freedom of expression), "Mafoko a kgotla…." (Tolerance, acceptance of diversity, free speech, democratic dialogue and acceptance of differing views). The country's perspective towards conflict was that of peaceful negotiations; "jaw-jaw better than to war-war" (Cooper,2013). As the first President of Botswana Sir Seretse Khama once said in 1978 in a National Assembly speech:

> Democracy, like a little plant, does not grow or develop on its own. It must be nursed and nurtured if it is to grow and flourish. It must be believed in and practised if it is to be appreciated. And, it must be fought for and defended if it is to survive (Lewis,2020; Boddy-Evans,2019).

For this reason, the country came to be renowned for peaceful co-existence with its hostile neighbours, more importantly, Botswana was dependent on countries like South Africa for her imports and access to the sea, therefore, for economic and political reasons the country continued to maintain a peaceful co-existence which was evident from her domestic and foreign policy; bilateral and multilateral relations.

Even at the time of political unrest in the region during the apartheid regime in South Africa and civil unrest in neighbouring Rhodesia (Zimbabwe), Botswana remained without a military force until 1977 (United States Central Intelligence Agency ([CIA], 2022).

Due to the political stability, Botswana maintained rapid and stable economic growth depending only on beef export until the discovery of minerals like diamonds, coal and copper-nickel (Mupedziswa et al.,2021; Ojo & Duyile,2020). Suffice it to say that the discovery of diamonds in the late sixties led to the country's rapid economic growth that led to rapid development of the infrastructure, education sector and various sectors further leading to improved living standards for citizens (Mupedziswa et al.,2021). The country's per capita income tremendously increased, hence the United States Department of State (2006) opined that "Botswana has had the fastest growth in per capita income in the world since its independence". According to Mupedziswa et al. (2021) and Stockton et al. (2010) thriving economy was evident in making education a priority in the national development plan leading to the provision of ten (10) years of free basic education. This in turn necessitated massive investment in manpower development and training, not just focusing on teacher training but in all the government sectors, therefore, the government became the major job creator in the country.

Rapid development created a booming economy which brought with it complex societal challenges, especially in schools and larger communities. Therefore, the need for psychosocial support services or mental health services became a major gap that needed to be addressed through policy development, hence The Revised National Policy on Education ([RNPE],1994) was formulated and one of its recommendations was to strengthen psychosocial support services in the country.

This resulted in the transformation of career education into a holistic Guidance and counselling programme with a school counselling service to address psychosocial issues that ranged from teenage pregnancies, school dropouts, truancy, support for children living with HIV, orphanhood and issues of disadvantaged and vulnerable learners.

Therefore, guidance and counselling services were not only introduced in schools but in communities as well to address social ills, Human Immune Virus and Acquired Immune deficiency syndrome (HIV and AIDS) related issues (Boutayb,2009; Jefferis et al.,2006; Piot et al.,2001; Seloilwe & Tshweneagae,2007).

2.5.2 Brief Background of Counselling in Botswana

Looking at the developmental journey of counselling in Botswana, we can make sense of the situation of clinical supervision in the country. Professional counselling in Botswana is still a new phenomenon and can be described as being in its infancy stage. The service was introduced following consultancies that were informed by the RNPE, most of which emphasized the significance of counselling and mental health wellness across all ages, but most importantly to address the needs of the youth.

The same was echoed by Coker (2013) who asserted that "formalized counselling is still a relatively new phenomenon in Botswana". According to Msimanga and Moeti (2018); Muchado (2018) and Stockton et al. (2010), the outbreak of HIV and AIDS influenced the development of counselling as the country grabbled to address the psychosocial issues surrounding the epidemic that threatened to annihilate the population.

Before the introduction of contemporary professional counselling and the emergence of various and complex psychosocial challenges, counselling formed part of the family support system and was anchored on traditional practices wherein extended family members such as uncles, aunts, grandparents and the whole village community contributed to socialization; offered guidance and counselling, hence the African proverb; "It takes a village to raise a child". To this perspective, Muchado (2018) and Olanyika (1979) opine that in Africa guidance and counselling are as old as human existence; "as old as man". Nonetheless, the current complex psychosocial issues required empirically researched, evidence-based and scientifically proven interventions underpinned by relevant theories because traditional forms of guidance and counselling appeared to be limited in addressing some issues such as; substance use disorders, depression, living with HIV and AIDS, child-headed households, the emergence of nuclear family and urbanization that transformed the traditional family into the modernised family unit, dysfunctional and disintegrated family system.

This constantly changing cultural setup called for vigorous approaches to address psychosocial challenges that were emerging in the country. Notwithstanding, the ever-changing technological development and its adverse influence on all areas of life, which in some cases led to negative outcomes in interpersonal relationships. These socio-economic changes brought with them highly stressful social phenomena that necessitated researched coping strategies and improved mental health service intervention because not every change has positive implications (Botswana National Policy on Mental Health,2003; Maphisa,2018).

The societal and environmental changes called for the strengthening of psychosocial services because counselling that was provided by members of the extended family and community leaders were equally disintegrating as traditional culture was being eroded leading to the undermining of cultural practices. Some continued to make use of the traditional counselling services offered by the elders, as well as seeking help from traditional doctors and spiritualists to address their issues before they could consider seeing a professional counsellor. The perceptions were influenced by the belief in secrecy, stigma and ideas of preserving family integrity instead of "airing dirty linen" to strangers. However, there seemed to be a change with time as more people started accessing the "modern" professional counselling offered by qualified counsellors, social workers and psychologists.

Traditional counselling was merely a provision of guidance in line with customary practices and customary tribal laws and differed from one ethnic group to another (Bhusumane, 2007; Muchado,2018; Stockton et al.,2010). Traditional counselling and guidance that was provided also formed part of the socialization of the young into adulthood and incorporated into the training of gender roles and responsibilities through initiation schools. Initiation schools took place when young girls and boys came of age to prepare them for adulthood and responsibilities; including discussions on health, sexuality and family life in general, and the same groups then formed regiments following the completion of their initiation (Bogwera and Bojale) graduation (Tlou & Campbell,1997,1984).

According to Muchado (2018) and Stockton et al. (2010), tribesmen and women who facilitated the initiation schools could be considered the "first counterparts of professional counsellors", because their role

was significant in providing guidance, psychoeducation and advice to youths to instil responsible behaviour, and empower them to make informed decisions and sound problem-solving skills in adult life.

The introduction of professional contemporary counselling and any form of psychosocial support and counselling service provision in Botswana was anchored on cultural traditional customs and practices provided by significant members of the extended family, and key community traditional leaders like the Dikgosi (Bhusumane,2007). There is therefore still a link between modern counselling and traditional indigenous approaches to helping individuals who are experiencing psychosocial issues.

Modern counselling was introduced as a response to the national health crisis (HIV and AIDS) that faced the country. However, both the modern and the traditional indigenous guidance and counselling services continued to run concurrently depending on clients' preferences and presenting issues.

However, there was a tendency to seek family support and advice (counselling) before consulting a total stranger (professional counsellor). This was in line with traditional customs, perceptions and beliefs on secrecy and stigma associated with seeking a mental health service (Coker,2013; Hinga,2021). This involvement of relatives for counselling was common when couples experienced marital problems and when there were challenges with raising teenagers.

The Revised National Policy on Education ([RNPE],1994) made several recommendations about comprehensive educational institutions, one such recommendation for strengthening and training teachers on guidance and counselling Article 19 of the RNPE (1994, p.4.7.36) states: "The guidance and counselling program in primary schools should be strengthened and teachers trained to provide the services".

Based on the recommendations by the RNPE (1994) and mental health policies such as the Botswana Mental Health Act of 1969, and the Botswana Mental Health Policy of 2003, consultancies were carried out to establish the needs and come up with recommendations that echoed the same concerns for improvement of services, not just in schools but in other settings as well (Hinga,2021). In 1985 Navin's needs evaluation report recommended the development and establishment of guidance structures from primary to institutions of higher

learning, and in wider communities. Similarly, Maes' (1995) consultancy echoed the same recommendations on the need for the establishment of counselling services in educational institutions and communities.

Apart from the consultancies, a few researches mostly conducted by counselling students in tertiary institutions decried the concerns, and recommendations from such research studies further emphasised the need for strengthening counselling services of Botswana, communities, districts and primary health care centres (Bhusumane et al.,1990; Hinga,2021; Modie-Moroka,2016; Muchado,2002).

Botswana Guidance is traceable to the late 1960s when teachers without any training in the field of psychosocial support, school counselling or counselling psychology were appointed as career masters to take on the responsibility of offering career guidance. Their role was mainly to help the General Education Certificate (GCE-University of Cambridge) Form 5 graduates with career advice in making career choices as they progressed to the tertiary level (Muchado,2002).

There was however, a need as per recommendations from consultancies and from the National Mental Health Policy (2003) to introduce holistic mental health programmes to meet the needs of the learners and communities rather than just offer career advice. According to the National Mental Health Policy of 2003, there were emerging complex issues to be addressed as articulated in item 1.6 (p,3) of the national mental health policy (2003), some of which included alcohol and drug abuse, violence, suicide and suicide attempts, unemployment, social isolation, stigma and discrimination, school dropouts, teenage pregnancies, baby dumping, serious crime, streets children and many other issues exacerbated by HIV and AIDS. This push for the introduction of comprehensive psychosocial support services or guidance and counselling programmes in the country emanated from the complex socio-economic issues young people were grappling with in the country.

To this fact, counselling in academic institutions was introduced in the late 1990s as an implementation of RNPE (1994); Maes (1995); and Navin's (1985) recommendations, for example, the first appointments of

teachers to the newly created post of Senior Teacher 1 - Guidance and Counselling was late 1995, and they were expected to provide counselling in secondary schools.

This was after the establishment of a Division in the ministry which was tasked with the responsibility of developing holistic Guidance and Counselling (G&C) curriculum guidelines, and G&C programme implementation policy guidelines in schools. Following the development of the guidance and counselling programme, came challenges related to the implementation of G&C in the country.

The education system experienced implementation-related challenges such as a lack of qualified school counsellors, a lack of appropriate counselling resources and facilities such as therapy rooms and counsellors' supplementary material and students' G&C books, as well as G&C programme teething problems such as role ambiguity, role conflict, lack of support by key stakeholders, lack of recognition by school administrators, lack of clinical supervision and other teachers' perceptions towards the G&C programme and more value placed on examinable subjects resulting in some counsellors assigned to teach academically examinable subjects rather than focus on offering psychosocial support to learners. More emphasis was given to academic subjects and less effort and resources on guidance and counselling by school principals, hence the time allocated was often used for academic subjects to prepare for exams and complete the syllabi (Rollin,1990).

The effectiveness of counselling in schools was therefore negatively impacted by this, similarly in communities counselling offered by social workers was not easily embraced due to held perceptions towards counselling and social workers' role viewed mainly as to distribute social welfare food baskets to the needy. As a result of held perceptions, counsellors' and social workers' services were shrouded with stigma (Modie-Moroka,2016; Montsi et al., 2000; Muchado,2002,2018). On these grounds of limited and unqualified psychosocial support service providers, Levers (2007) argued that there was a need to train Batswana in counselling and trauma counselling.

2.5.3 The National Crisis that Catapulted Counselling

In the early 80s, Botswana encountered a health-related national crisis that challenged the existing status quo that impacted the counselling field and mental health as a whole. The sector and the nation faced catastrophic enemy in the form of HIV and AIDS that put pressure not only on health resources but on mental health as well leading to the need for psychosocial support services which catapulted counselling to a level never seen before. Counselling stretched available limited resources and magnified the need for clinical supervision for those offering psychosocial support to the infected and affected. The country grappled medically and psychosocially to address the emerging scourge and related issues (Bollinger & Stover,1999).

The country was ranked the third most affected in the world with the highest transmission rate and high mortality rate that threatened to annihilate the small population and cripple the country's economy. The situation baffled the world as the virus posed a threat to the small diamond-rich country. The crisis demanded a strategic and immediate national response not just medically, but socially, economically and psychologically.

There was a need for an inter-sectoral, multidimensional approach to the national crisis through engaging all relevant stakeholders from governmental and non-governmental entities; faith-based organizations, legal organizations, Civil Societies, religious organizations and non-profit non-governmental organizations (NGOs). A national response strategy was needed to avoid haphazard interventions and efforts; hence, a National HIV and AIDS Coordinating Agency (NACA) was formed for the coordination of support for the epidemic and for seeking international support ([NACA],2009,2015). The third (3^{rd}) Botswana AIDS Impact Survey (BAIS III) of 2009 and the (BAIS IV) of 2013 showed that the country had a high prevalence rate of 26.3 percent among people aged 15-49 years in the year 2000 and ranked fourth with 20.3% prevalence rate among the same cohorts (NACA,2009,2014; Avert,2021; Kroeger et al.,2011; WHO,2022,2001,2014).

The dire situation needed evidence-based psychosocial interventions to support affected populations and provide counselling on related issues such as coping with grief and loss, coping with orphanhood and living in

child-headed families. There was a massive response through the establishment of mental health service providers and counselling centres throughout the country to meet the needs.

In schools, the situation called for the training of Guidance and counselling teachers or school counsellors and the position of Senior Teacher 1 – Guidance and counselling was established to provide counselling in school and coordinate the G&C programme. The national response to the crisis was a widespread establishment of counselling centres throughout the country by non-governmental organizations, individuals and privately owned companies, many of whom did it out of compassion despite not having appropriate qualifications, skills or training in counselling.

In the education sector, the Ministry of Basic Education (MOBE) emphasised enriching Career Guidance and adopted the holistic approach to include counselling of learners and staff. However, psychosocial support services in the form of counselling were offered by newly promoted teachers in the position of senior teachers 1-guidance and counselling (Guidance Teacher) who lacked training in the field. In communities, counselling services were equally provided by ill-equipped lay counsellors with inadequate qualifications but had the compassion to help. Private individuals with resources saw an opportunity to establish private practices and NGOs that received government funding and international financial support for orphanages to provide "mental health services" to vulnerable and disadvantaged groups.

Despite this mushrooming of counselling centres and the introduction of counselling in the education system, the coordination of interventions and programmes lacked coherence and there was a lack of a counselling regulating body, no standards of practice, and no professional code of ethics and as a result each organization came up with procedures and protocols and implemented what they deemed right. Interventions lacked common pedagogy nor empirical study to inform the programmes or monitoring strategies. As a result, the country witnessed the haphazard implementation of psychosocial support services that left helpers vulnerable, exposed to imposter syndrome, and counsellor fatigue with beneficiaries of their services open to harm and malpractice (Msimanga & Moeti,2018; Muchado,2018).

Local literature (Coker & Majuta,2015; Kroeger et al.,2011; Msimanga & Moeti,2018; Muchado,2018; Stockton et al.,2010) revealed that there were uncoordinated psychosocial support efforts to address HIV and AIDS-related issues in Botswana, as well as lack of relevant training in counselling that demanded an extensive investment in the mental health area from the government. The situation called for evidence-based interventions, qualified counselling professionals and regulating bodies. Though the National AIDS Coordinating Agency (NACA) was established and given the mandate to nationally coordinate HIV and AIDS support programmes, and bring governmental and non-governmental organizations together to draft and implement a national HIV and AIDS strategy to address the scourge, more was needed in monitoring to ensure effective implementation of initiatives and ensure sustainability when international donors financial support came to an end.

Lack of regulation to ensure adherence to ethical standards; professional ethics and clinical supervision of counsellors in the national plan was a challenge as practitioners offered what they deemed fit, moreover, clinical supervision was not a common practice even though counselling was provided by paraprofessionals and lay counsellors struggling with "imposter syndrome" where professional counselling was equally foreign (Msimanga & Moeti,2018; Rollin & Witmer,1992). This historical background on guidance and counselling mirrors Botswana's economic development history following independence which was faced with varied and complex issues that influenced what the country is today.

Botswana's rapid economic growth and foreign influence brought both positive and negative changes to the lives of Batswana, the changes led to the emergence of socio-economic and psychosocial issues associated with modernization, cultural shift and diversity. Hence, Navin (1985) opines that the positive economic changes that led to Botswana's transformation from a poverty-stricken country into a middle-income economy led to the emergence of complex social challenges, and societal ills associated with modern societies; such as the high unemployment rate, an increase in crime, use of illicit drugs, increase in substance use disorders, unplanned pregnancies among the youth and high HIV prevalence as the economic boom led to increased population in cities, increased migration from rural areas to towns, abandonment of agriculture resulting in

crowding in towns and a shortage of housing further leading to urbanization and the disintegration of the extended family support systems.

Therefore, all these issues necessitated training of professionals who could competently address such myriads of complex psychosocial issues and the evident need for a standardised pedagogy across all mental health professions to bridge the gap created by missing fathers and the disconnect from extended family support. Investment into counselling through training psychologists, educational psychologists, counselling psychologists, Guidance and counselling teachers, clinical social workers and psychiatric nurses was a significant development that should have been accompanied by clinical supervision provision of the same to all including the paraprofessionals (Bhusumane et al.,1990; Coker,2013; Msimanga & Moeti,2018; Rollin,1990).

2.5.4 Research and Training of Counsellors

Rollin (1990) asserts that; "One of the hallmarks of every profession is its commitment to continuing education or staff development". Local literature (Bhusumane,2007; Maes,1995; Montsi et al.,2000; Msimanga and Moeti,2018; Muchado,2002,2018; National Mental Health Policy,2003; Navin,1985; Revised National Policy on Education,1994; Stockton et al.,2010) provide evidence that the need for trained professional counsellors was echoed by many over the years either through research studies, consultancy reports, seminars and conferences.

In her consultancy report (Navin,1985) emphasised the importance of introducing a guidance and counselling training program at the University of Botswana and colleges of education which saw the programme introduced at the University of Botswana, Molepolole and Tonota Colleges of Education. Similarly, Maes (1995); Rollin (1990) and Rollin and Witmer (1992) recommended the need for training counsellors to provide psychosocial support services in schools and to out-of-school youth and parents.

According to Montsi et al. (2000), the existing teacher training programs in colleges of education needed upgrading to empower teachers to specialize in Guidance and Counselling and reiterated the importance of

offering counselling degrees at the University of Botswana and other counsellor education training institutions. Similarly, Muchado (2002) argued for the importance of training school counsellors to ensure effective implementation of the G&C programme in schools. The need for developing a holistic and comprehensive counselling programme in schools and having an effective counsellor-in-service training programme for the effective implementation of G&C was also echoed by Stockton et al. (2010). These consultancies were underpinned by the Revised National Policy on Education (RNPE) recommendation number nineteen item three (19:3) which stated; "the guidance and counselling program in primary schools should be strengthened and teachers trained to provide the counselling service". The same applied to secondary schools.

As a response to the RNPE recommendation, a significant number of teachers were sent outside the country for further training in Guidance and Counselling, Counselling psychology, educational psychology and career Guidance and counselling between 1999 and 2005, mostly to South African Universities. At the same time, counselling and human services, social work and psychology were introduced at the University of Botswana whilst in teacher training colleges like Molepolole and Tonota College teachers acquired diplomas in guidance and counselling as a minor in the pursuance of their Diploma in Secondary Education (DSE). Recently, privately owned institutions like Phronesis International College (PIC) in Ramotswa and Boitekanelo College in Tlokweng were established to offer counselling courses to help close the gap and the national need for trained counsellors in the country.

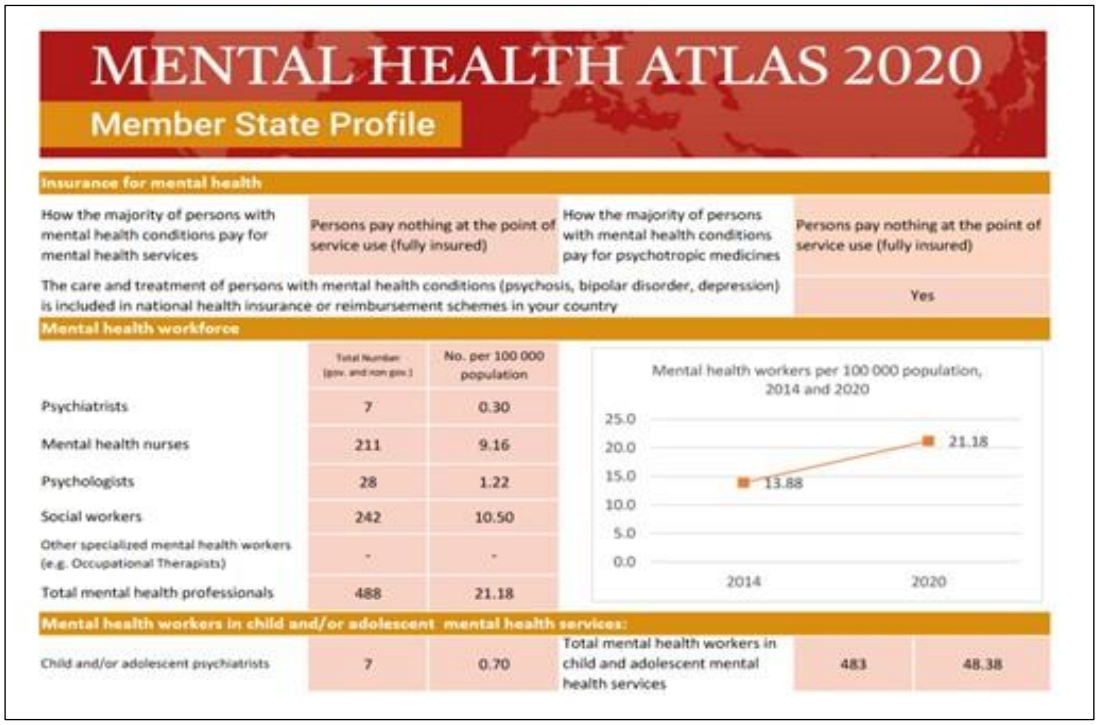
These privately owned institutions offer courses from certificate to degree. Despite the training of guidance teachers, due to the basic education being more academic and exam result-oriented, the implementation of the G&C programme in schools encountered challenges as most of the G&C-qualified teachers had to teach their core academic subjects like maths, science and so on resulting in little time for the provision of G&C services leading to poor implementation of the programme (Coker & Majuta, 2015; Levers,2007; Muchado,2018; Stockton et al.,2010).

Post-COVID-19, many professional counsellors despite their training at Masters' and Doctorate degree level in counselling Psychology, Guidance and Counselling (G&C), Educational Psychology, and Marriage

and Family Therapy (MFT) still find themselves not recognised as mental health service providers and excluded by the Botswana Health Professions Council (BHPC) and the Botswana Mental health ACT despite providing professional counselling in communities (WHO Mental Health Atlas,2020, p.1);

Figure 5

Botswana Mental Health Workforce



MENTAL HEALTH ATLAS 2020

Member State Profile

Insurance for mental health

How the majority of persons with mental health conditions pay for mental health services	Persons pay nothing at the point of service use (fully insured)	How the majority of persons with mental health conditions pay for psychotropic medicines	Persons pay nothing at the point of service use (fully insured)
The care and treatment of persons with mental health conditions (psychosis, bipolar disorder, depression) is included in national health insurance or reimbursement schemes in your country			Yes

Mental health workforce

	Total Number (gov. and non gov.)	No. per 100 000 population
Psychiatrists	7	0.30
Mental health nurses	211	9.16
Psychologists	28	1.22
Social workers	242	10.50
Other specialized mental health workers (e.g. Occupational Therapists)	-	-
Total mental health professionals	488	21.18

Mental health workers in child and/or adolescent mental health services:

Child and/or adolescent psychiatrists	7	0.70	Total mental health workers in child and adolescent mental health services	483	48.38

WHO Mental Health Atlas (2020) Botswana Member State Profile (p.1)

The largest number of counsellors in Botswana are in the Ministry of Basic Education (Guidance and Counselling teachers) because each school from primary, secondary to brigades/vocational training centres and other tertiary institutions have counsellors, followed by the Ministry of Health and Wellness, and Department of social welfare with their community-based counsellors, marriage and family therapists and social workers (Coker & Majuta, 2015; Bhusumane,2007; Modie-Moroka,2016; Muchado,2018; Stockton et al.,2010).

The issue of substance use disorders (SUD) has increased drastically in the country, and to address the concern, the Ministry of Health and Wellness in collaboration with the Colombo Plan International Centre for Credentialing and Education of Addiction Professionals (ICCE) in partnership with United States of America's

Department of State trained professional counsellors (Master's Degree holders) from various government sectors and non-governmental organizations (NGOs) from the year 2016 -2020 and beyond.

As national trainers of trainers, they were expected to train others to help address the issue of drug and substance use amongst young people in the country as it had become a major concern to families, schools, communities, the government and the nation as a whole. The main aim was drug use reduction; to "reduce the significant health, economic and social problems associated with SUDs" in Botswana as imposing an alcohol levy had not deterred alcohol abuse.

Regardless of these national challenges, there remained uncoordinated psychosocial efforts, a dearth of literature; empirical clinical practice for practitioners operating in different environmental settings, an evident lack of research output in CS among counsellors in Botswana, and limited documentation or poor database on the existence of any form of clinical supervision and professional counselling from the year 1963 to 1999.

The few research studies that existed appeared after the introduction of counselling at the University of Botswana and following the sending of teachers abroad for training in Guidance and counselling. Even then, their research focused mainly on the challenges facing the implementation of G&C in Botswana schools, which was not surprising as these were conducted by guidance and counselling teachers (Guidance teachers), Guidance and counselling curriculum developers, policymakers, educational officers of counselling studying in Botswana or abroad mostly between the years 2000 and 2015 without specific focus on clinical supervision (Muchado,2002,2018).

Clinical supervision and research play a significant role in the counselling profession as both help to strengthen counsellors' effectiveness; and enable counsellors to monitor their efficiency and their ethical and clinical practice. The counselling practice is grounded on researched theories and so is clinical supervision; the development of the two services is equally informed by research.

It was on this understanding that the Botswana Counselling Association (BCA) organised a few conferences to encourage, inspire and instil the incorporation of research into interventions, develop evidence-

based initiatives to inform change, strengthen professional development and create public awareness. However, as Muchado (2018) asserted, most of the research papers presented at conferences were mostly presented by guidance teachers and focused mainly on the G&C implementation challenges faced in schools, which was not surprising as many were ill-equipped for the school counselling position.

This situation correlates with Inman and Ladamy (2008) in Watkins (2014, p.263) who raised concern over the limited research done in clinical supervision; "the number of supervision studies produced each year still tends to be somewhat limited, estimates have indicated that approximately 10 supervision investigations appear annually". In Botswana, this situation could have had a lot to do with a lack of counselling regulation and a lack of guiding principles and protocols.

2.5.5 Counselling Regulation in Botswana

Literature shows that there was enough evidence to suggest that counselling was growing rapidly in Botswana and therefore the need to coordinate the counselling services was apparent as it was becoming a new profession in mental health. However, Botswana's counselling scenario is unique; there are different levels of counselling practice; the paraprofessionals who are mostly "lay counsellors" and mostly volunteers in NGOs, Guidance teachers with no training and no qualifications in counselling, thirdly, guidance teachers with diplomas or a degree in guidance and counselling, and the fourth group made of professional counsellors with Masters' or Doctorate degrees comprising of teachers in schools, those who work mostly in higher institutions of learning(tertiary schools) as counsellor educators, university counsellors and those in private practice or working as officers in various ministries and governmental departments such as curriculum developers, policy advisers, in social welfare department, NGOs, in the police force and the army (Msimanga & Moeti,2018; Muchado,2018; Stockton et al., 2010). These same groups have been offering psychosocial support services as a response to HIV and AIDS and recently during the severe acute respiratory syndrome coronavirus (SARS-CoV2) as COVID-19 pandemic support. Despite this, literature is silent on CS; there is no record of CS practice in the country which makes one wonder about the quality of services offered without clinical supervision.

Therefore, issues of professional ethics, counsellor fatigue, burn-out, case management, client welfare, and clinical self-care remain a cause for concern as long as CS is non-existent. Therefore, due to this scenario of various groups of unqualified people providing "counselling services," there was a need for some form of coordination, hence the Botswana Guidance and Counselling Association (BGCA) was formed in 1998 but lasted only six (6) years and stopped operating in 2004. In its place, the Botswana Counselling Association (BCA) emerged in 2005 and officially launched in 2007. In addition, the Botswana Association for Psychosocial Rehabilitation (BAPR) was established and started functioning in 2000 and is still operational (Muchado,2018).

BCA's mission was to promote and protect the interest of the clients, the counsellors and the reputation of the counselling profession by ensuring the ethical provision of psychological and evidence-based counselling services in Botswana. The association attracted affiliates from schools (guidance teachers), educational psychologists, clinical social workers, counselling psychologists and professional counsellors.

According to Muchado (2018), apart from regulating service provision, all these organizations provided counselling services, and these included the Botswana National Association of Social Workers (BONASW), Botswana Family Welfare Association (BOFWA) and Botswana Association of Psychologists (BAPsy). However, due to ineffectiveness and working in silos, more continue to emerge such as the Botswana Society of Professional Counsellors and Psychotherapists (BSPCP) and the Federation of Professional Counsellors Botswana (FPC-B) established in 2021 and 2022/2023 respectively.

Since its establishment, Botswana Counselling Association (BCA) has relentlessly continued to advocate for the counselling profession in Botswana. It facilitated the formulation of the Botswana Counselling Act which still has to gain approval at the national assembly and be enacted into law to regulate counselling services and licensure in the country. Besides regulating the counselling practice, BCA frequently hosted seminars and conferences for counsellor development to keep up with the global trends and conduct research to inform the strategies for strengthening professional counselling in Botswana.

Muchado (2018) posits that the Botswana Counselling Association (BCA) has roughly six hundred registered members and a draft Code of Ethics available to provide a framework to BCA members.

2.6 The Current Status of Clinical Supervision in Botswana

Literature concerning clinical supervision in the counselling profession in Botswana appears to be non-existent at this point, the only available literature on clinical supervision is on teachers' instructional teaching by Moswela and Mphale (2015) who looked at the "barriers to clinical supervision practices in Botswana Schools" with specific reference to classroom teaching, and Msimanga and Moeti 's (2018) doctoral paper on the "challenges hindering the provision of effective supervision for counselling students in Botswana", specifically focusing on clinical supervision of university student counsellors during practicum and internship; decrying lack of clinical supervision due to lack of resources and qualified clinical supervisors.

Schools offer counselling from primary to secondary schools and yet the only supervision available to guidance teachers is administrative one, even then there is a lack of clarity as to who supervises the senior teacher 1- guidance and counselling between the school head, the Deputy School head and the Head of Department (HOD Pastoral Care). Guidance and counselling lessons are currently allotted 45 minutes in the school timetable for psycho-education as a non-examinable subject, this is done by volunteer teachers who also teach their other core subjects together with the guidance teacher, though in some cases it is done solely by the Guidance teacher.

There is no evidence of clinical supervision offered to school counsellors, if done, it will be by guidance teachers (mostly paraprofessionals) who have very little understanding of what they are supposed to do, hence, Rollin (1990) and Rollin (1990, p.5) quotes one teacher saying; " I have had no training; I do not know what I am doing". However, a few privately owned schools seemed to have qualified school counsellors or educational psychologists. As Msimanga and Moeti (2018, p.51) point out; "Students from counselling and human services (CHS) undertaking practicum and/or internship have been placed under the care of nurses, social workers,

psychologists and worse still, police officers and some paraprofessionals commonly referred to as HIV and AIDS coordinators/counsellors".

Some schools may happen to have a senior teacher 1 - G&C who is a qualified professional counsellor or a para-professional with no qualification or someone with a diploma or degree who offers administrative supervision to those teaching guidance lessons, many of whom form the school Guidance and Counselling Committee. In some colleges of education, though G&C is taught, often there are no structured counselling services or any record of clinical supervision offered. However, in some cases, there may be a few lecturers who take the entitative to offer counselling services to a few college students out of compassion.

So far, only the University of Botswana (UB) has a well-established Careers and Counselling Centre with counselling professionals such as counselling psychologists, pastoral counsellors, career counsellors, educational psychologists and clinical social workers who offer counselling services to university students and walk-in clients from the community (Bhusumane,2007; Msimanga & Moeti,2018; Muchado,2018; Stockton et al.,2010).

In communities, there are clinical social workers, psychiatric counselling nurses, NGO counsellors and counselling psychologists who offer counselling services to families, couples and groups, even in different governmental departments. There is enough evidence to suggest that the counselling service in Botswana is developing into a recognised, needed mental health service and a profession that is growing rapidly in different settings. Despite this, there is still very little evidence of clinical supervision practice and not much research found giving the impression that very little has been done in that area (Bhusumane,2007; Msimanga & Moeti,2018).

According to Modie-Moroka (2016); Msimanga and Moeti (2018); Muchado (2018) and the World Health Organization ([WHO],2014); many mental health counselling services are still specific to HIV/AIDS issues, and general counselling services are increasingly being offered through various government departments, non-governmental organizations; faith-based organizations, civil society and private practice.

Modie-Moroka (2016); Msimanga and Moeti (2018); Rollin (1990) and Rollin and Witmer (1992) concur that in Botswana, some of the people offering mental health services such as counselling and clinical supervision are not qualified enough to provide such services, hence, Stockton et al. (2010) opined that in rural and remote parts of Botswana, psychiatric nurses find themselves having to provide counselling as opposed to clinical supervision. Whereas, in other environmental settings, paraprofessionals are most likely to be providing counselling services, some form of case review, case management, peer debriefing or informal peer CS when facing ethical dilemmas.

As Msimanga and Moeti (2018) alluded to; "There are innumerable problems that impede the adequate provision of clinical supervision to counselling students at the UB's Counselling …" The situation may not only be synonymous with the University of Botswana (UB) but may be an occurrence in other settings where counselling is offered regardless of Watkins Jr.'s (2014, p.251) 'argument that;

> Where there is psychological treatment, there is a need for psychological treatment supervision. As the practice of psychotherapy and counselling has become increasingly globalised, the practice of clinical supervision has been accordingly challenged to become increasingly globalized as well.

Regardless of the global trends, in Botswana, the counselling profession is still underdeveloped because there are no professional standards of practice, no effective regulatory body, no national licensing body and no clinical supervision. The mental health service provision in the country is still disjointed despite the country facing various complex psychosocial challenges, there are widespread counselling services offered throughout the country signifying a massive demand for psychosocial support though largely provided by paraprofessional counsellors.

The development of an effective professional counselling regulating body has remained a challenge. The current status of counselling services in the country both in schools and communities remains elusive, hence the implementation of the clinical supervision practice in the country has equally remained elusive

(Charema,2008; Msimanga & Moeti,2018; Muchado,2002). Therefore, there is a growing concern about issues of standard of practice due to paraprofessionals offering counselling with little or no clinical supervision. Similarly, the counselling practice in Botswana is not regulated, as the case, there are concerns regarding the safety and welfare of the clients, the quality of the service and the clinical well-being of counsellors.

The problem of malpractice and misconduct by professionals will always be a great concern as long as there are no regulatory standards and a lack of effective regulating bodies to ensure ethical practice and clinical supervision (Laschober et al.,2012; Msimanga & Moeti,2018; Thompson et al.,2011). There are no ethical standards, no directory of practitioners, no certification or licensure protocols, no accreditation and no structures in place for the approval of counselling programs offered by the different training institutions and no training of clinical supervisors.

This lack of clinical coordination, regulation and licensure has become a major concern in the country among professional counsellors (Msimanga & Moeti,2018; Muchado,2018). According to Inman and Ladany (2008) in Watkins (2014, p.267); the "strongest conclusion that we can make about... supervision is that it continues to be a path less travelled", therefore, Botswana's situation is not surprising.

Hohenshil et al. (2013) and Watkins (2014) assert that there is evidence to the fact that counselling service is provided throughout the world; in various countries from Africa, Asia, Europe, the Middle East, North America, Oceania, and Central and South America, and "where there is a psychological treatment, there is need for psychological treatment supervision". Similarly, Falender and Shafranske (2012) argue that just because counsellors underwent training and completed their various degrees in counselling and Clinical supervision does not equate to the application of the practice. Falender and Shafranske (2012) further opined that "it is no longer acceptable to simply assume that competence has been attained". This implies that the application of skills learnt through accessing or conducting clinical supervision is essential for the explicit demonstration of competencies, and yet in Botswana, little seems to be known about the concept and practice of clinical supervision.

2.6.1 Clinical Supervision for Guidance Teachers

There is enough evidence to suggest that clinical supervision has become a critical part of counselling and other mental health professions, hence it is practised in various environmental settings such as educational institutions, medical, armed forces, social welfare and so on. However, there is also evidence of little being done in some parts of the world (Borders,2005; Msimanga & Moeti,2018; Watkins,2014).

Walsh-Rock (2018) argues that in a school setting, as the mental health needs of students have increased and become more complex over the years, clinical supervision for guidance teachers/school counsellors though crucial is lacking and the situation has led to guidance teachers being overwhelmed by student mental health issues and concerns from parents and key stakeholders in the communities where schools are located. Walsh-Rock (2018) goes on to say that this lack of clinical supervision has led to "burnout, role confusion and a withering of counselling skills resulting in students' needs not being met".

In Botswana, the situation has led to the weakening of the guidance and counselling programme and limited psychosocial learner support in the education system. Guidance teachers (school counsellors) do not access systematic clinical supervision, and most paraprofessional Guidance teachers are not competent or qualified to provide clinical supervision for their colleagues. This could also be due to guidance teachers feeling overwhelmed because apart from providing school counselling, they have to teach other subjects.

Moreover, as noted by Walsh-Rock (2018), the issues surrounding guidance teachers' ability to access clinical supervision are intricate and compounded by the value that guidance teachers attach to clinical supervision, the clinical supervision competencies or lack thereof, as well as the extent to which school management and ministry management are prepared to provide resources for guidance teachers to receive clinical supervision. Walsh-Rock (2018) opined that it is only through clinical supervision that guidance teachers could effectively provide a meaningful service to learners in their schools. Despite this fact, research on the practice of clinical supervision of guidance teachers or school counsellors is elusive, and counsellors' knowledge, attitudes and practices of clinical supervision have not been established as literature is scanty on the subject in Botswana.

Currently, there are no ethical standards that provide a framework for guidance teachers counselling providers. Though Botswana National Mental Health Policy (2003) exists, it is silent on the clinical supervision of school counsellors and other mental health practitioners. Therefore, though G&C in schools has evolved from mere career guidance to a holistic guidance and counselling programme, clinical supervision is still lagging, as Walsh-Rock (2018) opined; "clinical supervision still falls short in recognizing the similarities between essential supervision experiences for mental health counsellors as well as school counsellors".

It is not surprising that Herlihy et al. (2002) argue that; student counsellors' inadequate clinical supervision ultimately produces school counsellors who are limited in providing clinical supervision, and it gets perpetuated by the lack of effective supervision they received during their practicum from their onsite clinical guidance teachers (supervisors) who had no training in clinical supervision or any formal training in guidance and counselling or school counselling, "eventually, these inadequately supervised students become school counselling supervisors themselves" , hence creating a cycle in schools.

Similarly, Borders (2005) opined that; "during the 1990s, researchers documented lack of clinical supervision for school counselling practitioners and their growing need and desire for it". She went on to mention a few countries such as Australia, Israel, and the United States of America where school counsellors received very little supervision. With these global trends in mind, one can make inferences about the current status of clinical supervision in Botswana.

2.6.2 Clinical Supervision Among Counsellors in Other Settings

It has to be noted that counselling is offered in other settings apart from schools in Botswana, and these communities are diverse; rural, semi-urban, urban and remote, and in different departments that may be governmental or privately owned (Msimanga & Moeti,2018; Muchado,2018). The assumption is that service providers in these different settings have an awareness of clinical supervision, its benefits and are accessing it. However, literature reveals very little is known about the practice and level of its implementation in Botswana.

This status quo appears to be trending not only in Botswana but in other parts of the world, for example, Borders (2005) states that there are few studies on the clinical supervision of counsellors in settings other than schools. Moreover, research studies conducted indicated that; "fewer counsellors reported having received limited clinical supervision and desiring more". Consequently, despite knowing the benefits of clinical supervision, counsellors appear not to be accessing the service (Borders,2005; Walsh-Rock,2018). According to Borders (2005, p.80), there was scanty research on the issue related to supervisor competence; "Only one study related to supervisor competence was located". This global trend enables inferences to be made on the provision, accessibility and practice of clinical supervision in Botswana where the counselling profession is still developing and far from reaching global standards.

Lack of Botswana evidence is a sign of a lack of research in the field. Borders (2005) opined that "hopefully, over the next five years, counselling researchers will find creative approaches to further enhance supervision practice and refine supervisor training".

This same view is what Botswana professional counsellors are equally hoping for, as Msimanga and Moeti (2018) pointed out, "there is nothing justifiable enough to compromise the provision of adequate and effective clinical supervision…...". Similarly, Landon (2016) asserts that, though counselling has evolved and clinical supervision has made strides in other settings, little attention has been given to clinical supervision practices in the non-profit and private/for-profit practice settings, and this is worth noting, as most of the organizations that continue to offer counselling in Botswana since the advent of HIV and AIDS are mostly NGOs. However, there is no evidence of any literature from NGOs, Civil society/faith-based organisations and governmental organizations concerning this issue.

With this in mind, similarities hold across the different settings concerning clinical supervision; whether in the school setting or other various environmental settings revealing the very fact that very little has been done in terms of research on CS in the counselling practice in Botswana, hence, Msimanga and Moeti (2018, p.54) made a couple of recommendations for the improvement of the current situation concerning clinical supervision in Botswana, the most significant of them being the importance of establishing a licensing

organization; “licensing council is overdue in Botswana” to ensure that client’s welfare and interests are protected; accrediting authority can ensure that the counsellor education program offered is well-structured, and goes on to argue that;

> it will take a considerable time for Botswana to develop and sustain a well-functioning program such as those programs bound by the CACREP requirements. In the meantime, the ideas and insights that have been documented by CACREP and other accrediting bodies can be utilized as framework (p.54).

2.6.3 Conceptual Clarification

Watkins and Milne (2014) assert that the benefit of the literature review is “to borrow minimally from the neighbouring literature”; to appreciate the process and progress done thus far in the field of practice concerning research, and on that basis extend one’s knowledge “reasoning-by-analogy” and in this research study, “reasoning-by-analogy” provides the ability to infer the issue of knowledge, attitudes and practices of CS among counsellors and how these variables may influence counsellors’ ability and influence acquired knowledge and held attitudes towards performing clinical supervision.

Based on this reviewed literature; it has become apparent that local literature is scarce, therefore assumptions, inferences and conceptual clarifications can be made concerning the practice in Botswana that; most counsellors in the education system and from other settings either lack the knowledge of clinical supervision or there are possible negative attitudes towards the practice which may have impacted the practice and limited research in the area. In line with this view is Rollin’s (1990, p.1) interview with a guidance teacher in Botswana, captured verbatim as saying; *" I have had no training, I do not know what I am doing”.*

Therefore, the reasoning-by-analogy as purported by Watkins and Milne (2014), in the case of Botswana where there is no literature on clinical supervision; “borrowing has become “burrowing”; creating comfort zone that only led to this perspective; how can they implement that which they do not know, and how can they

access what they know very little of its benefits, as knowledge influences attitudes and consequently practices. With no training, no regulation, no licensure and no protocols there are bound to be certain attitudes towards CS practice. Therefore, it is not surprising for Msimanga and Moeti (2018) to argue that; "skill development and supervision encourages the socialization of professional values through the exposure of standards of practice and modelling, supervised practice and feedback…".

Therefore, certification and licensure in counselling if implemented in Botswana, could minimize a multitude of factors hindering the provision of effective supervision to counsellors in different settings; not just student counsellors at the University of Botswana. Notwithstanding, with limited knowledge and skills there is bound to be limited or lack of implementation as alluded to by Watkins (2014) in saying; "... supervision continues to be a path less travelled".

Similarly, Falender and Shafranske (2012) purport that "it is no longer acceptable to simply assume that competence has been attained", just because training took place and knowledge and skills were acquired, there has to be a willingness to put theory into practice, for as purported by theory of planned behaviour, individuals' attitudes in performing a behaviour are influenced by intentions and high levels of perceived behaviour control, and in most cases, people are motivated to act on behaviour if they believe they will gain something positive from it and when they believe they have the competence to perform the behaviour.

It is inherent in human behaviour to weigh the positives against the risks; to weigh the benefits against the possible losses and choose to act in line with what is beneficial. Moreover, it is common for individuals to act on the behaviour when they have the confidence that they can do it well. In the case of counsellors in rural Botswana, especially guidance teachers encounter challenges related to their ability to provide effective counselling services to students. Often, they are the only mental health providers in their communities despite most being paraprofessionals (Bardhoshi et al.2014).

This statuesque calls for a change in Botswana as global benchmarks showed CS is fully established in many countries (Bardhoshi,2014; Msimanga & Moeti,2018; Thompson,2011; Watkins,2014).

2.7 Models of Clinical Supervision

Every scientific intervention is based on empirical evidence derived from a series of research studies to test its effectiveness; hence such are known as evidence-based frameworks or models. CS as an evidence-based intervention has various models discussed herein.

2.7.1 Introduction

Several clinical supervision models have been identified; a plethora of such models are utilised in different settings across mental health professions clinical process. Some are specific to certain settings whilst others could be utilised across the different mental health settings, for example, there are those developed specifically for utilisation in schools either for student counsellors in training or by school counsellors.

Glaes (2010) asserts that Clinical supervision has existed in the mental health professions since the late 19th century for individualised or group learning of supervisees (counsellors) focusing on their professional work with their clients. The systematic manner in which this professional development is facilitated hinges on specific frameworks or models as guiding templates.

Therefore, the knowledge, competencies, attitudes and experiences counsellors have on models of supervision are crucial towards the effective and ethical practice of CS and the counselling process. Clinical supervision models discussed in this section fall into three different categories; those that describe the functions of the roles played by clinical supervisors, and the developmental models process as it imparts professional growth in supervisees. Murphy and Kaffenberg (2007) assert that models of supervision can be divided into three basic types; psychotherapy-based models underpinned by specific theoretical orientation within the supervision process; Social role models mainly focusing on various roles of the supervisor and developmental models' stages and processes. Similarly, Bernard and Goodyear (2004) reiterated supervision models classified into three; viz.; Psychotherapy-based models, Developmental and social role models. Therefore, herein discussed; IDM (Stoltenberg, McNeill & Delworth,1998); Stoltenberg and Delworth (1987), theoretical Orientation Specific Models which are psychotherapy-based supervision models anchored on theories of

counselling, Integrative Psychological Developmental Supervision Model (IPDSM), and Social Role models such as Discrimination Model (Bernard,1979,1997). However, because most of the research participants for this study were drawn from schools, there was need to discuss the school-based models such as School Counsellor Supervision Model (SCSM) by Bernard and Luke (2006).

2.7.1.2 Significance of Supervision Models

Supervision models provide a general framework upon which the process of supervision is structured. They are meant to assist clinical supervisors in conceptualising the supervision intervention process, the models provide grounding for easier facilitation of the supervision process and help with decision-making during the supervision process. The models provide clinical supervisors with protocols to follow as they serve as a point of reference. Through the models, supervisors can appropriately evaluate the content and context, review cases, determine the developmental level of the supervisee and come up with appropriate interventions (Glaes,2010). Counsellor support supervision is carried out for the benefit of the clients and the supervisees' growth; therefore, the supervisors' role is that of quality assurance and a buffer or gatekeeper.

Extensive literature on clinical supervision reveals that models are critical in the supervision process for providing frameworks, systematically arranging knowledge and skills transfer. Supervision models' function could be equated to the role of counselling theories in the counselling process; just as counselling theories provide a framework for the counselling process; CS models perform a similar function in the CS process. The CS process is informed by theories and various theoretical models. Blakely (2009); Cinotti (2013); Cook (2012) and Luke (2006,2003) assert that knowledge and clinical experience are highly essential, hence for one to be considered an experienced supervisor they must have at least two thousand to three thousand hours of practice.

According to Leddick and Bernard (1980), supervision models provide heuristic value to practising supervisors on how best to structure and facilitate the clinical supervision intervention, this is despite Lyth's (2000) argument that the models commonly used are not grounded on empirical research evidence to suggest that they are either effective or appropriate. However, the literature is replete with enough evidence of evidence-based models developed and underpinned by the theoretical framework with extensive research

invested in their development. Moreover, those who have used the models testify to having experienced great benefits.

On these grounds, these models have found popularity in various fields such as nursing, social work, psychology and counselling. No wonder, Lyth (2000, p.726) argues that; "within counselling, supervision is a mandatory requirement for practice and supervisors have a code of ethics to follow". Numerous models were proposed by various scholars as already alluded to, some of which included Goals, Roles, Functions, and Systems (GRFS) by Wood and Rayle (2006) anchored on Discrimination Model by Bernard (1979), Systems Approach to Supervision (SAS) by Holloway (1995) and Working Alliance Supervision Model by Bordin (1983). Some scholars have also suggested Self-Supervision model as being equally beneficial for an individual professional counsellor to regularly do self-evaluations and monitor their performance in their work with clients (Luke, 2006; Yager & Park, 1986).

2.7.1.3 Self-supervision

Yager (1986,1987) proposed a self-supervisory model even though clinical supervision has always been viewed to be offered by counsellor (supervisor) with experiential skills acquired working as a clinical supervisor. Self-supervision is a form of self-monitoring, clinical self-reflection and self-evaluation that an individual objectively utilises to assess their work with their clients.

Through the model, supervisees establish their areas of development needing improvement for effective counselling. According to Yager and Park (1986), counsellors need to possess the necessary skills for objective self-supervision, and personal and professional growth needed for effective counselling service delivery.

This model could be useful in a school setting located in remote inaccessible rural areas where a school counsellor or psychiatric nurse may be stationed in remote inaccessible areas where there are no qualified supervisors, and has to be self-reliant for objective self-evaluation (Benshoff,1988; Blakely,2009; Luke,2006). However, this does not nullify that counsellors benefit immensely from consultation and feedback received from other counsellors since the model has the inherent possibility of finding it challenging to objectively

self-evaluate to identify areas of improvement. Some argue that self-supervision may be shrouded with biases unlike receiving neutral unbiased feedback from a colleague or an independent clinical supervisor who does not work in the same setting. It is from this perspective that Benshoff (1988) argues that rather than rely on self-supervision, "it can be advantageous to enlist the support and feedback of competent and trusted colleagues in the ongoing process of self-evaluation".

The self-supervision model proposed by Yager and Park (1986) is simple; it recommends pair work and supervisee collaboration with colleagues to share challenges, especially with those from different settings to gain insight, get constructive feedback and critical evaluation in a formal and informal setting from those not based in the same working environment. On the other hand, some propose dual-supervision model approaches of having two clinical supervisors co-supervise a group of supervisees in a supervision session.

2.7.2 Social Role Models of Supervision

Include Discrimination Model (Bernard, 1979, 1997), Hawkins and Shohet model (Hawkins & Shohet, 1989) and the Systems Approach to Supervision Model (Bernard & Goodyear, 2004). Decision on which model or which combination of models to use is usually informed by the supervisee's need, level of competencies and the supervisor's supervisory experience (Bernard, 1997; Lazvosky & Shimoni, 2007,2005; Stoltenberg, McNeill & Delworth, 1998).

The models focus on the roles deployed by the supervisor, hence the name social role model. Literature has differing views on which factors influence the selection of the supervision model to deploy. Some scholars argue that the supervisory role has to be based on the working alliance and social attributes such as the supervisor's expertise, level of experience, trustworthiness, commitment to supervision, the supervision setting as well as the preferred theoretical orientation of supervisor and supervisee (Goodyear et al., 1984; Goodyear & Bradley, 1983; Goodyear & Robyak, 1982; Heppner & Roehlke, 1984; Lazvosky & Shimoni, 2007; Luke,2007). Nonetheless, regardless of how the model to utilise is selected, the supervisory role has the distribution and shared responsibility of power between the supervisor and supervisee inherent within.

Literature is replete with considerable debate on the application of social role models, reasons being these models stipulate behaviours and expected outcomes regarding the supervisors' roles, and styles in the supervisory relationship with their supervisees (Bernard & Goodyear, 2004; Luke,2007; 2006; Pearson,2006). Needless to say, literature seems to be silent concerning supervisees' preference for any specific supervisory role and model (Fernando & Hulse-Killacky, 2005; Lazvosky & Shimoni, 2007). Moreover, there hasn't been any empirical evidence of the benefits and efficiency attributed to any particular role.

However, since social role models like the Discrimination Model are considered to be atheoretical (Bernard, 1979, 1997), they can be utilised in combination with other models and across different theoretical-oriented models. It can be inferred therefore that; the Discrimination Model has remained one of the extensively utilised and researched conceptual frameworks in the clinical supervision practice (Borders & Brown, 2005; Luke,2007). The model has gathered extensive support and gained popularity in mental health professions according to Lazvosky &Shimoni (2007).

2.7.2.1 Discrimination Model (DM)

According to Glaes (2010), the discrimination model was developed by Bernard in the 1970s and has since become the most extensively utilised clinical supervision model and extensively discussed in literature.

This model is usually integrated and part of that focus on critical role and the significant experience of the whole process for effectively functioning as a counsellor, teacher and consultant in the supervision process. This model can be used by the supervisors in any stage of supervisee development; hence Bernard (1977) opined that; "the discrimination model was conceived as a teaching tool".

Trant (2000) posited that in the late 1970s, a variety of models emerged which were unrelated to a specific theoretical orientation, the models began to emerge based on the developmental model of Hogan which was developed in 1964.

Such models assume that psychotherapy supervisees follow a developmental process in their learning process and that an effective clinical supervisor will modify their methods and style accordingly to suit the

needs of the supervisee. The models are different from the theoretically based models that emerged following World War II which were mostly psychiatry or psychoanalytic. One such model that emerged in the 1970s perceived as atheoretical and received popular support is the Discrimination Model proposed by Bernard in 1979.

According to Bernard and Goodyear (2004,2014), the model was proposed to provide a framework and address the lack of a guiding framework or models for training supervisors to provide clinical supervision services (Bernard, 1979). It was specifically developed to be used by experienced supervisors as well as novice clinical supervisors as a training model. Bernard (1997,1979,2004) opined that the Model assists supervisors in assessing the developmental level of student counsellors/ trainees and helps the supervisor to utilise the relevant role between counsellor, teacher and consultant within the supervision relationship. Moreover, the model was believed to enable the clinical supervisor to identify areas of development and target such limitations regarding supervisees' counselling skills; it helps clinical supervisors identify which counselling competencies are limited in the supervisees.

According to Bernard (1979), the three essential areas of focus should be the evaluation and identification of basic skill areas that need to be enhanced by the actual skills process. Therefore, through the Discrimination Model, the supervisor can evaluate to establish areas that need attention and based on the assessment, decide on the appropriate role that the situation demands; whether to function as a counsellor, consultant or teacher depending on the situation at hand; "the here and now". By so doing, the clinical supervisor helps the supervisee to sharpen their skills and develop appropriate counselling skills (Benshoff,1988; Luke,2007,2003). Discrimination Model assumes that clinical supervisors can utilise skills identified.

The clinical supervision intervention skills utilised in the supervision process are intended to help the supervisees provide meaningful counselling intervention to their clients and maintain a healthy professional counsellor-client relationship (Bernard, 1979; Cummings,2004; Levy,2004). Therefore, according to the Discrimination Model, for clinical supervision to be considered effective, there has to be a process of identifying areas that need to be addressed concerning the supervisee's competencies, then the identification

of the relevant supervisory approach to adequately mitigate the identified areas of limitations for the improvement of the supervisee's clinical counselling skills for the provision effective therapeutic counselling. In the development of the model, Bernard (1979) came up with three roles of counsellor, teacher and consultant deemed necessary for the clinical supervisor to alternate during the supervision process to achieve supervisee professional and personal development. Suffice it to say, based on the identified areas of limitation, the Supervisor provides area-specific supervision to enhance future clinical performance and clinical functioning. Luke (2007) opined that the Discrimination Model (DM) is similar to Integrated Developmental Model (IDM) by Stoltenberg, McNeill and Delworth (1987,1998).

According to Borders and Brown (2005), the model has become one of most popular, acknowledged, most utilised and highly regarded by scholars compared to others, for example; it was described as the most impactful model and easier to utilise due to its clarity on the clinical supervisor's clearly outlined roles of counsellor, teacher and consultant (Lazovsky & Shimoni,2007).

The utilisation of the Discrimination Model identifies areas requiring attention for improvement, decide which role to perform, subsequently offer the specifically needed intervention to help the supervisee function better in counselling. According to Luke (2007), the model derives its name from the use of the discrimination process that the supervisor has to deploy to offer clinical supervision.

The model is considered eclectic and atheoretical due to its utility, as it can be utilised in a three-dimensional focus utilising either one of the three supervisory as well as the ability for clinical supervisors to arrange, evaluate and monitor their progress and their supervisory outputs. It is therefore not surprising that literature shows that the Discrimination Model has received extensive acknowledgement in numerous research studies; such as in Abadie and Efros (1984); Bernard and Clingerman (2004); Ellis, Dell and Goodyear (1988); Fall and Sutton (2003); Glidden and Tracey (1992); Goodyear, Ellis and Dell (1986); Goodyear and Robyak (1982); Lazovsky and Shimoni (2007) and many other scholars.

2.7.2.2 Utilization of the Discrimination Model

The discrimination social role is different; consultant, teacher and counsellor (Benshoff,1988; Luke,2007). The Model looks at underlying factors of supervision in an atheoretical manner rather than theoretically oriented, hence it is user-friendly even to those who are more theoretically oriented in nature.

This Model was intended to provide a holistic approach to training for supervisors though it was initially conceptualized to be two dimensional focusing only on the necessary skills for becoming a competent counsellor, and on the supervisor's role, it was later improved to become three-dimensional focusing on counsellors competencies by looking at three areas. Looking at counsellor shows the strength of the model as largely being knowledge empowerment-based.

This approach was intended to meet the needs of the supervisees, which if left unchecked could negatively impact their personal development. The role of a consultant allows the clinical supervisor to focus largely on finding ways of enhancing the professional supervisory relationship to help develop supervisees' professional growth and enhance their professional relationship with their clients.

According to (Trant,2000), the model was made more relevant and specific for training programs as it can make supervision feedback and evaluation easier for clear understanding and a conducive environment for authentically discussing issues, problems impacting the counselling process and ultimately develop strategies and approaches towards improving the process.

The Discrimination Model (Bernard, 1979, 1997) was developed as a much easier framework to implement for the benefit of student counsellors, to conceptualize categories of counsellor behaviours. The model proposed three foci supervision roles focusing within clinical supervision in counselling.

The intervention skills looked at supervisees' perceptible behaviours that distinguish counselling as a meaningful and intentional interpersonal process (Luke & Bernard, 2006). The use of the model was intended to help supervisees become effective counsellors for the sake of their clients; therefore, it is done for the therapeutic benefit and welfare of the clients who seek counselling services. However, unlike intervention

skills, conceptualization skills may not be easy to identify and hence it may be necessary for the supervisor to indirectly engage with the supervisee through an informal discussion to assess and identify the conceptualization skills. In a nutshell, through this approach, the supervisor helps to enhance the supervisees' cognitive skills and ability to prepare and respond effectively to the client's presented psychosocial issues.

Similarly, personalization skills may also require the supervisor's interpretation of personal responses and attributes within counselling and supervision settings together with the supervisees, encouraging the supervisee to reflect on the process and work together within the supervisory relationship of "counsellor", "teacher" and "consultant" (Trant,2000).

The three foci can be approached through any of the three roles (Bernard,1979; Bernard & Goodyear,2004; Luke,2007) and each of the roles has differential effects on the supervision process, for example; when functioning as a teacher, the supervisor uses a structured instructional and educational approach and is concerned with information giving or instruction modelling and evaluation of performance. Whereas in the role of the counsellor, the supervisor functions simply as a facilitator as opposed to instructing or directing the supervisory engagement process; this role helps the supervisee with reflection and exploration of their internal reality concerning their facilitation of the counselling process such as in case review to address dilemmas. Subsequently, performing the consultant role is a dyadic process as both control development within the supervision process, all being done to inspire the supervisee to grow professionally by reflecting and utilizing their internal frame of reference which then helps to effectively function in providing counselling to clients.

Given this understanding, when supervisors act as consultants they help supervisees through blind spots, and ethical dilemmas, addressing transference, countertransference and vicarious reactions, and when acting as counsellors, they help supervisees resolve personal issues that may interfere with the therapeutic process (Bowers & Hatch,2005; Luke,2007). According to Borders and Benshoff (1999) and Borders and Brown (2005), the Discrimination Model is the most utilized in the supervision of counsellors for those still in training and those already in practice hence Knight (2019, p.19) asserts that;

Bernard's discrimination model of supervision is one of the more
Widely known, investigated, and utilized perspectives on supervision
The supervisor helps supervisees "move from relatively passive
learners to those who take an active role in enhancing their knowledge.

There are numerous advantages purported by many scholars concerning the utility of the Discrimination Model, one of the obvious advantages revealed by literature is that the model is easier to understand, and the roles of the supervisor are elaborated (Ellis & Ladany, 1997; Wortham,2009). The Model provides a cognitive blueprint for easier monitoring of areas of focus in the supervision intervention and enables the supervisor to establish the best supervisory role necessary to meet the targeted needs of the supervisee (Bernard,1981; Ellis and Dell,1986; Holloway,1995; Trant,2000). The Model is therefore considered user-friendly hence there have been theoretical and conceptual proposals for incorporating its supervisory context in group clinical supervision settings (Gingrich & Worthington,2007; Okech & Rubel,2009,2007; Wortham,2009).

Polanski (2003) and Gingrich and Worthington (2007) argue that the Discrimination model is equally applicable in spirituality or faith-based supervision, whilst McGlothin, Rainey and Kindsvatter (2005) suggest it could be used to supervise clinicians working with people with suicide ideation and school counsellors, and especially for School Guidance and counselling school programme implementers such as Guidance teachers in the case of Botswana. Knight (2019) suggests integrating trauma-informed principles into the discrimination model; "the model lends itself to incorporating a trauma-informed lens" and Bernard and Luke (2006) reiterate that the model is appropriate for use in comprehensive school counselling program implementation.

There is notable literature suggesting that the Discrimination model of clinical supervision has received immense attention from mental health researchers and clinicians, for example, Russell et al. (1984) pointed out that despite limited research on social role models of supervision, the Discrimination Model was the most extensively researched and the situation appears to have remained the same.

2.7.2.3 Controversies for and Against Discrimination Model

There seems to be significant literature in favour of the Discrimination Model since its inception, literature is replete with research suggesting that the model has received extra-ordinary attention in the mental health field concerning clinical supervision of practising clinicians and student counsellors. This is evident in the number of researchers who used the model for grounding their research studies (Clingerman & Bernard, 2004; Fall & Sutton, 2003; Goodyear et al.,1984; Goodyear & Robyak,1982; Hart & Nance, 2003; Lazovsky & Shimoni,2007). Moreover, literature shows that the Discrimination Model has been extensively explored, scrutinised, analysed, reviewed and tested in numerous investigations (Ellis et al., 1988; Ellis & Dell,1986; Glidden & Tracey, 1992). However, according to Ellis and Ladany (1997) and Luke (2007), there hasn't been any research that has ever established the validity of the Discrimination Model and its utility across different supervisory settings and contexts, the other argument is that the model has been easily conceptualised for supervisory practice and the roles are designed for supervisors to easily function within the suggested supervisory roles.

Nonetheless, the foci of supervision context and supervisory roles are clearly outlined to guide the supervision process. Therefore, this can be viewed as being too prescriptive, but without a framework, there could be no common pedagogy and the result will probably be a chaotic and unstructured clinical supervision practice. This Discrimination model was originally developed as a conceptual framework to assist novice supervisors in facilitating their supervisory process. The model adequately provides a brilliant structure for the supervisor to use in providing target-specific supervision and determining the most appropriate supervision role and strategy to deploy at the time of need (Luke & Bernard, 2006).

This model stresses the attention paid by supervisors to unethical dual relationships; for example; the reason for operating as a "counsellor" in supervision is to establish the supervisee's unresolved personal issues that may interfere with professional performance, and objectivity and possibly impair their judgement in the therapeutic relationship. The objectivity of the supervisor and their role is to offer support to supervisees and encourage them to seek therapy from an independent practitioner and not from their clinical supervisor.

The Discrimination Model highlights three areas of focus for the supervisor to promote the supervisee's professional growth; therapeutic process, case conceptualisation and personalisation. Processing issues are the first area of focus to examine the process of supervision, then the process adopted by the supervisee in their practice; for example, assesses how and if the supervisee processes reflect the client's emotions, whether the supervisee adequately reframes the situation and use strategies that could help them enable their client to address the defence mechanisms and be less resistant during therapy.

The Conceptualisation of issues includes how well supervisees conceptualise their client's case in the context and identify issues presented by the client without being judgemental in the therapeutic process. Such includes clarifying reasons supervisees have for the approach they deployed, the therapeutic skills utilised with the client and further possible approaches and skills to be applied in the future; similar to developing a treatment plan (Luke & Bernard,2006; Luke, 2007). The Discrimination Model is primarily a training model that assumes that supervisors can appropriately discern and determine what supervisory role to utilise in time of need.

2.7.3.1 Developmental Models of Supervision

Despite extensive research that has gone into the discrimination model to date, literature is replete with a plethora of strong empirical support for the development of more developmental models of supervision (Heppner & Roehlke, 1984; Levy,2004; Reising & Daniels,1983; Worthington & Roehlke,1979). Cummings (2004) asserts that the integrated development model (IDM) of supervision based on Stoltenberg and Delworth (1987) and Stoltenberg, McNeill and Delworth (1998) focuses on the developmental process of those training to become counsellors and counsellor supervisors. Cummings (2004) goes on to say that the practice of clinical supervision was influenced by the belief that to facilitate and inspire therapeutic principles in student counsellors there has to be clinical supervision, and an integrated development model enables clinical supervisors to achieve just that. Therefore, in the process of gaining competencies, counsellors have to go through three developmental stages and each stage has its unique approach to achieve optimum professional growth.

The developmental models of supervision assume that learning is a continuous process that combines experience and predisposed attributes that enable counsellors to grow professionally. Through this model of clinical supervision, supervisors can identify areas of limitation and areas needing attention and provide appropriate intervention to inspire professional growth. Since in developmental models, learning is a continuous process, it is common to continuously identify new areas of growth to focus on between the supervisor and the supervisee. According to Haynes, Corey, and Moulton, (2003) and Smith (2009), there is enough empirical evidence supporting the integrated developmental model of clinical supervision.

This model articulates three progressive stages that supervisees have to go through from the level of a novice (Beginner) to expert, and each stage has specific characteristics and skills to attain. For instance, supervisees in the Beginner stage are characterised by limited skills and low levels of confidence to successfully provide counselling to their clients, whilst at the Middle stage they appear to have gained more skills and increased confidence in providing counselling, though often accompanied by conflicting emotions towards having to constantly seek support from their clinical supervisor.

However, in their Expert stage of the developmental spectrum, supervisees are comfortable and confident to execute their counselling skills and hence are deemed less dependent as they have acquired problem-solving, intuitive and reflective skills to function effectively in their counselling and supervisory process (Corey et al., 2003).

2.7.3.2 Assumptions of the Developmental Supervision

Stoltenberg and Delworth (1987) described the developmental model as having three levels that supervisees have to undertake viz., beginner, intermediate and expert, of which there are different levels of observable characteristics, such as; a beginner having tendencies of lacking flexibility and having limited confidence, then with time, as they develop and gain more knowledge and skills become conversant, confident and comfortable providing counselling to clients, and effectively execute their therapeutic functions as counsellors. Foci in the observation of the supervisees' development consider the three areas; awareness of self about others, self-motivation and autonomy.

Beginner counsellors' first experience of clinical supervision is usually relatively dependent on the supervisor for client diagnoses and for developing client treatment plans. It is assumed that at the Intermediate stage supervisees only consult their clinical supervisor for complex cases and when they experience ethical dilemmas, it is also assumed that this stage is characterized by defensiveness and conflict due to perceived threats to the self-concept. On the other hand, at the Advanced stage, supervisees operate more independently and only consult the supervisor when facing a challenge about their work with clients, or facing personal issues that may interfere with their clinical functions as therapists (Corey et al.,2010; Luke,2011; McNeil & Stoltenberg,2016). The other assumption is that supervisors who choose to utilise this model of supervision should be able to adequately and accurately identify the supervisee's stage of development and be equipped to provide the necessary intervention, feedback and any other appropriate clinical support for developmental growth. In so doing, the supervisor would be facilitating the supervisee's developmental progression to the next stage (Blakely,2009; Stoltenberg & Delworth, 1987). This model encourages interactive professional relationships between the supervisor and the supervisee and uses the upward gradual progression of developmental stages activities. Some scholars equate this to the "scaffolding approach"; where the supervisor has to identify and evaluate the supervisee's knowledge and skills and use the gained data to inform the intervention for the enhancement of the supervisee's professional growth and advancement of new skills and knowledge. As the supervisee approaches the mastery of each stage, the supervisor gradually moves the scaffold higher to incorporate more complex knowledge and skills from the next stage to be achieved by the supervisee (Stoltenberg, McNeill, & Delworth, 1998; Trant,2000).

Unlike the social role models of supervision that emphasize the roles and functions of the clinical supervisors, the Developmental models of supervision hinge on continuous assessment, evaluation of supervisees' competencies and identifying new developmental areas to be addressed throughout training, internship, practicum, mentorship and close monitoring of new practitioners in the field (Falender & Shafranske,2012; Falender et al.,2004; Glidden & Tracey,1992). Moreover, social role models require providing structure to clinical supervision by clearly outlining the supervisory foci and roles in the clinical

supervision process. Some scholars in the clinical supervision field have classified these very same models into integrated, process-based and eclectic respectively (Borders & Leddick,1987; Bradley & Ladany,2001; Falender & Shafranske,2004).

However, according to Falender and Shafranske (2004,2012), despite the semantics and terminology differences, there is a common understanding that these models provide a conceptual framework for mental health professionals to effectively facilitate the clinical supervision process.

2.7. 3.3 Integrated Model

The earliest models of clinical supervision were mostly underpinned by theories of psychotherapy and mainly relied on psychotherapeutic processes. The integrated models assumed that counsellors who were experienced and skilful in their chosen therapeutic approach or theoretical approach of counselling would equally be competent in offering clinical supervision (Haynes, Corey & Moulton, 2003; Stoltenberg, McNeill & Delworth, 1998). Needless to say, initially, supervision in these models was not viewed as a separate entity or distinct event, but as an additional part of therapy.

It was only in the late 1970s that clinical Supervision started being recognized as an area of speciality with its unique processes and competencies necessary for the professional growth of counsellors that more models started being proposed and formulated in the early 1980s and these were intended to address the legal, and multicultural issues, prevent unethical practices and protect clients through developmental mentorship of student counsellors and those new in the counselling practice (Bernard, 2005; Haynes et al., 2003). Given this, McNeill and Stoltenberg (2010,2016,2011); Stoltenberg and Delworth (1987) and Stoltenberg et al. (1998) assert that the integrated Model of supervision has since received theoretical and empirical attention from numerous scholars in the field of clinical supervision.

Smith (2009) purports that, because some counsellors perceive themselves as being “eclectic” in approach in their practice; there are certain models that could be successfully utilised with a combination of various therapeutic orientations, for example, the Discrimination Model is considered to be “a-theoretical” (Bernard &

Goodyear,1992; Leddick,1994). This implies that the model could be utilised regardless of one's theoretical orientation. While some supervisors prefer to use theoretical-oriented approach models in clinical supervision, the eclectic approach-based models are synonymous with clinical supervisors who prefer integrated models.

2.7.4.1 Theoretical-oriented Supervision Models

The theoretical oriented-based models hinge on counselling theories of preference, for example, counsellors who adopt and consider themselves to be Cognitive behaviouralists, Freudian, Rational Emotive Behaviour Therapists, Adlerian or solution-focused and so on, usually have beliefs that effective supervision should be grounded and assessed based on the specific therapeutic orientation practice and have strict compliance to the respective therapy. Therefore, the assumption is that supervision should be therapy-focused and theoretically consistent (Leddick,1994).

Literature shows that the major advantage of the psychotherapy-based or theoretical-oriented supervision models is derived from the fact that both the supervisor and supervisee share the same theoretical orientation, and therefore the compatibility on that aspect enables maximization of the modelling process because the supervisor simply coaches the supervisee on how to successfully integrate a particular theory into therapy during the supervision process (Bernard & Goodyear, 1992). Secondly, sharing theoretical orientation enhances growth and reduces possible conflict that may negatively impact the clinical supervision process, especially in a situation where theoretical orientations differ between supervisor and supervisee. The following are just a few examples of the theoretical-based clinical supervision models:

2.7.4.2 Client-Centred Supervision

This supervision model derives from client-centred therapy and from Carl Rogers' client-centred theory to counselling (Patterson,1992,1997; Watkins,2019). In this model supervisor is non-directive and non-instructional, and the client (supervisee) plays an active role in the clinical support they receive, the supervisor's role therefore is didactic despite the whole aim being to help the supervisee understand and treat the clients' issues in the same manner. The supervisee determines the pace and direction of the intervention

whilst the supervisor simply facilitates self-understanding about the supervisee's work with their clients in the therapy process.

The model assumes that the best way to teach student counsellors the non-directive approach of person-centred therapy is best facilitated through a client-centred approach to clinical supervision (Brodley,2019; Patterson,1983; Smith,2009). This client-centred therapeutic approach hinges on the belief that in therapy the healing process can be stimulated through a healthy, genuine, authentic and non-judgmental therapeutic relationship, and similarly the same should be the case in client-centred supervision. Therefore, under this premise, instruction and advice given are inconsequential (Patterson,1997; Watkins,2019).

Another assumption is that the clinical supervisor is skilful enough to place themselves into the supervisee's experiences to better influence professional growth and that the supervisee will embrace the supervisory relationship for professional growth. Similarly, there is an assumption that an effective client-centred supervisor should be able to trust the supervisee's intrinsic motivation and willingness to desire professional growth, enough to allow supervision intervention to positively influence them to explore the supervisory relationship, to self-reflect and objectively self-evaluate. The trust accorded the supervisee by the supervisor is expected to be mirrored in the supervisee-client therapeutic relationship. However, according to Smith (2009), the challenge that often arises when utilising pure client-centred supervision could be the supervisee's inability to envision self-actualisation as an achievable possibility. With that being the case, some supervisors who consider themselves Freudian and psychodynamic in orientation often prefer the psychoanalytic model of supervision.

2.7.4.3 Psychoanalytic Supervision

Psychoanalytic supervision is one of the oldest psychotherapeutic approaches to clinical supervision, according to Leddick (1994), from its inception, psychoanalysis had conceptualized and incorporated supervision as part and parcel of the therapeutic practice. The psychoanalytic-oriented supervision is meant to inspire therapy through mirroring, therefore through mirroring, the supervisor can mentor, teach, coach and impart to supervisees the analytic skills that will enable them to emulate specific critical attributes like

authenticity, being non-judgemental, patience, honesty, trust, empathy and "respect for the power and tenacity of client resistance".

The psychoanalytic supervision model assumes that the effective way a supervisee can learn these qualities is for them to experience the qualities from their supervisor in the supervisory relationship. In this supervision approach, there are four critical stages involved, viz.; the opening stage, the mid-stage, the working stage and the last stage. The opening stage involves some form of evaluation between the supervisor and supervisee to establish each other's strengths and possible limitations, and according to Leddick and Bernard (1980), the process often leads to some form of power struggle, assertion or some degree of influence over the other. This has the potential to escalate to the mid-stage which is usually characterised by defensiveness, avoidance, aggression and negative or productive conflict (Nellis et al.,2011). The resolution of the mid-stage issues usually leads to a "working" stage for supervision which is a productive stage. The last stage is characterised by a more silent supervisor encouraging supervisees in their tendencies toward independence. Despite this, the model is supervisee-centred, patient-centred and supervisory process-centred and mostly has limited conflict between supervisor and supervisee due to shared theoretical orientation, except in cases where they may interpret the theoretical orientation differently (Smith,2009).

2.7.4.4 Cognitive Behavioural Supervision

The Cognitive-behavioural supervision model hinges on Doctor Aaron Beck's cognitive therapy and cognitive behavioural therapy (CBT). Doctor Beck worked as a clinician in the 1960s and was considered the father of cognitive therapy and cognitive behavioural therapy (Beck & Fleming,2021; McLeod,2009; Miller,2022). Cognitive behavioural therapy assumes that both adaptive and maladaptive behaviours are learned and can be unlearned. According to Beck and Fleming (2021), "CBT is based on the psychological construct that individuals' interpretations of situations influence their reaction (emotional, behavioural, physiological), more so than the situation itself."

It is on this premise that, the supervision process from a CBT orientation is expected to be systematic in addressing the supervision goals and focusing on thoughts, emotions and behaviour as impacting the

therapeutic process. At the initial stage the model is concerned with creating a rapport, then analysing and examining the supervisee's skills, helping supervisees in setting goals, implementing strategies, and then monitoring and evaluating performance for the benefit of the supervisee's clients.

In CBT supervision, the supervisors' responsibility is to ensure that supervisee learning occurs, to ensure professional growth. The bottom line in CBT supervision is the ability to assess supervisee's potential to learn and help them demonstrate their professional counselling competencies (Beck & Fleming,2021; Smith,2009). Behavioural supervision views the supervisee's challenges as a learning process; therefore, the supervision process mostly involves two critical skills; the ability to identify the challenge and the ability to deploy the right techniques to empower the supervisee to address the challenge. Learning this same process enables the supervisee to mirror the approach when counselling their clients (Erdy et al.,2020; Leddick & Bernard, 1980; Smith,2009). It is common for Supervisors to be expected to role-play behavioural techniques before working with clients, supervisors need to model the relevant conditions of unconditional positive regard, being non-judgmental, empathy and genuineness to supervisees (Leddick & Bernard, 1980).

2.7.4.5 The Social Cognitive Model of Counsellor Training (SCMCT)

The Social cognitive model of counsellor training (SCMCT) and supervision by Larson (1998) is underpinned by the Social Cognitive theory developed by Albert Bandura in 1982. By this model, Larson (1998) intended to address what he perceived as limitations in the existing models of supervision in addressing the counsellor-client relationship and what transpires in the actual counselling session.

Larson (1998) chose to divert attention from the traditional developmental skills and pay attention to "variables that may influence actions with clients, such as the counsellor's cognitive processes, goals, and counselling self-efficacy". It was from this perspective that, it became clear that the individuals' Self-concept has significance on their resilience, intrinsic motivation, tenacity, the potential to take risks, setting realistic and achievable goals as well as the supervisee's anxiety-coping skills; all of which could influence the supervisee's decision-making during the counselling process. Similarly, Larson (1998) views personal agency and self-efficacy as being essential during the therapy session due to their ability to influence the supervisee

on the implementation of counselling and the use of specific strategies. This shows that counsellor self-efficacy (CSE) is an important factor in counselling and most importantly in the clinical supervision processes (Trant,2000).

2.7.4.6 Structured Peer Supervision

The Structured Peer Supervision Model (SPSM) was proposed by Benshoff (1988). This is a seven-session model that provides a structured framework that enables student counsellors/trainees to modify and enhance their traditional clinical supervision experiences by utilising their counselling skills to supervise one another in dyads.

Literature shows that it is common for counsellors to experience irregular and limited clinical supervision. Therefore, to this fact, Benshoff (2008) argues that often "counsellors find themselves practising in situations where clinical supervision is infrequent, insufficient or even unavailable". Similarly, in settings such as schools, the counsellor might be the sole mental health professional among the staff which makes clinical supervision difficult. Therefore, this self-supervisory model may be essential in rural parts of Botswana where the practice of supervision and availability of qualified and experienced clinical supervisors is questionable. Benshoff (2008) asserts that the presence of qualified supervisors does not guarantee adequate, high-quality clinical supervision due to other limiting factors such as perceptions, time, interest, education and experience in clinical supervision. Raising the same concern, Falender and Frashanske (2012) argue that; just because individuals went through clinical supervision training does not necessarily mean that skills have been acquired; "it is no longer acceptable to simply assume that competence has been attained".

Though some scholars and counsellors may be sceptical about the quality of clinical supervision derived from peer supervision because it is conducted by student counsellors for one another, having a peer supervision relationship with a colleague may be a better option than not receiving any clinical supervision at all or receiving irregular, inadequate and probably ineffective clinical supervision from an administrator, school principal, instructor or consultant (Benshoff,1988; Oberman,2005). If done properly, the professional peer

supervision relationship can create a beneficial environment for student counsellors to receive crucial unbiased constructive feedback, support and assistance from fellow student counsellors.

Apart from these models, there are models developed specifically for school settings because school systems operate differently from most environments, hence school-based supervision models are herein discussed.

2.7.5.1 School-based Models of Supervision

The American School Counsellor Association (ASCA) developed a national model to provide a framework for the formulation of school counselling programs that cover emotional counselling, academic planning and career exploration. The majority of schools in the United States of America recognize the ASCA national model as a comprehensive framework that transformed school counselling and augmented the role of the school counsellor from focusing on individual students to developing a holistic school program that could identify existing challenges and limitations regarding student performance (Bowers & Hatch,2005; Martin & Carey,2014; Oberman & Studer,2006,2005). Clinical supervision models for school counsellors emerged from models that initially were used for clinical mental health counsellors and other mental health professions (Cook et al.,2012; Luke et al.,2011; Walsh-Rock,2018; Wood & Rayle,2006).

2.7.5.2 Goal, Roles, Function and Systems (GRFS)

One of the role-based models is the Goals, Roles, Function and Systems Model (GRFS) developed by Wood and Rayle (2006). The model was meant to be utilised in school settings to address school counsellors' unique characteristics related to their work with their clients (students). According to Miller and Dollarhide (2006), the model helps to explore a variety of school counsellors' roles. GRFS model outlines the systematic processes to be considered in the unique working conditions of the school counsellor; for example, the GRFS model's goals are aimed at the development of leadership roles in the school setting, stakeholder collaboration, development of advocacy skills, providing counselling to the student body, delivering curriculum based on national standards, being conversant with counselling and crisis management interventions, as well as implementing individual planning and student profiling (Wood & Rayle,2006). Consequently, the model encourages flexibility in addressing the specific needs of the school and students making it not to be a "one

size fits all" but client-centred based on school needs assessment. GRFS model borrowed from Holloway (1995) has the "monitoring, instructing, advising, modelling, consulting, and supporting activities" and shares the same attributes as those from Luke and Bernard (2006) concerning the assumption of the supervisor's awareness and the use of roles to meet the needs of the supervisees.

The GRFS Supervision model focuses on the functions the supervisors deploy in their work with their supervisees, in this model, the supervisors' functional roles are that of teacher, adviser, coordinator and mentor. According to Wood and Rayle (2006), the main purpose of the function of the supervisor as articulated by the GRFS model is to help the supervisor empower the supervisees, and the function requires supervisors to have awareness and consistent discernment towards the needs of the supervisees to appropriately deploy specific roles, function and skills as needed at the right point and time.

2.7.5.3 School Counsellor Supervision Model (SCSM)

Luke and Bernard (2006) proposed the School Counsellor Supervision Model (SCSM) as a framework intended to give specific supervision strategies for school counsellors; concerning their roles in working with their client in a school environment. The model is an extension of the Discrimination Model. SCSM motivate supervisors to assist school counsellors with developing and planning school interventions, conceptualizing case reviews as well and personalizing their work roles as teachers, counsellors, and consultants. Expanding on the discrimination model, the SCSM added another aspect to the supervision process; the evaluation of counsellor-students' interaction, including such things as how well they plan, and coordinate interventions, perform group counselling, individual achievement, consultations, group interventions, group achievement as well as monitoring and evaluation.

The SCSM was developed to close perceived gaps in the areas that were previously not adequately addressed by other clinical supervision models, for example, due to the uniqueness of the school counsellors' work environmental setting and their unique characteristics, their professional developmental needs were not adequately addressed by other models. The SCSM emerged and took cognizance of the unique and complex characteristics of school counsellors functioning in a diverse environment with dynamic students/clients to

serve as well as the significance of clinical supervision of the school counsellors' professional growth and the overall effectiveness of the counselling services they provided (Corey et al.,2010; Glaes,2010; Oberman,2005).

2.7.5.4 Support, Accessibility, Advocacy, Teamwork, and Feedback (SAATF)

According to Walsh-Rock (2018), this model focuses on the identification of Support, Accessibility, Advocacy, Teamwork and Feedback (SAATF). The model was designed with school counsellors' needs in mind (Borders et al.,2014; Cook et al., 2012). Walsh-Rock (2018) asserts that the model emerged out of observation and acknowledgement of the fact that support, access, constructive feedback, advocacy and teamwork in supervisory relationships are essential for school counsellors to feel motivated and empowered to offer the same attributes of support, access to counselling, advocacy, feedback and teamwork to their clients/students. Walsh-Rock (2018) goes on to say that the SAAFT model came from a group of supervisors who were specifically trained to offer supervision using the Professional Assessment Response Model (PARM) that incorporated teaching, counselling and management supervision model concepts and approaches.

Unlike other previously discussed supervision models that focused largely on the supervisor-supervisee roles, skills and competencies, the SAAFT model focuses on the relationship between the roles and the impact of the quality of the supervisory relationship with school counsellors, and subsequently the quality of the relationship they will have with their students(clients). It is on this premise that Cook et al. (2012) emphasize that increased support, accessibility, advocacy, feedback and teamwork experienced by supervisees are essential for the effective provision and coordination of school interventions.

2.7.5.5 Professional School Counsellor Supervision Model (PSCSM)

Glaes (2010) and Walsh-Rock (2018) share the same view that the Professional School Counsellor Supervision Model (PSCSM) was intended to create opportunities to explore the experiences of the supervisors and supervisees. The model encourages enhanced self-reflection, enhanced dialogue, and increased structure and frequency of supervision resulting in improved quality and frequency of continued supervision and assessment of strengths and limitations of supervisees (Glaes, 2010).

According to Cook et al. (2012); Luke et al. (2011) and Wood and Rayle (2006), the supervision of school counsellors has to focus on the school systems interacting with school counsellors, and positively impact their clinical interaction with the learners they serve.

The development of clinical supervision led to more reflection and advancement in the development of yet more field-specific, cultural-specific and multi-cultural focused models, and in the process, it became clear that not every model was suited to the school counsellors' setting. On this premise, school-based models such as PSCSM emerged.

There is a plethora of empirical support for the efficacy of clinical supervision for school counsellors; some of the documented positive outcomes by various scholars include; enhanced effectiveness, improved counselling skills, stimulated professional development and increased counsellor confidence (Benshoff & Paisley, 1996; Glaes,2010; Luke et al.,2011; McMahon & Simons,2004; Walsh-Rock,2018). Walsh-Rock (2018, p.50) profoundly asserted that; "only when the majority of school counsellors not only receive clinical supervision but also value clinical supervision, will this essential component be valued to aid in school counsellors developing their counselling skills".

2.7.5.6 Integrative Psychological Developmental Supervision Model (IPDSM)

This model may be deemed appropriate for counsellor education and utilisation in Counselling training Institutions. The integrative Psychological developmental Supervision Model (IPDSM) was proposed by Lambie and Sias (2009). The model was formulated for the facilitation of clinical supervision for student counsellors and school Counsellors. IPDSM helps to provide psychological development for school counselling interns and school counsellors, the main purpose of the model is to provide a framework to those providing clinical supervision to counselling interns, counselling students as well as school practising counsellors.

The aim is to develop their knowledge and skills through undergoing specific developmental stages to attain professional growth and gain confidence in providing therapy, in the process supervisors provide

expertise gained over years of experience to supervisees for the good of the clients they serve (Borders,2015; Corey et al.,2010; McNeil & Stoltenberg,2016). The supervisor serves as a coach, mentor, teacher, advisor and sounding board upon whom the supervisees seek clarity on clinical issues when stuck (Corey et al.,2010; Luke & Bernard, 2006; Wood & Rayle, 2006).

2.7.5.7 Administrative Supervision

Administrative supervision is mostly provided by school administrators and focuses on organizational issues such as time management, punctuality, staff relations, school protocols, policies and responsibilities (Dollarhide & Miller, 2006; Smith, 2009; Walsh-Rock,2018). According to Page et al. (2001), in schools, the most popular type of supervision provided to school counsellors is administrative provided by school administrators (School Heads/Principals) mostly focusing on non-clinical or non-counselling-related roles and activities.

Page et al.'s (2001) survey revealed that school counsellors received inadequate supervision which could be attributed to a lack of supervision experience and competencies by the school principals; Administrators continue to be the most likely professional to provide supervision coupled with deficiencies in understanding school counsellor development (Perera-Diltz & Mason, 2012,2010; Walsh-Rock,2018). Walsh-Rock (2018) argues that the major stumbling block to the provision of quality supervision for professional school counsellors by administration emanates from role ambiguity and conflicting role expectations. These conflicting expectations often result in ethical dilemmas that negatively impact the supervisory relationship and compromise the school counsellors' effectiveness in the provision of counselling services.

Due to a lack of training in clinical supervision, school counsellors may not be equipped to lobby for support and clarify their clinical role and their professional identity in line with counselling best practices (Borders et al.,2014), this may be perpetuated by school administrators who may be unfamiliar with the school counsellors' responsibilities (Oberman, 2005; Walsh-Rock, 2018). Similarly, Perera-Diltz and Mason (2012) argue that the situation may be improved by advocating for awareness among school administrators on the roles of school counsellors, incorporating certain aspects of the counselling programme as part of the

sensitization training on school counsellors' roles and responsibilities for the school administrators to lobby for support and create awareness on the importance of school counsellor's need to access clinical supervision for professional development. In clinical setting, the administrative role of the supervisor entails ensuring compliance with organizational policies, record-keeping standards, adherence to legal boundaries and requirements on clients' welfare and organizational integrity (Corey et al.,2010).

How Student counsellors and professional counsellors organize knowledge influences how they learn and apply what has been learnt in practice, often People arrange and choose what new knowledge to incorporate to enhance their performance. Similarly, motivation influences what supervisees choose to do and how to do it, it is worth noting that resilience and motivation sustain consistency and have to do with supervisees' personal goals and desired expected outcomes in line with the theory of reasoned action (TRA) and theory of planned behaviour (TPB).

Their motivation could be inspired by the inherent benefits of the activity and by the value attached to their goals and anticipated benefits. Therefore, applying what is known is equally influenced by the level of motivation and the willingness to embrace an intervention, especially a new phenomenon like clinical supervision. The interplay between knowledge, attitudes and practice in counsellors' practices of clinical supervision can be better explained by TRA and TPB.

2.8 Types of Clinical Supervision

Facilitation of Clinical supervision for counsellors can be conducted through different modes, methods or formats; it could be individual, peer to peer or in a group setting. Live supervision is used mostly in counsellor education, however, in other situations, self-supervision may be utilised for those who find themselves working in areas where there are no other mental health practitioners such as in remote rural areas.

The main aim of these methods of supervision is to help address counsellors' developmental needs, and process anxieties and self-doubts centered around counselling competencies and the ability to provide quality

counselling service to clients. Clinical supervision is offered through these three modes to reduce anxiety, increase confidence and self-efficacy, and consequently enhance counsellors' counselling skills.

Literature shows that there are emotions involved in giving and receiving feedback; whether positive or negative, therefore, clinical supervision as an intervention for counsellors' professional growth has inherent within it the feedback-giving aspect, which can evoke a variety of emotions regardless of how it is given, and this is why the Supervisors' competencies are critical in the process (Pich,2000). Pich (2000, p.15) goes on to say that the very idea of mentioning "feedback can cause the counsellors-in-training to react with several feelings, therefore great care must be taken in the delivery of feedback, especially the negative type".

Nonetheless**,** the three types of supervision discussed here all play a significant role in the clinical supervision process. As Chang et al. (2020, p.606) assert; the mode of supervision deployed in the supervision process is as important as the role played by supervisors in the different settings within the mental health professions. Chang et al. (2020) continue to say; "Supervisors are often gatekeeping, assessing competence, monitoring progress, and serving as a role model and spokesperson for their discipline all at once."

2.8.1 Individual Supervision

As can be deduced from the word individual, this type of supervision is a "one-on-one" supervision that involves the supervisor and supervisee meeting for clinical supervision purposes. It is supervision arranged for an individual professional counsellor or trainee counsellor by a more experienced professional counsellor qualified in clinical supervision. The process is conducted to provide professional development; mentorship, teaching, coaching and guidance for the benefit of the supervisee's clients, and the effective delivery of the counselling process.

According to Singo (1998, p.5) "Individual supervision, is a process where an instructor or doctoral students in counsellor education supervises a master's level counselling trainee on a one-on-one basis".

The Council for Accreditation of Counselling and Related Educational Programs ([CACREP],2009, p.63) views individual supervision as; "a tutorial and mentoring relationship between a member of the counselling

profession and a counselling student" whilst Wallbank (2010, p.67) describes it as, a "process of supporting an individual practitioner to develop knowledge and competencies to assume responsibility of their practice and consequently enhance clients' protection and safety in complex situations".

Wallbank (2010) goes on to posit that individual supervision is essential because it promotes self-evaluation and critical, analytical and reflective skills in individual counsellors. Sharing the same opinion, are Hunter and Bowers (2009) who opine that individual supervision is the most frequently used mode of counselling supervision that was developed out of the psychoanalytic culture of therapy, and developed rapidly from that period when psychoanalysts were expected to be in psychoanalysis practice. Similarly, Glaes (2010) points out that individual supervision has been utilised for many years, and is perceived by many to be one of the most popularly deployed, and most significant formats among all the other types of clinical supervision. There is a plethora of literature supporting the significance of individual supervision purporting that it is the most widely utilised method of supervision in mental health compared to other types (Bland,2012; Carter et al.,2009; Lawrence,2017).

Bernard and Goodyear (2009, p.218) argue that individual supervision is the "cornerstone of professional development", this same view is shared by many other scholars like Berney & Bourquin (2019); Chang et al. (2020); Falender & Shafranske (2008); Garcia (2015); Glaes (2010); Greacen et al. (2017); Hunter & Bowers (2009); Lewis et al. (2017) and Naylor (2016). According to Prieto (1998), many supervisors and supervisees consider the individual or one-on-one type of clinical supervision to be the most effective and helpful mode of supervision, therefore, it has become the preferred method.

Garcia (2015, p.1) also opines that "Since the inception of helping professions, individual supervision has been the primary method of supervision for training new clinicians". Moreover, Ray (1998) and Ray and Altekruse (2000) purport that, student counsellors tend to prefer individual supervision to other forms of supervision. Ray (1998) goes on to argue that, there are several positive benefits for supervisees derived from accessing individual supervision, therefore, generally individual supervision is perceived by supervisees as the most important part of training.

Bland (2012) borrowing from CACREP (2009) describes individual supervision as, “a tutorial and mentoring relationship between a member of the counselling profession and a counselling student”, whilst, Lyman (2010) describes it as a one-on-one professional relationship between supervisor and supervises to offer tutorial and mentorship to the counselling student for the developmental outcome. Lyman (2010) goes on to state that; over the years individual supervision has been the main method and mode of clinical supervision of choice for many supervisors as an off-shoot from the psychoanalytic therapy approach.

Usually, the first session is the most challenging for both the supervisor and supervisee, hence the session often starts with icebreakers for rapport-building followed by the rules of engagement; discussing what their expectations are from the supervision process and how they would like to work together and set boundaries.

The supervisor and supervisee contract on the frequency of the meeting, the format and the venue where the supervision process will take place, as well as the time and ways in which each of them has to prepare for the sessions. In some settings, there may also be some company protocols and procedures to discuss and agree on issues such as reporting requirements on the supervision process and progress, and submission of client session audio recordings to the supervisor on agreed time; for example, whether quarterly, monthly or annually.

Often, the supervisor explains to the supervisee the specifics concerning how they would expect their case materials to be packaged or presented for discussion during the supervision process, as well as what is expected from them for each session or before each session convenes (Bernard & Goodyear, 2004; Forshaw et al.,2019). Moreover, the supervisor may also ask the supervisee for input and ideas on how they would like the process to be facilitated and how they wish to be evaluated.

There is room for flexibility within the supervision process and depending on the supervisors and supervisee, it can be as creative as any counselling session, though it has to be clear that clinical supervision is not a therapy session despite having similar characteristics.

Given this, some may use various creative ways such as narrative; story-telling, use of videos, audio, letter writing, dialogue, metaphors guided meditation and so on (Forshaw et al.,2019). When supervision works well,

it is invaluable for the supervisee and their clients. Indirectly, it is also beneficial to the supervisor not just for monetary reasons but for safeguarding the profession.

The process relies greatly upon the supervisee's ability to have sufficient self-awareness and honesty to disclose any issues or concerns they may have relating to their clients. Hunter and Bowers (2009) argue that; it is common for such disclosures to evoke certain emotions and feelings of fear and anxiety within supervisees who may be uncomfortable about exposing their limitations, vulnerabilities or weaknesses in service provision or not equipped to receive constructive feedback concerning their areas of development, and not wanting to be perceived as incompetent; particularly when they are still in training. Therefore, they may not disclose enough in the supervision (Fischer,2020; Hunter & Bowers,2009). Nonetheless, despite the fears of some counsellors in training or experience, individual supervision is considered advantageous to counsellors, the profession and the clients they serve.

2.8.1.1 Strengths of Individual Supervision

Literature reveals that individual supervision has numerous advantages for the supervisees, the practice, and, most importantly, the supervisee's clients. One of the purported advantages is the belief that it gives counsellor supervisees a comfortable environment to disclose their challenges, limitations, dilemmas and any other possible self-doubt concerning the therapy sessions they offer to their clients. They are expected to freely and, in the privacy created between them and their supervisor disclose and receive clinical support without intimidation (Lyman,2010).

Ray and Altekruse (2000) also state that counsellor trainees and professional counsellors enjoy receiving individual attention which enables them to obtain case-specific guidance and the necessary support that empowers them to initiate and enhance their personal and professional development geared towards the effective provision of counselling. Individual supervision helps develop counsellors' skills and gives insight into their clients' cases and the whole clinical process.

Literature is replete with empirical information on supervisees' freedom, and being less time-constrained since the session is solely devoted to helping them without worrying about the time unlike in a group setting supervision.

According to Borders et al. (2012) and Garcia (2015), individual sessions are more supervisee-focused; individualized to help one specific supervisee at a time, and thus more intimate and deeply focused on professionally assisting the supervisee at specified times and places. The format has the advantage of undivided attention and time more focussed on the individual supervisee; the supervision process is easily personalized and specifically tailored to meet each supervisee's specific needs. That alone, creates an opportunity for effective mentorship and consistent monitoring of professional growth.

Additionally, the individualized approach gives the supervisee an environment adorned with flexibility for each counsellor to develop at their own pace within their capability. It is also deemed effective in the sense that it allows the supervisee to focus on many of their client's issues due to adequate time and support individually awarded to them. Being able to receive supervision individually from the supervisor creates a non-competitive and non-threatening environment without fear of being dominated by others. The process makes it easier for both the supervisor and the supervisee to monitor the supervisee's professional development and confidentiality assured unlike in a group setting (Fischer,2020; Garcia,2015; Lyman,2010; Ray & Altekruse,2000; Watkins,1997,2020). According to Ray (1998), despite the growing popularity and support for group supervision, individual supervision continues to be the most widely used type.

Similarly, Goodyear and Bernard (1998, p.89) argue that individual supervision is "still considered the cornerstone of professional development". Garcia (2015) also opines that there are so many advantages enjoyed by supervisees from the individual method of supervision as it provides an environment most conducive to self-disclosure concerning their counselling work. Sharing the same views are Hunter and Bowers (2009) who purport that the main advantage of individual supervision is the feeling of safety due to the confidentiality inherent in the supervision process, and the potential for the supervisee to objectively and critically evaluate or appraise their work with clients to improve their counselling process.

According to Borders et al. (2012), there is a reported higher satisfaction level among supervisees who are exposed to individual supervision. Borders et al. (2012) in their study investigating the perceptions of supervisors and supervisees towards the advantages and disadvantages of individual, triadic, and group supervision found that individual supervision was positively perceived or favoured. The study reported significant benefits, advantages and of course disadvantages of individual supervision as well.

A Plethora of literature also shows that individual supervision feedback can be personalized to meet the specific developmental level of the supervisee (Borders et al., 2012; Garcia,2015). Moreover, since the supervisee–supervisor relationship mirrors the client-therapist relationship, it can effectively be utilised to assess the possible transference and countertransference issues and parallel processes between counselling and the supervision process. Therefore, the process provides a focused way for supervisees to assess their professional conduct, and receive feedback and guidance from their supervisor who is considered a more experienced practitioner than they may be.

Bernard and Goodyear (2004) opine that the supervisor has an important teaching and mentoring role that positions supervision as the cornerstone of the professional development of therapists. This implies that the effectiveness of the supervisees as practitioners is derived from the individual supervision that they receive to enhance their performance.

The quality of the supervisors-supervisee relationship may enhance the advantages derived from the supervision process or if not properly done, may harm the chances of the supervisee's professional growth. Therefore, appreciation of the Supervisors-supervisees relationship and its significance in the success of the supervision process is highly critical. However, the numerous advantages highlighted herein do not in any way imply that there are no challenges associated with individual modes of clinical supervision. There are some of the disadvantages found in the literature associated with the use of individual supervision (Borders et al.,2012; Lyman,2010; Ray,1998).

2.8.1.2 Limitations of Individual Supervision

There are several limitations or disadvantages pointed out by various scholars concerning the use of individual supervision; one of which is the limited multiple perspectives or lack thereof (Borders et al.,2012; Holloway & Caroll,1996). Moreover, when there is a challenge within the supervisory alliance, often the supervisees experience a challenge with self-disclosure of more sensitive concerns to their supervisors, at the same time when the supervisor operates from the counsellor role, there may be challenges experienced regarding the ability to establish appropriate boundaries within the supervision, and knowing which "hat to wear" and operate effectively from within each role of teacher, counsellor and expert as articulated by Bernard (1979,1997) and Bernard and Goodyear (2004) in the Discrimination model of clinical supervision.

Similarly, Supervisees may also struggle with the power distinction between supervisor-counsellor and supervisor-supervisee (Borders et al., 2012; Garcia,2015). Garcia (2015) and Lyman (2010) opine that the following disadvantages are common in the individual supervision practice; being seen individually can be daunting for some supervisees, especially those with issues of low self-confidence due to the isolation context upon which the individualised clinical supervision is operated; additionally, there is also the aspect of limited feedback which is only derived from the supervisor, limiting the opportunity to benefit from multiple perspectives during the individual supervision process as the main focus is the supervisee and their counselling challenges with their clients.

Therefore, this could be discomforting for some, especially those new in the practice or counsellor trainees whose confidence and competencies in their work may still be limited (Milne & Watkins Jr.,2014; Msimanga & Moeti, 2018). Another noted disadvantage is the possibility of the supervisee developing dependency on the supervisor, as well as the limited learning opportunities due to the supervisee's only interaction with the supervisor in each meeting with no input from anybody else.

Some scholars talk of the potential power struggle that may emerge to interfere with the process of benefiting from the feedback given by the supervisor to the supervisee, which may lead to the possible termination of the supervisory relationship. Similarly, even though individual supervision provides the

opportunity to customize supervision for supervisees, supervisors may experience problems with shaping supervision to the aptitude and proficiency of the supervisee. The supervisor may struggle to establish appropriate boundaries within the supervisory relationship especially where the supervisor functions in the role of a counsellor.

Holloway and Carroll (1996) and Garcia (2015) noted that individual supervision provides a singular context since supervisees only receive feedback from one source and get only one perspective regarding their concerns, issues, and case conceptualization. Some of these disadvantages of individual supervision can be attributed to the supervisor-supervisee compatibility and working alliance and if the working alliance is good there are bound to be more advantages as compared to disadvantages. Between individual, peer and group supervision lies the triadic supervision which according to CACREP (2009), is "a tutorial and mentoring relationship between a supervisor and two counselling students". It is a tripartite format made of three people in a clinical supervision session commonly used among counsellor trainees. However, since this paper is more focused on practising counsellors and not on counsellor trainees, this literature review will not dwell on triadic supervision.

Another reason for not dwelling on triadic supervision, which is mostly composed of two supervisees and a supervisor is that; it could be considered to be the smallest group of three people, though its facilitation may be slightly different from the facilitation of a large group of 10 to 20 counsellors in a group supervision setting. However, in some areas, it is utilised by three student counsellors facilitating the supervision for themselves, with one acting as an observer and then giving feedback to the other two and doing it rotationally (Garcia,2015).

Ray and Altekruse (2000) opine that, the negative aspect that most counsellors perceive as a disadvantage of individual supervision is the issue of time, more time has to be invested in the supervisory report writing process of the supervision session process unlike in peer supervision.

2.8.2 Peer Supervision

Lewis et al. (2017, p.532) describe peer supervision as peer group supervision; the type of supervision consisting of "a specific group of colleagues meeting regularly to mentor each other". Benshoff (1992) describes it as reciprocal arrangements in which peers work together for mutual benefit where developmental feedback is emphasised and self-directed learning and evaluation are encouraged, whilst Cross (2011) assert that peer supervision exists as a supplementary to formal individual supervision, and Bachkirova and Jackson (2011) posit that, it usually involves two counsellors helping and supporting each other to address client cases and any other issue about their work with clients, or it could be consisting of a small group of counsellors.

Similarly, Clapper (1981) opines that; many people envisage peer supervision as implying "an informal arrangement over coffee wherein counsellor trainees help their peers", whilst some imagine it to be a highly structured arrangement in which counsellors meet in teams or groups to implement the outlined objectives of the administrator. For many hearing the word peer supervision, simply think of a supervision process by colleagues for one another to each other involving peer evaluation and appraisals of one another for professional development. It is a form of supervision where counsellors themselves take responsibility for their professional growth.

The process is completely controlled and implemented by supervisees "through the processes of observation, analysis, feedback, and evaluation of classroom performance" (Clapper,1981). However, Hunter and Bowers (2009) opine that there is a difference between group supervision and peer supervision, the distinction is that in peer supervision the facilitation process is coordinated by the supervisees who are peers in the profession, and it is done without the presence of an appointed senior member or an authority figure, and on this ground, the process does not incorporate any form of evaluation. Therefore, it is safe to say that peer supervision is more for peer-to-peer support than clinical supervision (Agnew et al.,2000; Bernard & Goodyear,2004). The success of peer support supervision is therefore solely dependent on the commitment and determination of its members towards achieving the mandate of the group; this is made evident from regular meeting attendance of sessions, as well as the quality of the interactions between the members. When it

functions well, it is expected to provide freedom of collegial friendship, access to guidance, as well as a sense of comfort to authentically disclose one's counselling challenges and experiences without fear of being judged.

This is enhanced by the inherent lack of formal evaluation coupled with the democratic nature of the self-managed peer group process facilitated by the beneficiaries of the process themselves (Agnew et al.,2000; Bernard & Goodyear,2009).

Peer Supervision is a planned meeting with two or more colleagues to provide clinical peer support supervision for professional growth. In such meetings, colleagues discuss cases, provide professional input and share resources to enhance the quality of their services to their clients. Peer supervision is viewed not only as a source of clinical support for trainees but also essential for personal and professional development for qualified professional counsellors. Often peer supervision emerges when a small group of therapists who know and respect each other choose to meet regularly for each other's professional support (Agnew et al.,2000; Bland,2012; Borders et al.,2014; Lawrence,2017.

Through this type of supervision, counsellors discuss complex cases, ethical dilemmas, transference and countertransference and help to address issues of feeling professionally isolated (Bernard & Goodyear, 2004). As purported by Benshoff (1988); Bland (2012) and Murray (1995), in peer supervision counsellors can choose a supervisor from among them, a peer with whom they share mutual respect, compatibility, and genuine interest to help each other to grow professionally, and to enhance each other's counselling skills.

This aspect of having to choose whom to work with or a team of peers to interact with in peer supervision can assess the interpersonal compatibility among those to work with, something often not possible in a traditional supervisory setting where the sessions are facilitated by a senior practitioner. Equally, the genuineness of the feedback given to each other in a peer group setting is critical for the success of the process and professional growth (Agnew et al.,2000; Grigg,2006).

Additionally, Bland (2012) asserts that peer supervision can be described as a structured supervisory experience in which counsellors provide supervision for one another. It is a process through which a counsellor

has a supervision relationship with another colleague to assist each other to become more effective and competent counsellors as the method allows for counsellors to utilise their professional relationship and professional skills for each other's professional benefit. Literature reveals that peer supervision is a practical way of addressing any existing supervision needs that counsellors may be yearning for but for some reason unable to gain from a senior supervisor (Benshoff,1988; Grigg,2006; Mills & Swift,2015; Murray,1995; Woodward & Grimes, 2018).

This type of supervision helps many counsellors to enhance their skills by interacting with other practitioners, it provides a platform for them to share their professional experience, and obtain feedback (Bachkirova & Jackson,2011; Cross,2011; Singla et al.,2020). Additionally, Singo (1998) argue that peer supervision is a process where counsellor trainees with the same level of experience and education supervise each other. Singo (1998) goes on to say that, peer supervision can either be dyadic, triadic or even conducted by a group of peers. Moreover, the literature shows that peer supervision is widely recognized in counsellor education by counsellor education institutions.

According to Borders (1991); Cook (2008) and Cook et al. (2018), Peer supervision was proposed as a method to provide ongoing professional growth for practising counsellors. It is however not always perceived as an effective method for clinical supervision; some view it as not productive, not helpful, or beneficial. On this premise, Borders (1991) proposed a structured peer group method which could be conducted mainly for a structured peer group of counsellors not exceeding six counsellors. Unstructured peer supervision sessions take place every week or every two weeks.

In that case, there is a supervisor whose role is mainly to be an observer and moderate the peer group supervision process, but the whole facilitation is done by the participants themselves. The members are responsible for setting goals, building cohesion, building rapport, creating a trusting environment, as well as developing ground rules and agreeing to honour them.

They also present case materials for peer case review; this may include; videos or audio tapes for review and feedback. In a nutshell, this method of peer supervision typically involves two or more counsellors not exceeding six people in a session, and they meet regularly to support one another in case conceptualization, problem-solving and exchanging best practice information (Agnew et al., 2000; Lawrence,2017; Lewis et al.,2017; Wilkerson, 2006). As purported by many scholars (Bland,2012; Fischer,2020; Forshaw et al.,2019; Wagner & Smith,1979), peer supervision provides an environment for counsellors to use critical, analytical skills and competencies to assist each other at the peer level to improve their performance.

A peer supervision relationship can provide counsellors with an opportunity to work through a variety of difficulties encountered in the therapy room and identify and address issues that may interfere with their counselling service or hinder their professional growth. Therefore, being part of peer supervision is viewed by many as a beneficial option to receiving clinical supervision from an administrator or consultant. Hence, Hansen et al. (1982) argue that there is enough evidence from the literature to support the success and benefits of peer supervision depending on certain factors and according to Lewis et al. (2017) the success of peer supervision depends on interpersonal learning and group cohesiveness.

Group cohesion is considered essential for creating a sense of belonging within the group and thereby heightening the significance of the peer supervision process which ultimately leads to increased participation, and increased constructive feedback. Group dynamics also has the potential to influence group trust within the peer supervision setting. Trust is considered essential for effective peer supervision where limited listening skills may lead to vulnerabilities for participants as compared to individual supervision settings where all the attention is focused on one supervisee.

Similarly, interpersonal attributes, personal differences and possible incompatibility of personalities may lead to conflicts within the group. Moreover, the members' level of experience may also be part of the dynamics with the potential to affect the success or lack thereof of the peer supervision process (Kennedy 2000; Lawrence,2017; Lewis et al.,2017).

2.8.2.1 Strengths of Peer Supervision

Each evidence-based intervention is developed with an end outcome in mind, hence there are specific objectives and intended goals of an intervention. Empirical literature shows that peer supervision has several benefits, strengths, advantages or outcomes enjoyed by the supervisees and equally benefiting the practice (Wagner & Smith,1979). The benefits are mostly towards the professional development of the supervisees by enhancing their counselling skills and competencies in addressing client issues to enable them to function effectively as therapists. It also facilitates self-evaluation, receiving and giving feedback and identifying strengths and weaknesses.

The supervision platform creates increased freedom to solicit for and utilize assistance from peers; explore and apply knowledge to practice, assist peers to address their own professional or personal issues, and create a platform for addressing issues that may impede their counselling practice and their work with clients.

Additionally, it motivates counsellors to be open to seek counselling when facing personal issues that may interfere with their ability to function effectively (Agnew et al.,2000; Benshoff,1988; Crutchfield & Borders,1997; Watkins & Scaturo,2013). The main strength of this type of supervision is that; it provides the opportunity for supervisees to be more reflexive of their counselling service, access ongoing learning and professional growth, and keep improving as they apply their skills to counselling situations. This is considered useful for therapists who feel isolated in their working environments such as school counsellors or those in rural areas.

It is evident from the literature that peer supervision has numerous advantages, most of which to do with the time invested by the counsellor and the conducive non-judgemental conveniently created environment for vicarious learning to take place through interacting with peers as they share their work-related challenges, ethical dilemmas, and case materials (Bernard & Goodyear,2004; Cater et al.,2009). Similarly, the significant advantage of peer supervision lies in the fact that a couple of counsellors benefit from the clinical process concurrently (Bernard & Goodyear,2004). On this premise, Wagner and Smith (1979, p.289) assert that; "peer supervision would require students to design collaborative working relationships and to use these relationships

for their development". In addition, each of the supervisees can develop supervisory skills since supervision is not always adequately accessible from qualified supervisors.

It is on these grounds that many scholars argue that peer supervision has great benefits, for example; Bernard and Goodyear (1992); Lewis et al. (2017); Ray (1998) and Singo (1998) share the view that peer supervision provides benefits such as sharing experiences and disclosure which has a calming effect on the peers, and provides a conducive, non-judgemental and supportive atmosphere for counsellors to present their concerns, share challenges, ethical dilemmas, vulnerabilities and frustrations. Moreover, it provides a special learning environment without intimidation.

Through peer supervision, counsellors learn basic skills by observing, listening and experiencing their peers' challenges and success stories. Moreover, in this type of supervision, supervisees are given opportunities to role-play and demonstrate various therapeutic methods before putting them into practice. Agnew et al. (2000) argue that the benefits of peer supervision possibly outweigh what may be considered limitations or disadvantages. Agnew et al. (2000) go on to say that, peer group type of supervision is a less threatening form of self-examination than the traditional supervision conducted by a hierarchical professional, and hence it is gaining popularity among clinicians.

Scholars continue to assert that peer supervision is an effective tool for providing support, encouragement, enhancing skills and professional development among counsellors. Similarly, dyadic peer supervision provides interaction among colleagues and creates a conducive clinical environment for supervisees to engage, reflect, review clients' cases and have a generally productive and professional interaction (Crutchfield & Borders,1997).

The most important strength of the peer supervision relationship is the critical feedback, support, and assistance that the supervisees give to each other concerning their work with clients, and the fact that the sessions are not fully evaluated as compared to when counsellors work with someone hierarchy (Agnew et

al.,2000; Benshoff,1988,1992). Similarly, for student counsellors, peer supervision is believed to provide a conducive forum for supervisory guidance without the anxieties associated with being graded.

Since the process is conducted by colleagues who may have similar levels of training and experience, the peer supervisors are more comfortable working together as equals without the discomfort and anxieties synonymous with the expert-novice; teacher-student; Senior Counsellor-Junior counsellor relationship, and without the fear of the grading. This freedom from fear of being evaluated and graded may influence supervisees' self-confidence, and ability to objectively and critically examine their counselling skills techniques, and approaches and authentically take the necessary measures to improve their performance (Bigley,1986; Cross,2011; Lewis et al.,2017). Moreover, considering the challenges of accessing regular individual supervision from more experienced supervisors, conducting supervision for themselves as peers may help in proactively addressing and reducing possible counsellor fatigue and burnout, hence Borders and Leddick (1987) assert that; "Peer supervision might also serve a preventive function in helping practising counsellors to cope with the occupational stresses that frequently lead to burnout".

According to Lewis et al. (2017), in a peer supervision environment, there is a combination of personality traits, and varied levels of experiences, and these can be a valuable factor for enriching the group with a variety of perspectives through diverse approaches to the presented case material, and to the whole supervision process and therefore add strength towards enriching the peers and their practice. Bernard and Goodyear (1992) also opine that peer supervision provides a conducive and supportive emotional climate that allows counsellors; especially counsellor trainees with feelings of anxiety, self-doubt, second-guessing themselves as well as possible feelings of disappointment to be addressed. Counsellors make use of peer supervision to teach one another through role plays, role modelling and other strategies to inspire each other, as a result, the process instils a sense of worth, builds their confidence, enhances self-efficacy and motivates them to continue making learning a life-long process to become better helpers by perfecting their counselling skills and interpersonal skills (Clapper,1981; Lewis et al.,2017; Singo,1998; Wilkerson, 2006).

Despite extensive literature advocating for peer group supervision, some argue that there is limited empirical evidence on how it contributes to counsellor supervision and training (Crutchfield & Borders, 1997; Singo,1998).

2.8.2.2 Limitations of Peer Supervision

There are a couple of limitations revealed by literature associated with the utilization of peer supervision, and these short-comings include the belief that the presence of peers may prevent some counsellors from openly sharing what goes on in their therapy rooms for fear of being judged or fear of allowing themselves to be vulnerable in front of their peers, there is also the issue of time constraints which may hinder each individual from fully getting their supervisory needs met. Similarly, the group dynamics may deter some from fully participating and benefiting from the peer group process (Bigley, 2006; Hunter & Borders,2009).

Another potential problem with peer supervision is that counsellors may view the peer supervisor as someone who possesses a more or less similar level of experience and qualifications and that alone may become a stumbling block to learning, due to feelings that the peer supervisor is not qualified enough for them to learn any new skills and techniques (Davis & Arvey, 1978). Some counsellors may also be sceptical about the quality of peer supervision, considering the experiences and competencies necessary to effectively facilitate supervision for others. However, there is no empirical literature to support the view that experienced counsellors provide more effective supervision as compared to that conducted by peers themselves.

On these grounds, Worthington (1984) argues that there is "no evidence that supervision provided by experienced supervisors is better than supervision provided by those less experienced". Sharing the same sentiments; Borders and Leddick (1987) maintain that one can still be an effective supervisor regardless of the relative counselling competencies. It is believed that the supervisor brings in a different perspective and insight into the clinical supervision than the supervisee and therefore, is expected to have the competencies to maintain objectivity than the supervisee (Borders & Leddick,1987). The expectation is that supervisors use the lens of a teacher, counsellor, consultant and expert to objectively help guide the supervisees. But it is not always as

simple as that, especially in a case where the supervisory relationship is complicated and shrouded with conflict, lack of trust, defensiveness and resistance which may negatively impact the supervision process.

The other weakness is that the necessary evaluative aspect of counsellors' abilities often creates anxieties and defensiveness that can interfere with effective learning and professional growth. Additionally, the fact that peer supervision does not emphasize the evaluative function of supervision, may encourage familiarity and comfortability with each other which may lead to supervisees being less critical in giving the needed feedback to each other (Agnew et al.,2000; Cross,2011; Singla et al.,2020).

Similarly, though peer supervision is significant and helps peers who may not be able to access traditional clinical supervision, where access is a challenge the supervisees in such situations have no other option but to rely on peer supervision, which they have to conduct for themselves whether dyadically or in a small group of mutual counsellors just to help prevent burnout among helping professionals.

Structured peer supervision provides a forum for counsellors to offer support, encouragement, and reinforcement to one another, as they struggle to provide effective service to clients (Bigley,2006; Hunter & Bowers,2009; Mills & Swift,2015).

2.8.3 Group Supervision

Individual and peer supervision are not the only methods of enhancing professional growth among practising counsellors, and novice and student counsellors in mental health professions. There is also Group Supervision. However, Group supervision is not necessarily composed of counsellors who are at the same level of qualifications, competencies and experience and yet gather in a group supervision process. This mode of supervision is commonly used by professional counsellors for clinical supervision to meet the supervision mandatory requirement.

It is whereby a group of counsellors meet for professional development, often there is a senior counsellor who is more experienced in facilitating the group clinical process; it has the issue of hierarchy inherent in the group process. However, concerning student counsellors in training; Singo (1998) asserts that; "Group

supervision, is where counsellor trainees are supervised under the leadership of an instructor/professor, a doctoral student, or an experienced counsellor".

Bernard and Goodyear (2004, 1998) define Group supervision as the regular meeting of a group of professional counsellors with an appointed supervisor for purposes of professional growth and self-awareness as clinicians to reflect on how they function as counsellors with their clients.

In this group sessions, supervisees and their supervisor present issues emanating from their therapy room from their work with their clients, and on their counselling process delivery. In so doing, the group's purpose is to offer clinical support on techniques, approaches and ethical dilemmas through interaction with each other in a group setting. Similarly, Ray (1998, p.2) also posits that; "the counselling field has supported the concept of group supervision for many years as a viable method of training counsellors".

He goes on to say that the significance of group counselling derives from the belief that the group process creates a healthy clinical environment for personal growth, self-awareness and peer support.

Additionally, Ray (1998) points out that accurate perceptions about self and the awareness of others through regular feedback from other counsellors create an opportunity to enhance empathy, social interest, a sense of psychological safety and support by reducing self-defeating perceptions, self-doubt, anxieties and professional isolation. Moreover, through group supervision interactions, supervisees develop improved self-confidence in their counselling abilities and in addressing the negative perceptions they may have about their competencies and fill the gap of intellectual or professional isolation. Bland (2012) borrowing from CACREP (2009) states that group supervision is "A tutorial and mentoring relationship between a member of the counselling profession and more than two counselling students".

Glaes (2010) and Holloway and Johnson (1985) describe group supervision as a process where someone designated as a supervisor facilitates supervisees' professional development within a group setting. According to Holloway and Johnston (1985), apart from individual supervision, group supervision is the second most popular method of supervision used to train counsellors. Despite the popularity of its usage, there is still a need

to understand how it is different from individual supervision, and how to effectively and appropriately utilize it (Bland, 2012; Glaes,2010; Holloway & Carroll,1996; Holloway & Johnson,1985; Prieto & Altmaier,1998; Prieto,1996).

Ray (1998) argues that Group supervision is simply a tutorial relationship between a senior member of the counselling profession and two or more supervisees, however, some groups can be larger than five members, but not more than fifteen supervisees. Ray (1998) goes on to say that group supervision offers supervisees the environment for vicarious learning and group process advantage which individual supervision is unable to offer to supervisees. There are numerous attempts to define what group supervision is, and the given definitions are mostly descriptions of group supervision rather than definitions. On this premise, Araneda et al. (2015) purport that; "there is no unique definition or single approach to group supervision".

Nonetheless, many scholars have adopted the definition that was proposed by Bernard and Goodyear (2009, p.244) and Bernard and Goodyear (2004, p.235) that views group supervision as a:

> regular meeting of a group of supervisees with a designated supervisor or supervisors, to monitor the quality of their work, and to further their understanding of themselves as clinicians, of the clients with whom they work, and of service delivery in general. These supervisees are aided in achieving these goals by their supervisor(s) and by their feedback from and interactions with each other.

Inherent in this definition are the benefits of group supervision, such as group feedback and group interaction which are significant factors towards achieving the mandate of the group process, and the ultimate goals of the group supervision intervention. According to Araneda et al. (2015), the main reason why group supervision has found favour among clinicians is mostly because of the assumed advantages as compared to the individual type of supervision. In most mental health professions, the establishment of groups for purposes of clinical supervision has become common and usually starts with setting up the goals and objectives of the

group process to be achieved and agreeing on the logistics such as; how often to meet, where and how many members a group should have and who the designated clinical supervisor would be.

The process of giving and receiving feedback through group interaction between the supervisees and the supervisor is key in this process and literature shows that when it is properly implemented it can be the most effective type of supervision. The success of the group process depends largely on healthy interactions among the group members and between the members and their supervisors. According to Bernard and Goodyear (2004) and Goodyear and Bernard (1998), supervision in a group setting is composed of professional counsellors who meet regularly to support each other and help each other to grow and become effective in their clinical practice. During their regular meetings convened by a more experienced and competent clinical supervisor/senior counsellor, the supervisees reflect on their performance as clinicians, and on ways they could improve to become a better practitioner who provides effective and safer services to their clients.

Such meetings are agreed upon; especially on the frequency, the venue, the maximum number of supervisees, and procedures are contracted.

Supervisees are open to allowing themselves to be positively influenced by the group process and by the role of the supervisor, all of which are consequential to their professional development individually and as a group. Similarly, supervisees are expected to utilize the group process to share their professional challenges, dilemmas and case material upon which the group and the supervisor are expected to utilise their knowledge, expertise, experience and the group process to facilitate the supervision.

In the group setting, the clinical supervisor is perceived as a skilled and experienced professional who deploys clinical supervision expertise, experience and competencies to create a positive environment for the group process and group cohesion. The supervisor also creates the essential group therapeutic alliance, which is critical in building a healthy group relationship essential for achieving positive group outcomes for individual group members and the whole group. Linton (2003) calls it; “the attractiveness of a group for its members” because when cohesion is achieved it leads to “catharsis” as members experience a conducive environment,

positive rapport, and positive feelings towards the group resulting in active participation, a sense of belonging, group acceptance and improved confidence to offer effective counselling to their clients.

2.8.3.1 Strengths of Group Supervision

Literature shows that this type of supervision has several strengths associated with having a group of professional counsellors in a setting for the clinical supervision process; if conducted in the right environment and facilitated by a knowledgeable, experienced and competent supervisor, the supervisees can benefit immensely from giving and receiving feedback, and objectively reviewing and critiquing each other's work. Being part of the group supervision process enables every member the opportunity to learn from each other. This is achieved by being privy to a wide range of clients' case material presented to the group and the shared achievements and struggles encountered by counsellors in the practice. Therefore, group interaction helps therapists process client issues differently in their future counselling sessions (Bernard & Goodyear,2014,2019; Carter et al.,2009).

The process also gives the supervisor a wider perspective on the supervisees as they interact with their colleagues and discuss each other's case materials. The supervisees also benefit from the group a wide range of input and support concerning their particular client's case. This is highly beneficial compared to deriving feedback solely from one source (the supervisor) as is the case with individual supervision. Therefore, according to Averitt (1988), group supervision offers distinctive process opportunities for group review and group feedback through interaction with different individuals, hence, it is viewed as an effective learning platform because group diversity provides varied, dynamic and better appraisal than individual evaluation.

Bernard and Goodyear (2004) argue that group supervision has several strengths such as time-saving, collective expertise, vicarious learning, less supervisee dependency, benchmarking from a range of case material, diversity, a more comprehensive perspective of the supervisee, and a greater opportunity to discuss and apply techniques as well as mirroring the supervisees' intervention. Similarly, this type of supervision helps to create greater accountability, safety, and improved service provision for the end user who receives counselling from the supervisees.

The supervisees receive rich clinical feedback and support from both the supervisor and group members (Hunter & Bowers,2009; Corey & Corey, 2007,2010). Many scholars articulate the advantages of group supervision as encompassing clinical competency (Borders et al.,2014), whilst others like Bernard and Goodyear (2019) talk of developmental skills as benefits acquired. Similarly, Anderson et al. (2022) and Snowdon et al. (2017) view advantages as including improved compliance. Moreover, using this type of supervision is said to be "the economy of time" as well as didactic and experiential learning for improved counselling processes.

Bernard and Goodyear (1992) argue that; the interaction between the supervisor and individual supervisees can somewhat be viewed as individual supervision conducted in a group setting since each group member gets to have an opportunity to present their issues and receive feedback and support for improved clinical practice. Additionally, supervisees are reassured and comforted by the realization that other counsellors also encounter similar issues needing clinical support.

Therefore, they perceive supervision as a platform for professional growth and the reduction of counsellor fatigue, burnout and work-related anxieties. Supervisees also immensely benefit from the application and demonstration of additional techniques through role-playing, modelling, coaching, experiential exercises, live demonstrations of counselling skills, role reversal, psychodrama and sometimes the use of videos (Hunter & Bowers,2009; Lewis et al.,2017).

According to Bernard and Goodyear (2009), the issue of cost and time due to processing many supervisees in one setting is a strength. Additionally, Linton (2003) asserts that supervisees are exposed to a broad range of clinical issues and opportunity to observe the application of different techniques used by members of the group, and therefore the diversity provides a wealth of feedback to supervisees (Bernard & Goodyear, 2009; Leddick,1994; Linton & Hedstrom, 2006). Similarly, Bernard and Goodyear (2004) and Trant (2000) purported that through this type of supervision both experienced and novice counsellors learn from each other, there is less risk of counsellor dependency, and limited unrelated issues emanating from the hierarchy as the group itself co-facilitates with the designated supervisor.

Linton (2003) and Sheppard (2018) believe that Group supervision enables supervisors to have a vast amount of information from which to gain a better understanding and evaluation of their supervisees' level of experience, competencies, value systems, cognitive abilities, and how that could play out in their work with clients. Moreover, supervisors get insight into how supervisees handle both positive and negative feedback and the implications of their reactions to their clinical work.

Nonetheless, Lawrence (2017) opines that this mode of supervision offers supervisees the opportunity to self-reflect, self-evaluate, be critiqued, overcome negative self-perceptions and allow themselves to grow personally and professionally into effective practitioners of integrity, credibility, and accountability to safeguard the lives of those they serve.

This type of supervision process creates a sense of oneness, solidarity and clinical support from different minds, different skills and competencies (Bernard & Goodyear, 2009; Linton,2003; Linton & Hedstrom, 2006). Similarly, Dies (1980) argues that this method of supervision does not require much effort from the supervisor and that the supervisory relationship has the potential to be mutually beneficial. However, Dies (1980) goes on to say that there can be a distortion of boundaries between supervision and therapy which could create confusion resulting in a supervisor's inaccurate understanding of the group process. Therefore, this shows that despite all these benefits, there are some limitations to the group supervision approach.

2.8.3. 2 Limitations of Group Supervision

Although group supervision has massive benefits and strengths, the literature reveals that some limitations do exist; for example, not everyone can readily embrace negative feedback, and it's not all personalities of people that can thrive in group settings. Often, due to lack of experience and poor communication skills, the way the feedback is presented may be more damaging than beneficial to some (Enyedy et al., 2003; Linton, 2003; Linton and Hedstrom, 2006).

Competitive feelings together with overt or covert conflict can hinder professional growth; especially if left unresolved by supervisors and negative effects such as decreased learning, negative opinion of the

supervisor, and disengagement in the supervision process may occur. Another challenge of group supervision may be the issue of time management (Enyedy et al., 2003; Linton, 2003; Linton & Hedstrom,2006); lack of punctuality by either the supervisor or the supervisees may impact the group processes.

As alluded to earlier, the literature reveals that group supervision has the potential to increase anxiety among some supervisees who do not fit well in group settings, so it is not for everybody (Enyedy et al., 2003; Linton & Hedstrom,2006). Given this, Supervisors need to be aware of group dynamics and other possible challenges and be competent enough to address them when and if they emerge (Murphy & Kaffenberger, 2007).

Moreover, there is always a potential for group dynamics and differences to interfere with the group process, for example, possible group pressure to conform to a particular view or mindset which may interfere with the learning process. Additionally, the group can be dominated by a few individuals and that could derail the group process and lead to a loss of focus.

This process requires skill and experience on the part of the supervisor to keep the group focused as the group mode of supervision may not accord each supervisee the attention they need to learn and improve their counselling skills; this may be the case for introverted counsellors who may not fit well into large group settings and feel left out, often due to time constraints because of caseloads, the size of the group and poor time management (Dies,1980).

Similarly, more time may be spent on the newbies leaving out the competent members and the more vocal members may dominate the group which may further impact the issue of time spent on case materials and create an imbalanced group process leaving others feeling neglected (Goodyear & Bernard, 1998). Hence, Naylor (2016) argues that poor time management has the potential to negatively impact the effectiveness of group supervision, but group CS may be highly beneficial when effectively conducted.

Naylor (2016) goes on to argue that group processes can impact supervisees' experience, therefore, the role of the supervisor is to encourage full and balanced participation by all members and prevent dominance by a few individuals because if not effectively facilitated, instead of building, supporting and motivating

members, the group could damage supervisees' morale, especially where the conflict in the group are not addressed, supervisees feeling vulnerable, attacked or not accepted in the group and feeling negatively impacted such that their self-confidence may be affected, they may feel left out, intimidated or threatened and leave the group.

The role of supervisees in this case is primarily to be supportive of one another whilst the supervisor is expected to be didactic and focused on clinically directing the group process and group professional growth. Furthermore, Gray (1988); Hunter and Bowers (2009) and Naylor (2016) assert that other than the logistical reasons of time and money, group supervision appears to offer greater clinical benefits than individual supervision despite also having the potential to damage group members, and possibly failing to meet the needs of some members within the group if the process is not well coordinated.

According to Lewis et al. (2017), the supervisor's ability to evaluate the relationship between individual traits and the group dynamics is highly beneficial towards advancing self-awareness, self-understanding, and understanding others in the group, consequentially leading to meaningful personal and professional relationships. However, understanding group dynamics requires a competent supervisor to drive the group towards functional and successful supervision. The literature further shows that group supervision can be a useful instrument to enhance growth by focusing on certain topics, such as psychological theories, therapeutic approaches, and group theory whilst providing an environment for reflection on individual case materials. However, unhappiness and disagreements may emerge if certain issues such as group processes and group conflicts are not addressed.

There seem to be mixed views concerning the outcomes of participation in group supervision, however, there are also strong arguments in favour of it for increased therapeutic skills and improved reflective skills as a result of participating in group supervision.

Nonetheless, despite these contradictory debates among scholars; for and against, there seems to be a consensus that generally group supervision is beneficial to those accessing it (Naylor,2016). Some

contradicting arguments are also centred around the group sizes and other logistics considered to be influential to the effectiveness of the group supervision process. Literature also shows that limitations of group supervision may include issues of confidentiality and group dynamics that may impede professional development (Bernard & Goodyear, 2004,2014; Lyman,2010).

Suffice it to say that, no intervention is without controversies; advantages and disadvantages or strengths and weaknesses. Due to a large number of people sharing and receiving information in a group setting, the confidentiality of supervisees becomes one of the major concerns. However, the benefits derived from these various types of supervision, and the learning platform created to empower counsellors in the mental health practice are undeniable.

2.9. The Benefits of Clinical Supervision

There are various benefits of CS purported by various scholars ranging from developmental, competency-based, psychological and clinical for counsellors' mental well-being. Empirical literature indicates that burnout and counsellor fatigue are synonymous with mental health professions, and through clinical supervision, they can be proactively prevented or reduced.

According to Bledsoe (2019), the major benefits of clinical supervision to counsellors are development, counsellor efficacy, competency-based, prevention of burn-out, prevention of emotional exhaustion, enhancement of therapeutic relationship through applying learnt skills and mirroring skills acquired from the supervision process as well as compliance to ethical standards. Therefore, clinical supervision serves as an instrument of quality assurance, counsellor and client wellness and counsellor self-care mechanism.

This section discusses both the positive aspects and perceived harmful side of clinical supervision where there are potentials for things to go wrong when supervision is not properly implemented; the negative aspects of clinical supervision that some authors term the "dark side" of clinical supervision (Butterworth,2022; Ellis,2017; White,2018).

The field of mental health can be mentally and physically draining and without clinical support, one can experience emotional depletion, and burn-out leading to non-performance, hence the significance of discussing the benefits of CS in this part of the research.

Literature is replete with information from the global platform to the fact that clinical supervision has massive benefits, though at the same time can be marred with negative outcomes. Though there is extensive literature globally on this issue, in Botswana it is none existent.

Ellis (2010) postulates that the Supervisor-Supervisee relationship eventually plays out in the counsellor-client relationship and the supervisory working alliance has the potential to intercept burnout and the effects of trauma and energise performance.

Similarly, literature shows that a conducive and therapeutic supervisory relationship is a major predictor of satisfaction and effective performance (Butterworth,2022; Ellis, 2010; Fama & Ellis, 2005; Gonge & Buus, 2011). Jones (2011) opines that clinical supervision can be equated to a meaningful professional discussion and relationship consciously developed to provide an appropriate environment for exploring issues intended for the improvement of professional performance and counsellor efficiency. However, it should be noted that clinical supervision is not a therapy-based relationship but creates an opportunity for clinicians to become more observant of issues related to their professional practice to enhance their therapeutic relationship with their clients.

According to Barletta (2017) and Jones (2011), the professional tasks of mental health professionals are complex and multidimensional, their jobs are demanding and some more stressful than others; especially for those working in crisis management and trauma treatment centres. Therefore, the nature of the services offered brings work-related stress and complexities that demand clinical support, monitoring and supervision to address some blind spots, to ensure proficiency, quality and ethical services.

This is done through constant self-review and review by an independent, objective, experienced and qualified expert known as a clinical supervisor. Barletta (2017) goes on to argue that; it is common for

counsellors to find themselves operating in silos with little interaction from their professional counterparts in various settings. Therefore, without the support and encouragement of colleagues, counsellors run the risk of finding themselves in professional and developmental stagnation due to professional isolation.

Therefore, it is on this premise that counsellors are encouraged to affiliate with professional organizations or associations for constant access to clinical supervision; either as individual, peer-to-peer- or in a group setting. Consequently, clinical supervision is for monitoring service provision to ensure client safety, self-evaluation, application of research and theory into practice, enhancing clinical skills, increasing the scope of practice, assessing and exploring values and beliefs, and ensuring ethical and legal practice.

Additionally, clinical supervision exists to improve supervisees' perceptions and stimulate clinical wisdom. Through supervision, counsellors can adhere to procedures and protocols; ethical principles and policies, and have increased self-awareness whilst at the same time strengthening teamwork, collaboration, consultation, peer support, collegial unity, uniformity and a standardised way of operating as clinicians.

Barletta (2017) postulates that clinical supervision creates team orientation, encourages the use of evidence-based approaches, allows for the assessment and identification of strengths and limitations and identifies possible hindrances to personal and professional development. CS empowers supervisees to objectively develop critical reflection skills to work towards becoming better at their work, setting realistic personal and professional development targets and goals and commitment to self-care.

The literature further shows that counsellors have become more aware of issues inherent in their line of work, such as; counsellor fatigue, compassion fatigue, burnout, emotional exhaustion, emotional depletion, vicarious traumatisation as well as the legal implications related to professional malpractice. Therefore, such issues create a need for CS to thrive in their practice and offer effective counselling services to their clients. The benefits of clinical supervision are immense, hence through various forms of clinical supervision counsellors attain clinical support, feedback and the much-needed professional development to operate effectively (White & Winstanley,2010; White,2017).

The benefits of supervision are without a doubt centered around the concern for the safety and security of clients who receive counselling from the supervisees as well as the integrity of the profession.

Through the intervention, counsellors receive clinical support and reflective skills relevant to the effective implementation of the counselling process and by sharing significant case material content in a case review process, counsellors get help with techniques and better strategies for building healthy therapeutic relationships with clients, addressing transference and countertransference, maintaining better ways of staying ethical, multicultural, unbiased, non-judgemental and self-aware of possible interference of own values in the therapeutic process.

Through the supervision process, supervisees' strengths are recognized and acknowledged by their peers and supervisors, whilst at the same time, their limitations are acknowledged and processed to enhance professional growth and efficiency (Butterworth,2022; Gonge & Buus,2011; White,2018).

However, in certain parts of the world, such opportunities are either scarce, inadequate or non-existent, for example; Hall et al. (2015) argue that burn-out among clinical psychologists working in low-income countries has been reported, and clinical supervisory support structures do not exist in such countries, this is despite empirical research indicating that clinical supervision is essential for effective counsellor performance and reduction of burnout among mental health service providers.

The supervision process encourages life-long learning through observational experiences and parallel processes within the supervisory relationship and enables supervisees to sharpen their therapeutic counselling skills. The benefits of clinical supervision are immense for professional support from peers and the Clinical Supervisor (Hendricks & Cartwright,2017; Hall et al., 2015; Walsh,2015).

The process of having clinical supervision emerged years ago to prevent malpractice; safeguard the counselling practice, protect the beneficiaries of the service and ensure quality service delivery. According to Milne and Reiser (2012), back in the seventeenth century, there were similar concerns centred around harmful and dubious practices by various infamous practitioners that came to be known as "quacks".

According to Lawrence (1910, p.202), quacks simply refer to people ‘‘who make loud and vain pretension, undertaking to perform cures by the application of ointments or cerates’’, or someone claiming to have the knowledge, experience, skills, competencies or the ability to practice in a certain field as an expert when they are not qualified, inexperienced and often even lacking the training in the profession they claim.

Back then, Lawrence (1910, p.206) decried how such people could not be stopped from continuing to practice largely because of those who utilised their services regardless of them running “quack” practices.

Additionally, their practice could only be inspected by experts from the occult science despite such practitioners not having formal training, licensing, or regulation; ‘‘No candidates are either examined or licensed or even sworn to fair practice’’ (Lawrence,1910, p. 229). This is despite Ellis’s (2010) argument that Supervision is essential for bridging the gap between theoretical science and practice, which is why there is vast literature emphasizing the significance of continued clinical supervision for counsellors for purposes of improved self-confidence, increased ability to systematically implement purposeful counselling interventions and increased self-direction.

The significant effect of clinical supervision derives from the positive impact the intervention is believed to have on the professional growth of the supervisees, similar benefits are said to be gained by school counsellors/Guidance teachers who get the opportunity to receive regular clinical supervision (Benshoff,1988; Wagner & Smith,1979). Wagner and Smith (1979) believe that for clinical supervision to be effective and benefit counsellors, both Supervisors and supervisees have to demonstrate their commitment to the supervision. Moreover, just as there has to be a willingness from the supervisor to facilitate the supervision process, a similar amount of energy has to come from the supervisees to desire to receive supervision in a conducive supervisory relationship.

Consequently, for supervisees to benefit from the process, clinical supervisors are to believe that supervisees can equally learn from each other in a peer setting as well as from a group setting, not just from individual supervision sessions (Benshoff,1988).

Atzinger et al. (2016) opine that through supervision, supervisees benefit from objective feedback, varied perspectives from other supervisees and the demonstration of improved techniques for processing clients' issues which they apply in their future counselling sessions.

The process gives supervisors more insight, the ability to perfect skills and to get skills re-tooling. Similarly, the peer relationship allows for increased support thereby reducing supervision anxiety which often interferes with the learning process. Moreover, in peer supervision, there is also increased accountability and fostering of shared responsibility, solidarity, team effort and collaboration for improved counselling services. Whether through a dyad or peer group supervision setting, the whole process of supervision provides opportunities for peers to help one another before they can meet with their clinical supervisor individually, therefore there is more clarity derived from the process for complex issues.

Supervision provides a learning forum that helps counsellors grow professionally. Atzinger et al. (2016) go on to argue that, whether the supervision is personal, peer or group; it offers critical benefits for counsellors resulting in decreased dependency on the supervisor as supervisees themselves can conduct peer-to-peer supervision or peer-group supervision instead of waiting for the clinical supervisor.

The Supervision process creates the environment for counsellors to assess their skills and those of their peers, to enhance the necessary skills and share experiences and by so doing effectively design their professional growth. There is an enhancement of self-confidence, self-awareness, self-direction, competencies, reflexivity and independence as Supervisees become efficient enough to function effectively with less dependence on their peers and the supervisor. At the same time, clinical intervention strengthens interdependence between professionals through the creation of a conducive learning forum from which they benefit from each other, and empower one another through the demonstration and application of techniques during the supervision session. As Atzinger et al. (2016) opined; CS has numerous benefits, some of which include; the provision of balanced professional support to supervisees for challenges they might be facing concerning their work with clients, support given according to supervisees' developmental level and level of experience, immediate and objective feedback for the betterment of counsellors' performance.

Koivu et al. (2012) in the study on the effects of Clinical supervision among nurses established enough evidence concerning the effects of clinical supervision in addressing emotional exhaustion, depersonalisation of supervisees and job satisfaction. Similarly, White and Winstanley's (2010) study with trainee supervisors revealed a relationship between clinical supervision and low burnout for those who accessed clinical supervision as compared to those who did not and an overall reduction in the level of psychological distress. Koivu et al. (2012) went on to talk about intrinsic motivation, commitment to the organization, less exhaustion, less cynicism and less burn-out as some of the benefits among those who accessed Clinical supervision.

Additionally, organisational-based self-esteem, general work-related well-being and a body of knowledge gained from clinical supervision are among those sighted by many scholars as some of the benefits derived (Ellis, 2017; Koivu et al.,2012; White & Winstanley, 2010).

However, according to the study conducted by White and Winstanley (2010), not every nurse benefited from Clinical supervision. Some found the process inefficient and were not satisfied with the process and went on to report increased incidents of psychological distress every time they accessed follow-up supervision sessions. Consequently, those who were dissatisfied with clinical supervision turned out to be those who experienced stress and distress the most, whilst many of them were reported to have experienced burnout symptoms (Koivu et al.,2012). Similarly, Lynch (2000) postulates that the benefits of clinical supervision include the provision of quality assurance and protection of the end users of the service offered by counsellors. Lynch (2000) further argues that the supervision process is highly beneficial for lowering stress levels, reducing complaints and in most cases resulting in improved staff morale. Moreover, the literature reveals that the supervision process leads to increased knowledge, awareness of possible solutions to clinical problems, improved confidence, reduced emotional strain, increased participation in reflective practice, and boosted self-awareness (Lynth,2000). The benefits identified have implications not just for practitioners but for the clients they serve, the organization's counsellors work for and the profession.

Clients who receive counselling from supervisees benefit from the process because the literature assumes that the supervision ensures ethical practice and effective service delivery, and clients' safety and quality of

service provision are guaranteed where counsellors access clinical supervision; especially where there is increased accountability for their actions as evident through legal and ethical practice and prevention and reduction of malpractice and legal battles and lawsuits (Borders, 2006). According to Muratori (2001), neophyte counsellors may benefit immensely from the clinical supervision intervention and the same can be said for the paraprofessionals alluded to by Muchado (2018) and Msimanga and Moeti (2018) in the case of Botswana counselling practice. Literature shows that clinical supervision has been associated with a reduction of burn-out, reduced emotional exhaustion, depersonalization and professional inefficiency caused by counsellor fatigue, which may ultimately result in emotional detachment and feelings of professional inadequacy among counsellors. It is believed to stimulate personal and professional growth (Hall et al.,2015; Koivu et al.,2012).

Hall et al. (2015, p.2) define burnout as "a multidimensional concept with a core component of emotional exhaustion when the practitioner's emotional resources have been depleted due to the demands and expectations of the work". Literature shows that effective clinical Supervision is beneficial to supervisees as a restorative instrument for emotional support, normative to maintaining professional standards, and formative by developing supervisees' skills, and therefore necessary for meeting the professional and developmental needs of supervisees. Therefore, the Supervision process helps to build confidence and provides a platform for clinicians to receive emotional support through discussion with the supervisor and peers. Hence, Hall et al. (2015, p.4) state that; "Anxiety related to supervision was said to be alleviated through discussion about the supervisory relationship." Moreover, through the parallel process within the supervisory relationship which mirrors the counsellor-client therapeutic relationship, the counsellor develops an effective therapeutic relationship with their clients.

Therefore, supervision creates an environment for acquiring and enhancing practical therapeutic skills to be applied in therapy. It can therefore be inferred that; Supervision creates a conducive learning environment for professional growth, as it enhances experience and counsellor competencies for better performance (Hall et al.,2015; Koivu et al.,2012).

The benefits of Supervision are immense and essential in helping counsellors to manage feelings of being overwhelmed, exhausted and fatigued. Through supervision, counsellors' morale and self-confidence are boosted and guidance, coaching, and mentorship are received from the Supervisor's roles of teacher, counsellor and consultant that help to address anxieties. In this premise, Hall et al. (2015, p.7) argue that; "Supervision has been shown to decrease symptoms of burn-out in low-income countries".

A plethora of literature shows that the supervision process has numerous benefits as postulated by many scholars; Koivu et al. (2012) emphasise that; supervision enables practitioners to develop knowledge and competencies, to take responsibility for their actions and it enhances safety for those receiving counselling from the supervisees. It is therefore sound to opine that the process of learning and growth, as well as the scope of practice, are centred around the continuous development of self-awareness, self-assessment, and analytical, reflective and reflexive skills for the supervisee.

Barletta (2017) asserts that many individuals and organisations benefit greatly from the provision of quality clinical supervision as it is centred on ensuring client safety, the provision of quality service, and the reduction of harm to clients due to assured ethical compliance for clinicians. Similarly, supervisees are assisted in achieving their professional goals, and though the immediate beneficiary of CS is the supervisee, the indirect beneficiary of CS is the recipient of the counselling service received from the supervisees, followed by the organization and the counselling fraternity. Therefore, the outcome is the respect, credibility and integrity of the counselling profession. On the flipside, the opposite would be the result if harmful and ineffective supervision is offered resulting in harmful and ineffective counselling services provided to clients.

Through supervision, counsellors who struggle with some aspect of their clients' cases receive support, insight, encouragement and enhancement of techniques as purported by Barletta (2017). Clinical supervision cushions the supervisees against work-related stress which often emanates from counsellor fatigue, vicarious trauma, emotional exhaustion and compassion fatigue.

However, if the supervisory relationship is not healthy, more harm can emerge, either knowingly or unknowingly caused due to ignorance or incompetence, hence Ellis (2010) asserts that, supervisors in their gate-keeping and evaluation roles have to always do what they know is right and maintain professionalism as they can heal or harm, and build or destroy.

McMahon and Patton (2000) argue that clinical supervision is underpinned by professional development, facilitation of continuous learning and continuous self-evaluation beyond the initial training of the supervisee as a student counsellor. McMahon and Patton (2000) continue to say that in mental health, professional growth is achieved through clinical supervision. Therefore, those not accessing supervision do not experience similar professional growth and benefits compared to those in supervised practice. Moreover, through supervision, "blind Spots" in the counselling process are identified and addressed. It is safe to say that supervision creates a conducive environment for reflection, discussion, feedback, and guidance with intentions to achieve desirable results of improved self-awareness, personal development, professional growth, improved confidence, sharpened competencies and life-long learning.

Similarly, McMahon and Patton (2000) argue that, because counsellors' roles come with work-related stress, there is a need for them to access support in the form of clinical supervision to help build genuineness, trustworthiness, respect, empathy, rapport, and receive constructive feedback in a non-threatening environment and working without clinical support could easily lead to counsellor fatigue, burnout and stress, which may ultimately impact negatively on performance, and adversely affect counsellors' wellbeing and their counselling work with clients.

Literature reveals that inadequate clinical supervision has the potential to negatively impact counsellor efficacy which may eventually affect the end-user who receives the counselling service from inadequately supervised counsellors. Due to extensive empirical literature on the benefits of clinical supervision, most counselling regulating bodies have since made clinical supervision a mandatory requirement for the professional development of counsellors, and it has become well documented in various ethical codes, for example, American Counselling Association ([ACA], 2014, p.8, C.2.d) under monitoring effectiveness states;

"Counsellors continually monitor their effectiveness as professionals and take steps to improve when necessary". ACA (2014) further stipulates that; "counsellors take reasonable steps to seek peer supervision to evaluate their efficacy as counsellors". Whilst Australian Counselling Association ([ACA],2016, p.9) also states;

> Clinical Supervision exists to support therapists, Professional supervision
> is also now a mandatory professional requirement…… 1hour,
> for every 20 hours of client contact, and Counsellors in full-time practice
> should receive supervision at least weekly, if not fortnightly.

Regardless of these, there are opposing views concerning mandatory supervision as there hasn't been enough empirical evidence supporting or justifying mandatory clinical supervision in counselling; for example, Cobia and Pipes (2002) conducted a study in which they investigated the theoretical and empirical bases that supported mandated supervision for practitioners and found out that, although there is a consensus about the effectiveness of supervision, there remained lack of empirical evidence to the effectiveness of mandated supervision as compared to non-mandated process. Therefore, there remain some arguments that the supervision process may lead to anxiety for some supervisees even if not mandated.

Jones (2011) asserts that; "supervised professional practice can be characterised by anxiety because of the supervisee(s) fearing criticism". Jones (2011) goes on to say that it is typical for supervisees to experience discomfort, self-doubt, and feelings of uncertainty about attending clinical supervision meetings, and that more often supervisees report concerns about whether the supervisor will be unbiased, fair, effective and respect their approach to professional practice, especially if operating from differing theoretical orientations. With that in mind, it is worth discussing the harmful side of clinical supervision.

2.9.1 The Harmful Side of Clinical Supervision

No practice is without some negative side because interventions are implemented by human beings with different personalities, strengths and weaknesses, and in some cases, personal traits and values are allowed to interfere with clean meaningful interventions just like in any field; be it in politics, the medical field or any other human and social sciences. Therefore, even in Clinical supervision, there is enough empirical literature alluding to the possible harmfulness, hence the reason why ethical codes exist in the mental health practice to minimise the harm that may befall the clients, practitioners, as well as the counselling practice. Ellis (2010) defines harmful clinical supervision as supervisory practices that result in psychological, emotional, or physical harm or trauma to the supervisee. Walsh (2015, p.69) coined it well in saying;

> It is likely that the potential to act unethically and cause harm is present in all psychologists, not just, as the cliché goes; a few rotten apples that spoil the barrel. Although we might take for granted that our scientific and professional activities, by definition, are fruitful or helpful, but sometimes they are not.

Similarly, Hendricks and Cartwright (2018) and Muratori (2002) describe harmful supervision as a form of supervision that is associated with a lack of training and lack of experience in supervision, coupled with supervisors who are either aggressive or passive, destructive or demanding, as well as being judgemental or authoritarian, all of which may also be shrouded with explicit and implicit conflict and disagreements as well as supervisor impairment. McNamara et al. (2017) also talk of harmful supervision as involving behaviours such as those clearly articulated in some of the narratives given by sampled supervisees documented by authors like Ammirati and Kaslow (2017); Beddoe (2017); Chircop, Creaner and Timulak (2022); Ellis (2017); Ellis et al. (2014); Hendriks and Cartwright (2018); Lovell (2007); McNamara et al. (2017). Literature reveals issues that often emerge in supervision that may impair the supervision process such as supervisors' abuse of power, discrimination of supervisees based on age, race, gender, sex, or other cultural characteristics; and instances where supervisees are publicly shamed, abused or humiliated.

Hendriks and Cartwright (2018) also share similar sentiments around issues of racial discrimination in a study done in South Africa where harmful behaviours have been proven to leave some supervisees emotionally distraught or physically hurt. Moreover, there have also been reported issues of supervisees experiencing high levels of stress, anxiety, intense anger and other negative emotions due to harmful supervision experiences.

According to McNamara et al. (2017), some have reported experiencing depression, anxiety and dreading having to attend a clinical supervision meeting, whilst other supervisees are said to have found themselves constantly experiencing heightened feelings of fear, anxiety and stress which left them emotionally scarred and paralyzed, resulting in poor performance and impacting their physical and mental wellbeing.

Some supervisees have reported experiencing harmful supervision that left them traumatised enough to negatively impact their health. Some harmful supervision experiences have been described as "traumatic', and leading to significant physical and psychological health problems such as fatigue, weight loss, chronic headaches, high blood pressure, digestive issues and other stress-related physiological reactions in the form of psychosomatic ailments (Ellis,2017; McNamara et al.,2017).

Literature is replete with information revealing incidents of victimization, helplessness, self-doubt, anger and complex emotional responses to harmful clinical supervision. The harmful effects of clinical supervision are multifaceted and complex to be ignored, hence more literature is emerging concerning the issue of harmful clinical supervision in counselling (Deihl 2009; Hendriks & Cartwright,2017; McNamara et al.,2017). Emerging literature shows that the issue of harmful clinical supervision is a common phenomenon in mental health just as it often happens in the medical field, it is on this ground that Ellis et al. (2014, p.2) assert that, this phenomenon of harmful supervision has so far been reported in the counselling practice in different settings; "In recent years, the phenomenon of clinical supervision that goes badly has received increasing attention". According to Ellis et al. (2014), the issue of harmful clinical supervision among student counsellors can be intense as it places the student counsellors in a completely vulnerable position as the evaluative, hierarchical relationship with the supervisors keeps their future uncertain, and their career hanging

in a balance because supervisors seem to hold the keys to the supervisees' future; at times, whether or not they complete or fail practicum/internship lies in the hands of their supervisor's decisions.

Literature shows that supervisees are also vulnerable to exploitation in various ways, they are left compromised and open to all forms of abuse at the hands of their supervisors such as; sexual exploitation, sexual harassment and sexual misconduct. The harm may also manifest in the form of aggressive, abusive violent behaviour or deliberate disregard for professional ethics and professional supervisor-supervisee boundaries (Deihl 2009; Deihl & Ellis,2009; Ellis,2017; Farma & Ellis,2007; MacNamara et al.,2017).

According to Ellis et al. (2014), harmful supervision that supervisees are subjected to may also be exposed to "bad clinical supervision" which may include but is not limited to; ineffective supervision that does not necessarily traumatize or harm the supervisee but is characterized by lack of interest and lack of time invested in the supervision process by the supervisor, lack of thorough preparation, mediocre supervision sessions, poor time management, inability to give immediate or timely feedback by the supervisor which creates more anxiety in supervisees, failure to effectively evaluate the supervisee's skills, ignoring the supervisees' needs and issues of concern, as well as supervisors' inconsistencies, biased treatment and failure to address the supervisees' professional and training needs by the supervisor which may result in supervisee's limited professional development. Bad supervision may also be evident from the supervisor's inability to engage with the supervisees to listen to their issues, thereby blocking or preventing dialogue, open communication, discussion and interaction necessary for sharing ideas, opinions and constructive feedback, which then leaves the supervisee feeling neglected, abandoned and stressed (Borders,2006; Ellis et al.,2014; Ellis,2010,2017; Hall et al., 2015).

Literature reveals that clinical supervision can either be harmful, bad or inadequate. Harmful supervision entails the supervisor's harmful actions, harmful inactions or inappropriate behaviours that may cause emotional, psychological or even physical harm to the supervisees. As purported by Ellis et al. (2014, p.7), harmful supervision is "supervisory practices that result in psychological, emotional, and physical harm or trauma to the supervisee".

Such may include behaviours or situations whereby the supervisor acts inappropriately with malice, discrimination, negligence, or violates the accepted ethical codes and standards of practice and care as stipulated in the ethical guidelines of practice for respective countries or the universally accepted standards and principles of justice, fairness and "no harm"; the ethical values that emerged following the atrocities committed in the past in scientific research involving human subjects such as the Tuskegee study.

Arguably, one may say that moral lessons were learnt from history concerning working with humans in evidence-based programs and interventions, as evidenced by the Nuremberg trials that led to the Nuremberg Codes of 1947, and to the Helsinki Declaration that was well documented in the Belmont report of (1979) upon which research guidelines were articulated to regulate and guide responsible behaviour in biomedical research and provides underpinnings in any practice that involves working with people.

This is to protect human life and be cognizant of moral values and principles of beneficence and nonmaleficence; responsibility, fidelity, justice, respect for autonomy and the right to choose not to participate/consent, integrity, right to be treated with dignity, confidentiality, privacy and to ethically do what is right in theory and practice (Benatar & Singer,2000; Cassell,2000; Walsh,2015).

According to Ellis (2017); Ellis et al. (2014) and McNamara et al. (2017), there is evidence to the fact that supervisees have been exposed to various harmful incidents and experiences ranging from abuse, avoidant approaches towards addressing any emerging conflict within the supervisory relationship, abusive interactions, mistreatments, multiracial, ethnicity, racial issues, differentiated treatment, emotional, mental trauma, biases that often lead to stress, loss of confidence, increased anxiety and fatigue which are detrimental to effective professional performance. Consequently, as Ellis (2017) opines; "a degree or experience alone does not equate to effectiveness as a supervisor", hence the significance of supervisors' abilities to self-evaluate and keep their biases out of the supervisory relationship.

The state of the parallel process plays a significant role in supervision and the supervisory relationship, and an unhealthy supervisor-supervisee relationship ultimately affects the supervisee's mental well-being and may ultimately negatively impact the counsellor-client relationship.

Magnum et al. (2000) in the year 2000 research study point out that, supervision could be harmful or ineffective depending on the characteristics that define and distinguish harmful supervision from what can be characterized as ineffective supervision. In that particular study, the data unanimously revealed perceptions towards clinical supervision as being "lousy supervision" or conducted by untrained people and thereby lacking professionalism.

Magnum et al. (2000) went on to say that harmful supervision is characterized by unbalanced, inappropriate, inflexible and sometimes shrouded with issues of racial, ethnic or cultural intolerance, whilst ineffective supervision, could be characterized by incompetence due to being untrained, unqualified, inexperienced and therefore having issues of inability to manage boundaries, to address supervisory relationship conflict, being less empathic, using poor techniques, lacking in clarity of models of supervision, poor modelling of professional supervision and personal attributes, lacking aspects of mentorship and often behaving unethically.

The study also delineated three aspects of "lousy" supervision failure in the administrative aspect to clarify expectations, not being adequately prepared; and in the technical and cognitive component of supervisors being perceived as unqualified, unskilled, unreliable, and often giving inappropriate, vague or delayed feedback to supervisees, and thirdly lacking or impaired in the relational or affective component which then manifests through insensitiveness, avoidance attitude towards addressing conflict and relational issues as well as intrusiveness. In short, ineffective supervisors are characterized as unskilled and lacking commitment to the supervisory relationship (Borders,2006; Magnum et al.,2000). Similarly, Chircop et al. (2022) perceive harmful supervision as a situation where the clinical supervisor demonstrates behaviours that lack sensitivity, accountability and ethical consideration, as well as cases wherein Supervisors fail to create a safe and

supportive environment, showing limitations in sharing knowledge and skills or rather lacking mentorship and coaching skills, which impact the professional development of the supervisees under their supervision.

Extensive literature shows that the effectiveness of the supervision process is greatly influenced by the quality of the supervisory alliance. Suffice it to say; that supervision can be helpful, it can build, but it can also be experienced as unhelpful and potentially harmful to supervisees, to the practice and ultimately to the beneficiaries if not properly implemented (Borders,2006; Chircop et al.,2022; Deihl & Ellis,2009,2017; Ellis et al.,2014; Falender,2018). Hendriks and Cartwright (2018) argue that the traumatic consequences of harmful supervision go beyond the supervisory relationship, as such traumatic encounters affect the supervisees' self-perception, self-confidence, counselling competencies, counsellor-client working alliance, and their professional development in the long run.

The components of harmful supervision are said to be centred around the harmful treatment and negative behaviours of supervisors towards supervisees which leave them harmed in some way by such behaviour, or it can be the type of behaviour that can be perceived as having the potential to cause harm, even if the supervisee may not identify such behaviour and actions as harmful. It is common for some supervisees to fail to identify or classify the way they are treated by their supervisors as being harmful until a later stage.

In this regard, it is worth pointing out that harmful supervision may be inclusive of situations where the supervisor acts unprofessionally or inappropriately.

Harmful supervision behaviours may harm clients as well in the sense that the supervisory relationship is usually played out in the counsellor-client relationship. Harmful supervision may consist of one or more repeated incidents, in some cases it can be a continuous pattern of harmful supervisory relationships (Deihl & Ellis,2009; Ellis,2001,2017; Hendriks & Cartwright,2018). According to Ellis et al. (2014) and Ellis (2017), inadequate supervision is also harmful when it inevitably amounts to neglect of the supervisee's professional development and personal growth. It is pure negligence when supervision ignores diversity and group dynamics in a group supervision setting.

Nonetheless, harmful supervision should not be confused with a situation where a supervisee finds it difficult to process and accept fair but painful issues within the supervision feedback, or where a supervisee received honest feedback that they find difficult to accept or hear, and probably find it emotionally upsetting due to their professional limitations, inadequacies and weaknesses being fairly and honestly pointed out to them rather than compromise the quality of the service. In such situations, such feedback is deemed necessary for the supervisee's professional growth and effective future counselling process despite being hard and painful to hear (Hendriks & Cartwright,2018). For some supervisees, even in a healthy supervisory relationship, the supervision process is associated with feelings of anxiety and fear before attending the supervision session. Some supervisees experience anxiety related to just having to attend a supervision meeting whether individually, with peers or in a group setting.

Therefore, the supervision event is on its own a measure of surmountable fear, especially for those who can't function well in group settings because the idea of a large group just produces anxiety for them. Literature shows that issues of supervision-related anxiety often emanate from the supervisor-supervisee supervisory relationship, whilst in a group setting, the fear mostly emerges from a possible inability to fit into the group or feeling of not being fully accepted by the group or the supervisor.

Sometimes conflict emerges in supervision groups and when such occurs, an effective supervisor addresses the issue before it can cause harm, but some fail to process such issues when they emerge which can be damaging, and even lead to the disbanding of the group if the issues causing the conflict are left unprocessed. Such situations may negatively impact supervisees' emotional well-being (Hall et al.,2015). Consequently, as Ellis (2010, p.106) opines, the perception that supervision is all about using the right theories and techniques is just a myth because with all the right techniques and theories, if the supervisory relationship is toxic, supervision will remain either harmful, inadequate or bad; "Good supervision is about the relationship, not the specific theory or techniques used in supervision", therefore, effective supervision is about the emotional connection than agreements on tasks and goals.

Additionally, Falender (2018) posits that when supervisors do not consistently model essential components of supervision practice, including adherence to ethical standards, such behaviours equate to inadequate and harmful practices articulated by scholars such as Ammirati (2017); Beddoe (2017); Ellis (2010); Ellis et al. (2014); Ellis (2017); Falender (2018); Hendriks and Cartwright (2017); Muratori (2002) and many others. However, in some countries, the intervention is not practised at all, hence, Hall et al. (2015); World Health Organization ([WHO],2010) survey involving 147 countries established that clinical supervision was practised in only 43.5% of the countries that were surveyed, and in some countries, there was no supervision offered, whilst the least supervision was offered in Africa by only 28.8% of the countries, something that is not surprising given the fact that most African countries are within the economic classification of low-income and very few within the middle-income category. Therefore, such countries have limited "human resources to provide such regular supervision" despite it being a mandatory requirement by most counselling regulatory bodies. Falender (2018, p.1240) decries this situation and articulates it well by saying;

> Clinical supervision is acknowledged as a distinct professional competence that requires specific education and training. However, it is all too often an inadequately addressed or entirely missing ingredients in psychology curricula and clinical research, including, for example, clinical trial protocols and evidence-based treatment implementation.

It is evident that without the practice of clinical supervision, situations similar to what Milne and Reiser (2012) and Lawrence (1910) term "quacks; whereby inexperienced, unqualified, inadequately trained, ineffective supervisors provide supervision to supervisees might cause harm to end users of the counselling service. Though globally literature is replete with evidence of harmful, inadequate and ineffective supervision that lacks good practice and theoretical basis, not much can be said in the case of Botswana.

Hence, Watkins (2014) asserts that the number of supervision studies produced each year still tends to be somewhat limited and laments how that kind of "output" could potentially be restricting towards research

advancement. Alluding to the same are Hendricks and Cartwright (2018) who lament that; “Only a few international studies on the prevalence of harmful, conflictual, and negative supervision exist”.

Literature on harmful supervision and lack of implementation in some countries takes us to the state of the developmental stage of clinical supervision in Botswana. The dearth of literature in this area in the country speaks volumes to the state of research in the country. However, globally emerging literature shows a concern regarding ineffective implementation and reported occurrences of harmful supervision with specific reference to multicultural aspects such as racial, gender, ethnic or cultural discrimination, hence this next section discusses cultural implications and multiculturalism in clinical supervision.

2.9.2 Cultural Implications in Clinical Supervision

This section of the literature review focuses on multiculturalism in clinical supervision and cultural implications on the supervision process. The reason for this discussion emanates from the premise that recently, issues of multiculturalism in clinical supervision seem to have captivated researchers and attracted a significant amount of attention, importantly so because people are shaped by their cultural backgrounds, and one way or another the cultural diversity is an unavoidable factor and phenomenon that permeates even scientific interventions not to be ignored. Multiculturalism encompasses variables such as culture, gender, religion, and ethnic and racial differences; all of which cannot be ignored for effective implementation of Clinical Supervision.

2.9.2.1 Multicultural Supervision

Rowell and Benshoff (2008) opine that although race and ethnicity involve separate constructs, it is common in literature to find them used interchangeably. Some scholars define racial identity as the sense of belonging that one has of being part of a certain racial group, often such a belief is based on perceptions of a shared racial background to that specific racial group. Therefore, racial identity is simply a socially constructed concept of race by a society that has greatly influenced people’s attitudes towards other groups of people or

ethnicities. Some view racial identity as referring to a set of values, behaviours, ideals and attitudes having to do with a particular ethnic or racial group that one belongs to and from which one derives a sense of belonging.

This same sense enables individuals to perceive themselves as different from other ethnic or racial groups (Chen,2022; Dupiton,2019; Helms, 1995; Inman et al.,2014; Phinney, 1992). It's through ethnic identity, that individuals and groups distinguish themselves from others, and the same creates a sense of diversity and shared common interest by people with similar values, culture, beliefs and heritage. It is on this premise that Vinson and Neimeyer (2003) argue that it is essential for supervisors and supervisees to understand that socialized attitudes are part of one's ethnic identity, and therefore may affect cross-cultural and cross-racial counselling and supervisory relationships.

With this in mind, it is worth pointing out that multicultural competency in clinical supervision is an essential aspect of clinical supervisors' and counsellors' development, education and training (Ho,2021; Hook et al.,2016b; Inman & Kreider,2013; Inman & Ladany,2014; Phinney,1992). It is therefore essential for the supervision process and approaches to take into account supervisees' values and cultural backgrounds.

During the training of counsellors and supervisors, incorporating cultural aspects is crucial hence empirical literature indicates that supervision models have since been developed to address the issue of multiculturalism in supervision (Bernard & Goodyear,2014; Hook et al.,2016a; Inman,2006; Ladany and Inman,2008); the reason being that effective supervision has to be cognizant of the role of multicultural competencies in facilitating self-awareness, own cultural background and how it has the potential to influence the supervisory relationship and their attitudes, values, and beliefs towards their supervisees.

Similarly, the supervisor's knowledge and understanding of the supervisees' cultural background, cultural diversity and utilization of culturally appropriate supervision strategies are critical for effective intervention.

According to Hook et al. (2016a); Inman and Ladany (2014); Inman (2006) and Gonzales and Papadopoulos (2010), multicultural competence has become an emerging issue in mental health professions, hence extensive literature shows how the needs of clients from "racial and ethnic minority" groups have not

been adequately met in mental health treatment over the years due to tendencies to overlook cultural diversity, multicultural issues as well as having limited competencies to provide multicultural clinical supervision. Estrada et al. (2004) and Patel et al. (2004) define multicultural supervision as a study that focuses on developing clinical supervision models that incorporate cultural and racial differences into the intervention. To this perspective, there were studies such as that by Bhusumane (2007); Dupiton (2019); Hendrick and Cartwright (2018) and Richards (2000) that investigated counselling and the supervisory process from the racial and cross-racial perspectives as well as from the African cultural view.

Multicultural supervision has to take into account the supervision process and supervision outcomes in situations where racial, ethnic and/or cultural differences have a high probability of influencing the supervisory relationship between the supervisor and the supervisee and eventually affecting the counsellor-client relationship. According to Dupiton (2019), scholars in mental health professions have established that race and ethnicity are significant factors influencing the therapeutic alliance between therapists and clients and the same has been said for the supervisory relationship between supervisors and their supervisees.

Cohen et al. (2022) raised a concern about cross-racial issues in supervision, whilst Dupiton (2019, p.3) argues that ignoring multicultural factors in supervision has to some extent contributed to African-Americans' hesitancy towards accessing psychological support services; “the mental health field has failed to address the intersectionality of the African American woman’s experience due to adhering to traditional psychological precepts that are primarily associated with white men… a situation that has caused African-Americans to mistrust psychology and counselling”.

Borders (2006) argues that multicultural variables are critical and should be made part of the supervision discussions. At the same time, some tend to use multiculturalism in supervision only with specific reference to race whilst ignoring other aspects like culture, religion, gender and other variables, whilst some like Pope-Davis et al. (2003), Ponterrotto et al. (2002) and Toporek et al. (2004) view multicultural factors as including variables such as ethnicity, sex, religion, socio-economic status, race, disabilities and sexual orientation.

Researchers such as Estrada et al. (2004); Borders (2006); Chen (2022); Cohen et al. (2022); Hendrick and Cartwright (2018); Inman and Ladany (2008); Inman et al. (2014); Richards (2000) and many others continue to explore multicultural issues in clinical supervision to establish the influence they have on the supervision process due to reported negative implications manifesting as harmful supervision practice.

However, Watkins (2014) asserts that discussing multicultural issues in isolation often results in a one-sided view and understanding of cultural issues in supervision, and goes on to say that each person has unique and multiple cultural identities, as such the way such identities interact and informs individuals' supervision experiences is crucial not to be ignored by researchers and supervision.

The significance of the influence of cultural issues in supervision and complex issues surrounding multicultural supervision practice is the reason why multicultural supervision research has sparked a lot of debate and interest from various scholars (Chen,2022; Cohen et al.,2022; Inman & Ladany, 2008; Inman et al.,2014; Watkins,2014). It is not surprising that Borders (2006) asserts that the international journals on supervision have recently included articles on multicultural supervision. Similarly, Robinson et al. (2000) argue in favour of having supervisors with cultural awareness, multicultural competencies and a clear understanding of the influence of the same on supervisory relationships.

Additionally, Borders (2006) opines that multicultural issues in supervision have since received increased attention including publications in the Journal of Multicultural Counselling and Development, whilst Hird et al. (2001) postulate that it is important for Supervisors and Supervisees to understand the influence of multicultural factors in supervision and how cultural differences can affect the supervisory relationship.

In a study conducted in Zimbabwe, Richards (2000) identified cultural and social issues impacting the supervision process and sighted variables such as family hierarchy, spirituality, mysticism and colonial history and recommended the use of group supervision instead of individual supervision, as well as suggesting the recognition of diversity, a traditional network of helpers from different cultural backgrounds.

In Botswana, a study by Bhushumane (2007) on multicultural counselling emphasized the importance of recognizing and incorporating indigenous cultural practices and cultural structures into contemporary western-oriented approaches; as the global trends of multicultural approach to counselling and clinical supervision were becoming popular and an acceptable practice. Bhusumane (2007) convincingly argue that there is a significant consensus among the helping professions internationally, and among researchers in various settings that the western-oriented counselling approaches and other emerging human and social support interventions such as Clinical Supervision will be more holistic and impactful if cultural aspects such as traditional healing practices, cultural knowledge systems, and social structures are integrated. Garrett et al. (2001) emphasises the importance of increasing supervisors' effectiveness in discussing cultural differences, values and beliefs with their supervisees early on at the beginning of their supervision relationship because proactively addressing cultural differences from the onset of the supervision will be instrumental towards having an effective supervisory process.

Estrada et al. (2004) also argue in favour of discussing cultural issues in supervision at the beginning of the supervision relationship focusing specifically on issues of race and ethnicity. According to Estrada et al. (2004), supervisors who resist addressing race and ethnicity in their work with their supervisees even when there are obvious racial and ethnic differences among them, risk having complications later on in the supervision relationship.

Astrada et al. (2004, p.312) further argue that; the result of avoiding discussions on cultural and racial issues in supervision often ends up with ineffective or harmful supervision. Moreover, the supervisees' failure to challenge clients' cultural practices even when these practices limit the client's psychological growth can be "classified as harm, and often happens due to a misguided notion that to challenge a client's values is tantamount to imposing one's values on the client".

Robinson et al. (2000) argue that clinical supervisors must have cultural awareness and understand its influence on the supervision process. Furthermore, cultural concepts need to be integrated into clinical supervision and theoretical-oriented approaches.

Basing her argument on a Zimbabwe-based study, Richards (2000) points out that discussing cultural factors such as spirituality, mysticism, family hierarchy and colonial history in supervision is crucial as it has the potential to impact the supervision relationship. Similarly, Bishop et al. (2003) emphasise the significance of a supervisor's competency in effectively facilitating supervisees' professional development to adequately address issues of culture in their counselling process. According to Estrada et al. (2004); Hays and Chang (2003); Patel et al. (2004) and Patel (2012), Cultural issues emerge even in matched dyads; for example, in White-White dyads and not just in what could be considered mismatched dyads such as White-Black and Black-White supervision. Given this, Gatmon et al. (2001, p.110) argue that the issue of cultural compatibility is of very little significance compared to "the presence and quality of the discussion of the differences and similarities" because Supervisees have reported greater benefits and self-awareness when cultural issues are discussed unlike when such are ignored.

Literature also reported supervisees' perceptions of a good working supervisory alliance and better rapport building with their supervisors when there is cultural transparency and open discussions on their cultural differences which lead to higher satisfaction from the supervisory relationship (Gatmon et al., 2001; Toporek et al.,2004).

There is enough empirical evidence supporting the view that Supervisees are comfortable discussing multicultural issues related to their supervision interactions, hence a couple of writers have suggested various strategies that could effectively be deployed to empower supervisors and supervisees to address cultural issues (Hays & Chang, 2003; Hird et al., 2001; Toporek et al., 2004).

Given these arguments, it is clear that Multicultural supervision and counselling competence have since become an integral part of counsellor education, and considered part of counsellors' professional development by regulating bodies in various countries; such as the American Counselling Association, American Psychological Association and the Australian Counselling Association (American Counselling Association [ACA], 2014; American Psychological Association [APA],2014; Borders,2006; Borders & Brown,2005; Ponterrotto et al., 2001; Rowell & Benshoff,2008).

The call for multicultural supervision by various mental health regulatory bodies, accreditation bodies and literature from the helping professions has resulted in the formulation of guiding principles, multicultural frameworks, ethical protocols and standards for multicultural supervision, counselling and training. The reasoning is that having supervisors who are competent in multicultural approaches will facilitate the development of multicultural counselling as supervisees become more conscious of their values, beliefs, biases, own assumptions, and cultural diversity and deploy relevant strategies in therapy (Chen,2022; Collins & Pieterse,2007; Rowell & Benshoff,2008; Torres-Rivera et al.,2001). Similarly, Anton (2022) argues that in today's era of working with clients of diverse cultural backgrounds, coupled with the complexities surrounding population diversity, multicultural competence in supervision and counselling is highly crucial if the needs of clients are to be adequately met.

Ignoring multicultural issues and cultural variables; such as gender, race, sexual orientation, country of origin and ethnic diversity in clinical supervision places some supervisees at a disadvantage, and makes them feel marginalization because cultural identity and cultural values influence behavioural interactions and cultural groupings (Anton,2022; Chen,2022; Cohen et al.,2022; Ho,2021; Madhurima & Purnima, 2022). Ho (2021) goes on to say that factors such as culture, gender, sexual orientation, ethnicity and race, have a significant influence on the clinical supervision process and on the outcome of the intervention not to be ignored.

Additionally, there has been a plethora of research exploring the multicultural issues in supervision, literature indicates that the way some supervisors address cultural factors affects the satisfaction derived from the intervention and the working alliance which ultimately affects the effectiveness of the supervision process Robinson et al. (2000) and Schroeder et al. (2009) opine that the issue of multicultural supervision has to do with cross-cultural and cross-racial aspects, though often these concepts are used interchangeably in literature; despite that cross-cultural and cross-racial refers to situations whereby supervisors and supervisees either come from the different cultural or racial background but having to work together in a supervisory relationship.

Therefore, if the differences are not addressed from the onset, conflict and misunderstandings may emerge in the supervision relationship and may impact the efficacy of the supervision process.

According to Bhusumane (2007) and Muchado (2018), Counsellors' inability to understand and acknowledge cultural diversity, cultural beliefs, values, religious background; multicultural issues and social expectations may lead to cultural conflict in counselling, and the same can be said for clinical supervision that disregards multicultural aspects in the supervisory process between supervisors and the supervisees. As Fish (2004, p.78) eloquently puts it; 'the result from culturally specific beliefs and expectancies of the participants, as well as from the emotional persuasiveness of the experience, which is also culturally specific" is a positive impact to those receiving the intervention. Therefore, the supervisor's understanding of the supervisees' cultural background and the ability to offer multicultural clinical supervision may reduce the possibility of conflict in supervision.

Despite some scholars' efforts to avoid acknowledging and accepting that multiculturism is an issue to be addressed in supervision, there is a need for supervisees to be empowered to know how to address it in their therapy room because it is a phenomenon that every effective supervisor has to address with their supervisees, and help them develop competencies to successfully engage with it because as Estrada et al. (2004) assert, several experts in the field of multicultural counselling and supervision have reported issues of race and ethnicity as having the potential to trigger anxieties when brought up and justifications conjured up to avoid the discussion; which is tantamount to sitting with a huge elephant in the room. Therefore, failure to empower supervisees to have the competencies to explore cultural and ethnic differences has possible implications for the efficacy of the intervention and could have psychologically limiting effects on supervisees and their clients. Multiculturalism has variables and cultural elements that may influence clinical supervision.

Though most issues of multicultural supervision emanant from race, sex and religion, Fuertes (2004) investigated issues of bilingual in counselling supervision between supervisors and supervisees and counsellors-client language preferences, as well as the dynamics related to mixing languages and switching languages, using multiple languages and language-based conceptualization of wellness, illness and mental

health, because often due to linguistic differences, some constructs may have different meanings from others. Therefore, being cognizant of issues of language, acculturation, the need for flexibility in theory and techniques in supervision for adequate support of clients' needs is crucial, but sometimes due to language barriers, clients' needs may not be adequately met (Borders, 2006; Ho,2021). Borders (2006) and Fuertes (2004) went on to argue that the issue of language plays a significant role in clinical supervision because supervisors, supervisees and clients may have different language preferences, and that may become a barrier to communication, therefore, Language may affect the effectiveness of the supervision process.

Hays and Chang (2003) talk of the importance of addressing "White privilege", oppression and racial identity within supervision, and argue that acknowledging the diversity that is apparent in client populations is critical because; the majority of counsellors are white and therefore the need to address "White privilege" within supervision is essential. Hays and Chang (2003) go on to say that there are several approaches that supervisors could deploy to introduce a discussion on White privilege in supervision to create awareness.

Supervisors need to have authentic and open discussions with their supervisees on their white heritage, the perceived inherent privileges and its influence on their supervision relationships and group dynamics (Brown,2009; Cook,1994; Cook & Helms,1988; Hays & Chang,2003). Supervisors and Supervisees' failure to openly and freely discuss multicultural issues in supervision has the potential to adversely affect the supervision process. Such conversations should begin early in supervision because not talking about their cultural identity and how they genuinely feel about their client's race, religious beliefs, ethnic background and cultural differences may affect the supervisory process because self-disclosures are critical to creating multicultural awareness and common understanding (Borders,2006; Borders & Brown,2005; Cook & Helms,1988; Cook,1994).

On the other hand, Hendriks and Cartwright (2018) in their study found that there were reported 'harmful' experiences among White supervisees who received supervision from Black supervisors in South Africa, this was synonymous with other existing research conducted among mixed-race and culture dyads.

Hendriks and Cartwright (2018) opine that such a situation may be due to ‘unintentional oppressive practices’ by Black supervisors towards White supervisees due to the historical background of apartheid and previous oppression of black people by the Whites in South Africa.

South Africa’s apartheid legacy and consequently racial tensions make issues of cross-cultural and cross-racial factors more important to address in the supervision relationship rather than ignore, especially because there has been reported a higher prevalence of harmful supervision among mixed-race and culture dyads internationally indicating the negative influence of neglecting race and cultural issues in supervision, ultimately leading to the intervention being classified as harmful (Hendriks & Cartwright,2018). The literature revealed incidents of Supervisors having to address multicultural issues or seeking to understand their supervisees’ cultural background in efforts to acknowledge cultural diversity in clinical supervision, as well as Supervisees who appear to have discomfort with cultural background self-disclosure to their supervisors or those comfortable disclosing; in which case immense satisfaction is derived from the supervision process (Borders,2006).

Literature shows that supervisors who lack multicultural supervision competencies find it challenging to address cultural and ethical issues in supervision, yet racial and gender biases in supervision have emerged as significant issues that are affecting the supervisory relationship (Anton,2022; Inman & Ladany,2006; Thielson & Leahy, 2001; Wheeler & King, 2000). Moreover, limited understanding and lack of awareness of racial and cultural issues such as racism and discrimination have been reported to harm the supervisory process; especially where supervisors can’t even acknowledge their biases and their racist tendencies (Brown,2009; Chen,2022; Cook,1994; Dupiton,2019; Patel,2012; Patel et al.,2004; Tummala-Narra, 2004; Walker et al.,2007).

According to Bernard and Goodyear (2014), there are documented incidents of racial and cultural stereotypes and biases that have negatively impacted the supervisory process. Suffice it to say; that where cultural competence is concerned, supervisors need to be aware of their values, prejudices, and biases, as well as their ability to acknowledge existing cultural and racial differences between them and their supervisees (Chen,2022; Hendrick & Cartwright,2018; Schroeder et al., 2009).

Borders (2006) and Estrada et al. (2004) emphasize the significance of discussing cultural issues in supervision, especially race and ethnicity during the initial supervision session. Estrada et al. (2004) argue that supervisors who resist addressing race and ethnicity in their work with supervisees risk having ineffective or harmful supervision shrouded with conflict, especially where racial and ethnic differences exist between them and their supervisees or within a group supervision setting.

To enhance cross-cultural supervision, Estrada et al. (2004) propose using cultural and racial identity assessments to help identify the supervisor and supervisee's culturally-based beliefs and assumptions, and in turn, the results of the assessment could be used in the initial supervision session discussion. This is because according to Bernard and Goodyear (2014) and Hendriks and Cartwright (2018), historically "Blacks" have been marginalized and oppressed, which resulted in negative perceptions and feelings of inferiority, vulnerability and disadvantages leading to low levels of assertiveness which then possibly led to an inability to adequately assert themselves or to comfortably self-disclose in a cross-racial supervision setting.

Often unconscious racial cultural stereotypes and microaggressions occur in supervisory relationships where certain interactions may seem derogatory or appear to be "subtle insults" towards people of colour (Anton, 2022; Brown, 2009; Chen, 2022; Cohen et al.,2022; Dupito,2019; Ho,2021; Hook et al.,2016b).

Hook et al. (2016b) argue that racial microaggression cannot be ignored as it encompasses constructs of racism, white racial privileges and oppression, therefore the importance of teaching and modelling cultural humility in clinical supervision cannot be ignored. Similarly, the issue of racial differences has also been reported in the literature as one of the factors negatively impacting clinical supervision. Hays and Chang (2003) postulate that racial identity, oppression, marginalization and White privilege within supervision have to be acknowledged and addressed rather than ignored. Hays and Chang (2003) go on to say that; there could be deliberate efforts to facilitate open discussions on values and on how White or Black heritage has somewhat influenced one's supervision and counselling relationships with counsellors one works with, The issue of gender has also become one of the factors implicated in problematic supervisory relationships (Paisley, 1994; Walker et al., 2007); gender disparity in supervision cannot be ignored.

There is no doubt that awareness of the role played by culture, gender, and race in supervision is growing and has since become an issue of critical discussion in clinical supervision literature (Schroeder et al., 2009). Literature also reveals that if the issue of diversity and cultural factors are ignored in supervision there is bound to be conflict in the supervision relationship (Cook, 2017; Cook,1994; Cook & Helms, 1988,1995; Hook et al.,2016a; Hook et al.,2016b).

Hendriks and Cartwright (2018) opine that gender bias has the potential to affect the supervisory relationship. Similarly, lack of gender sensitivity, racism and cultural awareness may result in supervisors ignoring their own gender biases, racism and other cultural stereotypes that may adversely impact the supervision process. Bernard and Goodyear (2014); Cook (1994); Schroeder et al. (2009) and Walker et al. (2007) postulate that it is important for supervisors to not only have a cultural understanding and multicultural supervision competencies but to be aware of their values, prejudices, biases and how that can impact their engagement with supervisees hence the significance of self-awareness in clinical supervision. On the other hand, Bishop et al. (2003) and Borders (2006) highlight the importance of infusing spirituality into the supervision process because spirituality is yet another aspect of client diversity that deserves attention.

Borders (2006) purports that supervisors' understanding of supervisees' spiritual and religious beliefs, their relevance to clients' presenting issues and how such belief systems may shape the supervision process is essential because it may play out in the counselling process; for example, knowing whether their clients' religion is a source of strength or guilt, how religious traditions influence their construct and their perceptions of God as well as how their religious institutions or inherent oppressive religious beliefs may influence their supervision experience is important. However, Frame (2001) posits that those who have challenges discussing religious and spiritual issues with their supervisees could "use spiritual genogram with supervisees and clients", Frame (2001) goes on to say that multigenerational patterns and themes are easily revealed through examination of the genogram which helps to provide self-awareness for supervisees to address issues that may affect their work with clients in situations of transference and countertransference.

In the case of Botswana being a multicultural society with diverse ethnic groupings with differing customs and cultural practices, multicultural competencies in supervision and counselling cannot be ignored. Hence, Bhusumane (2007) and Maes (1995) argue that Guidance and Counselling in Botswana have to incorporate the best of the indigenous cultural practices and strategies to address psychosocial challenges faced by clients in various social settings. Maes (1995, p.19) goes on to recommend that Batswana must; "shape programs in a way that is sensitive and complementary of cultural values and practices."

Bhusumane (2007) opine that it is not surprising in Botswana to find a client seeking help from several traditional sources in attempts to address a psychosocial challenge before considering psychotherapy. It is common for clients to seek help from extended family members, spiritual healers, indigenous healers or church leaders before visiting a counsellor, and sometimes they may choose to combine multiple services with contemporary counselling. This eclectic approach to psychosocial support intervention is rooted in Tswana beliefs and cultural practices. Therefore, Supervisors' awareness of such beliefs, indigenous interventions, and other multiple cultural responses to psychosocial challenges by supervisees and their clients is essential. It is also important for Supervisors to understand how such beliefs could impact their supervisory relationship and the therapeutic process between supervisees and their clients. However, failure to process issues within the context of the supervisee and client's culture may have negative implications on the efficacy of the intervention, on the supervisee and the client's response to the intervention (Bhusumane,2007; Chen,2022; Cohen et al,2022; Dupiton,2019; Ho,2021).

Bhusumane (2007) postulates that "Counsellors cannot ignore the relationship between mental healing and religion in Botswana"; thus, inferring that to understand the correlation between healing and Western-oriented counselling approaches there has to be recognition of the role played by religious beliefs and spirituality in Batswana's day to day lives. Sharing the same view is Muchado (2002) who purports that the community counselling model used in Botswana draws from the traditional counselling paradigm which is underpinned by the African cultural counselling perspective which is grounded on the principle of "Ubuntu", and from the premise that "it takes a village to raise a child or help an individual".

Summary and Critical Analysis

The critical analysis of the literature reviewed is that there is enough evidence to suggest that clinical supervision is an essential intervention in counselling, the literature confirms the dearth of local literature on the phenomenon, and the practice and implementation of CS as a planned behaviour could be influenced by knowledge and competencies, attitudes and practices. The conclusion reached is that there is adequate literature supporting the importance of CS as an evidence-based intervention anchored on scientific research underpinned on theoretical principles, models and theoretical framework, however, literature also indicated that there is not much research in Botswana regarding the state of CS.

Therefore, based on literature, the hypothesis made is that there is no CS practice in the country, and the situation could be due to negative attitudes, and limited knowledge resulting in ineffective CS practices leading to questionable standards of counselling services offered in the country.

This review of literature provided an overview of Clinical Supervision focusing on critical aspects to create a background to the study. The chapter gave a theoretical framework by discussing the theories underpinning the study, description of the industry field, definitions of key concepts, historical background of Clinical Supervision and counselling in Botswana, models of clinical supervision, types of supervision, the benefits of clinical supervision with special attention to reported harmful side of clinical supervision as well as cultural implications and the need for multicultural clinical supervision.

Each section reviewed available empirical contributions made in the field of clinical supervision by various authors from various data sources and this literature review noted differences, similarities, debates and controversies surrounding Clinical Supervision. The understanding of each section helped to shed light on what clinical supervision involves, what counsellors stand to benefit; what can be expected from Clinical Supervisors and what research gaps exist to be addressed by this study.

The next chapter discusses the research method for this study looking at the population sample, sampling procedures, data collection strategies; instruments and data analysis strategies.

CHAPTER 3: RESEARCH METHODS AND DATA COLLECTION

Chapter Introduction

The problem being addressed by these mixed methods (quantitative and qualitative) research is the knowledge, attitudes and practices of clinical supervision among counsellors in Botswana. Contemporary counselling is a fairly new phenomenon introduced in the early 80s as Career Guidance to prepare young people for the world of work. However, due to emerging and complex psychosocial issues in schools, the Ministry of Basic Education (MOBE) introduced a holistic Guidance and Counselling programme in 1996 where inexperienced teachers were appointed to the position of Guidance and counselling teachers and expected to provide school counselling (Ministry of Education,1996; Muchado,2002; Muchado,2018; Mutanyatta,1993; Navin,1985; Onyewadume,2008; Shumba, et al.,2011). Social issues did not only impact schools, communities were equally overwhelmed as grandparents became instant caregivers whilst battling grief and the loss of their adult children who left infants, toddlers and teenagers as orphans due to the HIV and AIDS epidemic.

Child-headed households struggled with not only economic issues but also with stigma and trauma. Counselling Centres were established in communities by people with little or no qualifications or skills in counselling to provide psychosocial support services. With the mushrooming of counselling centres throughout the country and the complex psychosocial issues addressed by counsellors, there was a need for clinical supervision. The clinical supervision process ensures professionalism, efficiency, and clients' safety and prevents malpractice. Msimanga and Moeti (2018) and Wheeler and Richards (2007) assert that supervision is caregiving clinical support to help counsellors gain confidence and address ethical dilemmas.

Literature shows that internationally CS is well structured, regulated and mandatory to ensure client safety and professionalism, however, Botswana is lagging. Msimanga and Moeti (2018, p.51) decry the absence of a budget to support supervision as an impediment to enhancing effective and adequate supervision…. and further argue that; "there is an extremely limited budget, if any laid aside to support supervision endeavours. Funds are needed to support clinical supervision as needs emerge."

Msimanga and Moeti (2018) further state that; “There are no accreditation and licensing authorities in Botswana”. Similarly, Watkins (2014, p.252) opined that; “At the recent International Interdisciplinary Conference on Clinical Supervision that international flavour was also nicely displayed, with attention being given to supervision in Botswana, Bulgaria, Cyprus, Denmark, Germany, Greece…...”. Muchado (2018, p.743) concurs in stating that; “The counselling profession in Botswana is at infant stage, there are no regulatory standards of practices, nor national licensure bodies and accredited training programs. The mental health services in the country lack cohesive structures…”. The fact that most people offering counselling in the country lack formal training shows how critical clinical supervision is in Botswana, as Watkins (2014, p.251) asserts; “Where there is psychological treatment, there is need for psychological treatment supervision”; hence many regulating bodies across the world articulate the guiding principles of counselling supervision. Wosket (2017) states that; “Supervision and accreditation are the ways we appear to have chosen to regulate counselling and raise it to the status of a profession”.

Despite the global trends, Botswana still has very little empirical evidence to support the existence of clinical supervision, the phenomenon has not yet been empirically established. There seems to be no coordination of counselling services in the country hence Muchado (2018) states that the services offered are haphazard, and Msimanga and Moeti (2018) argue that, there is a lack of a fully functional regulating body, lack of accreditation, well-structured guiding principles, and thus imply ineffective practices; therefore, there is a concern regarding CS in Botswana.

Purpose of this study was to investigate the knowledge, attitudes and practices of clinical supervision among counsellors since counselling is a fairly new phenomenon in Botswana. The aim was to determine the level of clinical supervision access, assess counsellors’ knowledge of clinical supervision, examine counsellors’ attitudes, determine the clinical supervision practice, investigate ethical principles that guide clinical supervision practice of counsellors and examine possible strategies towards improving the clinical supervision practice.

The next section discusses the research methods and design used.

3.1 Research Design and Approach

This section discussed the research approach, and research design adopted to facilitate the data collection and analysis in this mixed-method research. The section started by describing Mixed Methods and their benefits before discussing the selected Mixed Methods research design, and a few other designs which are part of the Mixed Methods research approach but were however not adopted for use in the study, justification for the decision made was also given.

3.1.1 Mixed Methods Research Approach

Mixed-methods research approach was used in this study by engaging two types of research methods; Quantitative and Qualitative methods for data collection and analysis. Though the Mixed Methods research approach has a variety of basic and advanced research designs, due to the project timeframe, basic Explanatory Sequential Design was preferred over the other mixed methods research designs such as Convergent and Exploratory Sequential research design. The mixed methods research approach preference for collection and analysis of data was based on the attributes to provide validation, corroboration, augmentation and triangulation of data to help gain better insight into the research problem.

The two methods mixed in this process helped to complement each other in giving insight and a better understanding of the perceptions of practising counsellors in Botswana towards clinical supervision in the Counselling profession (Chumney,2015; Creswell,2022,2013, 2007; Creswell et al., 2003; Estes et al.,2017).

The literature review established that counselling is a new phenomenon in Botswana practised in different environmental settings in the community from governmental to non-governmental organizations, for example; in the Ministry of Basic Education (Schools), other ministries and departments such as the Ministry of Health and Wellness, the Ministry of Home Affairs, the Ministry of Local Government, the Ministry of Defence and Security and so on, not forgetting the Private Practitioners and privately owned schools.

Therefore, to establish the knowledge, attitudes and practices of clinical supervision among counsellors in Botswana, it was essential to mix research methods to understand the issue from different perspectives and

paradigms; numerically (quantitatively), whilst also hearing the stories (qualitatively) from the counsellors' personal experiences regarding their knowledge, access, attitudes, their practices, guiding ethical principles as well as what strategies could improve clinical supervision.

Mixed Methods research was considered suitable to facilitate data triangulation and added strength to the process. The two methods mixed in this way were able to make up for each other's inherent weaknesses; relying only on one method was deemed inadequate to fully explore the problem; it would have been limiting to address certain aspects that needed the use of numbers and vice-versa. Similarly, the use of numbers alone would have been constraining towards probing and hearing the lived narrative experiences and stories of research participants (Caracelli & Greene,1993; Chumney,2015; Creswell,2022,2015,2013; Creswell et al.,2011; Creswell & Plano Clark,2007; Estes et al.,2017).

Mixed methods research facilitated the mixing of both quantitative and qualitative methods for data collection and analysis in a single study (Chumney,2015; Creswell et al.,2003; Estes et al.,2017; Hanson et al.,2005). Schoonenboom and Johnson (2017) define Mixed methods research as "the type of research in which a researcher or team of researchers combine elements of qualitative and quantitative research approaches". Mixed methods are both a methodology and a method that involves the process of collecting, analyzing, and mixing qualitative and quantitative approaches in a single study (Creswell et al.,2006; Guetterman et al.,2015).

The approach was also intended to help expand and strengthen research conclusions; as Creswell and Plano Clark (2017) state; "integration of quantitative and qualitative data maximizes the strengths and minimizes the weaknesses of each type of data". The main reason for the adoption of this approach for this study was to enable the researcher to have a complete understanding of the research problem being investigated from different lenses by obtaining data from different perspectives.

The reasons for utilising Mixed methods in this study were based on Schoonenboom and Jonson (2017) and Creswell and Plano Clark's (2017) argument that mixing methods allow triangulation, complementarity, initiation, development and expansion, all of which were considered essential for corroborating results of the

study, as well as enhancing the understanding of the meanings that participants gave to the phenomenon both deductively (QUAN) and inductively (QUAN) and thereby facilitated elaboration, enhancement and the ability to identify contradictions whilst at the same time providing the breadth and range of the research inquiry. All these attributes helped to give credibility to the research findings (Creswell & Plano Clark, 2017; Guetterman,2020). Mixing methods allowed for the use of qualitative (Open-ended data collection) through individual interviews, follow-up interactions and further probing between the researcher and the participants, and that created qualitative interactive flexibility (Walsh-Rock,2018).

The quantitative method through the use of questionnaires was considered appropriate to make it possible to quantify the data to establish the magnitude of the problem; whether significant or insignificant. Using the qualitative method alone was considered at first, as the method appeared to be a common practice in most of the social sciences and educational research studies The nature of the research topic, research questions and the purpose of the study necessitated the use of mixed methods.

In the mixed methods approach, both quantitative and qualitative methods are used; the two methods are mixed and, in this case, sequentially utilised.

The assumption here was that combining the two methods provided more insight, better understanding and a clearer picture of the problem being investigated as opposed to using only one method (Creswell et al.,2015,2006; Creswell et al.,2003; Estes et al.,2017). Using mixed methods was deemed beneficial as the two methods are stronger together in the sense that they compensate for each other's weaknesses, there are strengths derived from the two types of data collected (quantitative and qualitative), and the methods and the data collected are supportive of each's limitations and the approach helped to give an alternative perspective to the study than relying only on data collected from a single source.

Together they provided a complete and clearer picture of the problem being researched. The two data sets allowed for the expansion and elaboration of the phenomenon, and created the ability to supplement and explain quantitative data with qualitative data to give sound research findings and understanding of the problem as data

triangulation was enabled (Creswell & Plano Clark,2017,2007; Creswell et al.,2006; Fetters & Freshwater,2015; Guetterman,2020; Hanson et al.,2005).

The study adopted an Explanatory Sequential design to aid in the collection and analysis of data; quantitative and qualitative methods were deployed sequentially; one after the other. The assumptions around combining quantitative and qualitative methods were that mixing methods provides a strength that is not possible when using a single method or applied concurrently (Aarons et al.,2012; Bryman, 2006; Creswell,2013).

3.1.2 Research Design

This study used the explanatory sequential research design consistent with Creswell and Plano Clark (2017,2007); Creswell et al. (2015); and Creswell (2013). There are three types of sequential designs: sequential explanatory, sequential exploratory, and sequential transformative. Questionnaires were developed and pre-piloted among a few sampled people before the actual data collection phase. Through structured questionnaires quantitative data was collected, whilst semi-structured interviews were adopted for gathering qualitative data.

The use of mixed methods can involve a variety of research designs for data collection and analysis; such as the Convergent design that allows for simultaneous collection and analysis of data, which is later merged, connected or embedded within the other to play a supportive role to each other (Aarons et al.,2012)**,** the decision was made to collect and analyse data sequentially**;** one after the other using quantitative followed by qualitative in an Explanatory Sequential design, as the design was deemed more appropriate**.**

The other option that was considered was to use the Exploratory Sequential design; to start by exploring the issue through interviews (qualitatively) followed by questionnaires, but due to the time factor it was less preferred and the study adopted the Explanatory Sequential design rather than the Exploratory sequential design. Generally, using mixed methods is time-consuming due to the rigorous processes involved in planning, collection and analysis of two datasets and then merging the data.

It was also on this view that the Convergent design was deemed to be more time-consuming compared to the explanatory design due to the possibility of an offset for yet additional data collection, and the complexities inherent in the processes of identifying discrepancies and effectively connecting data sets (Estes et al.,2017; Guetterman et al.,2015). A Mixed-methods Explanatory sequential design adopted herein meant that the quantitative phase had to be followed by a qualitative phase to validate and explain the findings from the quantitative perspective. The hope was to improve the final interpretation and inferences of the study (Chumney,2015; Creswell,2022; Creswell et al.,2011; Estes et al.,2017).

Quantitative data were collected and analyzed first followed by qualitative data. Priority was given to the quantitative data whilst qualitative data primarily augmented and explained the quantitative data. Data analysis was connected and integration was done at the data interpretation stage and in the results discussion phase (Crewell,2013).

3.1.3 Explanatory Sequential Design

The Explanatory sequential design involved quantitative data collection and analysis followed by qualitative methods; the two methods combined but utilised sequentially to help augment each other. In this design quantitative (QUAN) was given priority followed by qualitative (QUAL) data; QUAN - qual (Creswell,2022,2013).

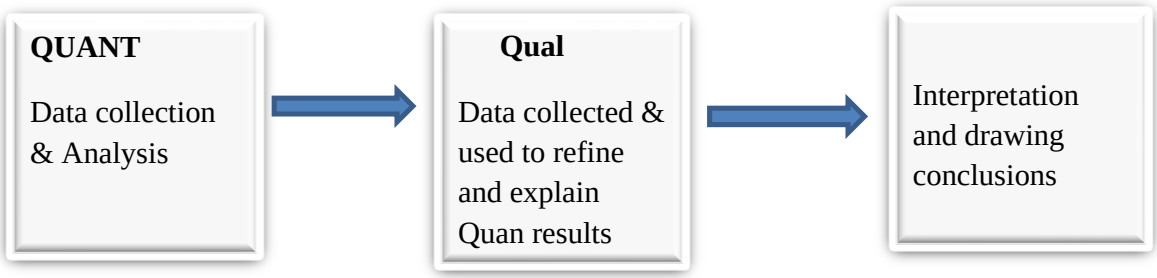
This design is often referred to as a “two-phased model” because it is usually carried out in two phases; the study started by collecting quantitative data through structured questionnaires and analysing it, followed by the second phase of collecting qualitative data through semi-structured interviews.

Qualitative in this case was intended to explain quantitative data. Quantitative data was collected first and qualitative data was used to refine, understand and help explain the quantitative data, therefore quantitative data collection and analysis, in this case, were given higher priority whilst the qualitative data simply played the supportive explanatory function (Aarons et al.,2012; Chumney, 2015; Creswell, 2022; Estes et al.,2017; Hanson et al.,2005). The Questionnaire instrument was pre-piloted before the actual administration.

Quantitative data was collected through questionnaires first, analysed then qualitative data was collected through interviews as a follow-up with a few sampled populations of supervisors who had not participated in the questionnaires to help establish corroboration, convergence and divergence.

Figure 6

Showing a Diagram of Explanatory Sequential Design



Adopted from Guetterman et al. (2015, p.152)

Using responses from the questionnaires through the Likert scales provided, data could be easily quantified such as (5. Strongly agree, 4. Agree, 3. somewhat agree/neutral, 2. Disagree, 1. Strongly disagree). A few participants (counsellors and supervisors) were engaged in semi-structured interviews to share their personal experiences to help make sense of the quantifiable results to reach conclusions.

Other research designs were considered but were deemed unsuitable due to a variety of issues, more specifically due to the rigorous processes involved that conflicted with the time factor. Such designs included the Exploratory Sequential design, Concurrent triangulation design or Convergent design, and Sequential Transformative design.

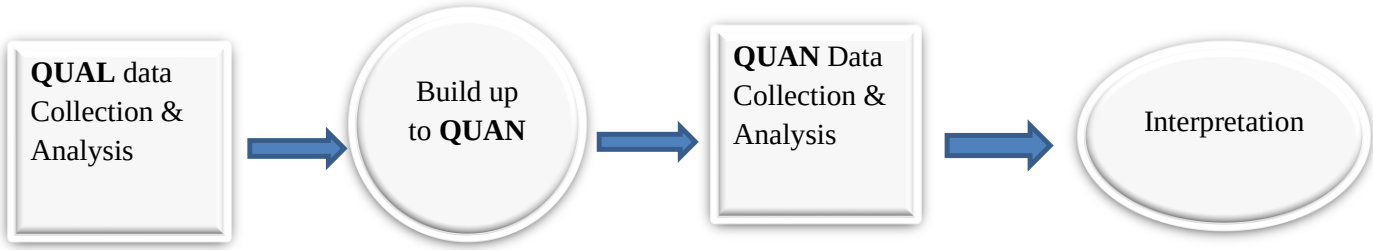
However, only Exploratory and Convergent designs are briefly discussed in this study as they were considered the highest possibility to use.

3.1.4 Exploratory Sequential Design

The Exploratory Sequential design is the opposite of the Explanatory Sequential design in the sense that instead of starting with quantitative data collection and analysis, one starts by exploring and analysing qualitative data first which is collected either through interviews or focus group discussions, then the findings are used as a build-up to develop a questionnaire for a larger population sample for collection of quantitative data. In this case, Priority is given to the qualitative data whilst quantitative data are used primarily to augment qualitative data (QUAL - quan). Data analysis is connected, and integration occurs at the data interpretation stage and in the discussion of the findings. This design is useful for exploring relationships when variables of the study are not known, when refining or testing an emerging theory or when developing new psychological assessment instruments. Since this study does not test any theory nor intended to develop a psychological assessment instrument and the variables of the study are known, this design was deemed unsuitable. Moreover, due to possible complexities that may lead to an offset and time factor, this design was not supported (Chumney,2015; Creswell & Plano Clark,2017; Creswell,2013)

Figure 7

Showing a Diagram of Exploratory Sequential Design



Adopted from Guetterman et al. (2015, p.152)

3.1.5 Convergent Design

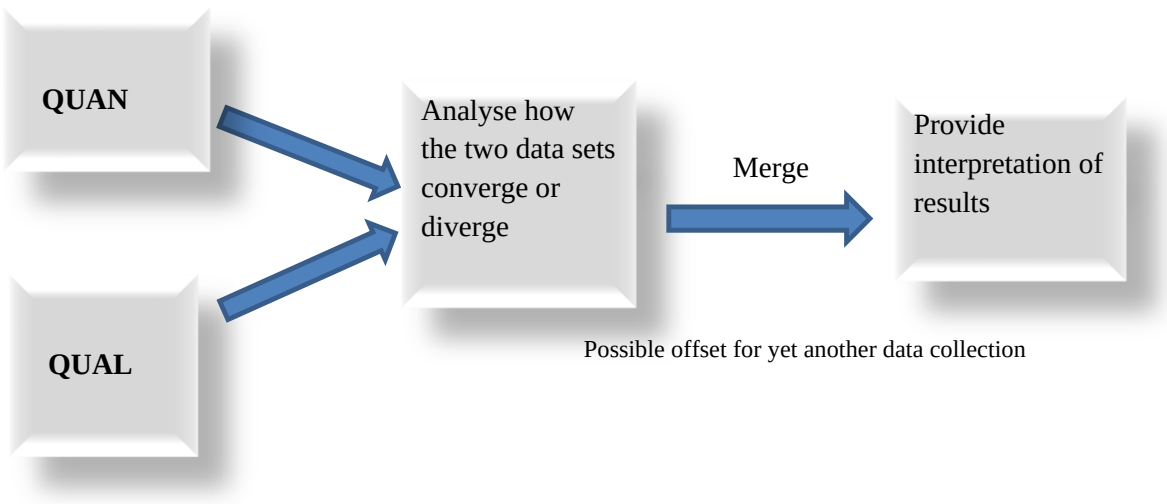
This design utilises a simultaneous collection of data; both the qualitative and quantitative data are collected at the same time but separately and then the two data sets are merged, it involves comparing the two data sets, data are analysed separately and discrepancies are identified between the two data sets, data merging results are carried out then research conclusions are reached. The strengths of this design are that; the weaknesses of either method are complemented by the strengths of the other; they create checks and balances on each other's limitations whilst at the same time combining each of their good attributes for better research outcomes.

There appear to be more strengths than weaknesses as qualitative data (open-ended data) and quantitative data (closed-ended data) are used to cross-check each other; for example, quantitative data from questionnaires is cross-checked with the data from interviews. Using two methods is considered better than relying only on one method of data collection and analysis. In this case, the two methods which are mixed are each given equal priority and none is more highly regarded than the other.

When mixed method research is used in this particular design it allows for the two methods to complement, offset and further explain one another and the process runs parallel (Chumney,2015; Creswell,2022,2013; Creswell et al.,2003; Guetterman,2020). The only challenges are that the results may indicate convergence or divergence of the data findings, and often there are difficulties in determining the source of the discrepancies in the data. Similarly, it can also be difficult to merge the two, analyse and reach clear research findings which may then offset the need for further data collection in the form of focus group discussions or further interviews with a few participants, which will even be more time consuming, especially for novice researchers. It was based on these inherent challenges, the researcher's competencies and time factor that this design was not preferred for this study.

Figure 8

Showing a Diagram of Convergent Design



Adopted from Guetterman et al. (2015, p.152)

3.1.6 Theoretical and Philosophical Paradigm

The methodology adopted for this research study is anchored on social constructivist theories and primarily underpinned by the Theory of Reasoned Action (Ajzen & Fishbein, 1975) and the Theory of Planned Behaviour (Ajzen & Fishbein,1985). The study also draws from two distinct paradigms; the quantitative component of the research which views the study from the positivist perspective that perceives patterns of behaviour in terms of quantifiable numbers, and the ability to observe and explain the study from the objective and detached causal laws of objectivity in science (Fossey et al.,2002).

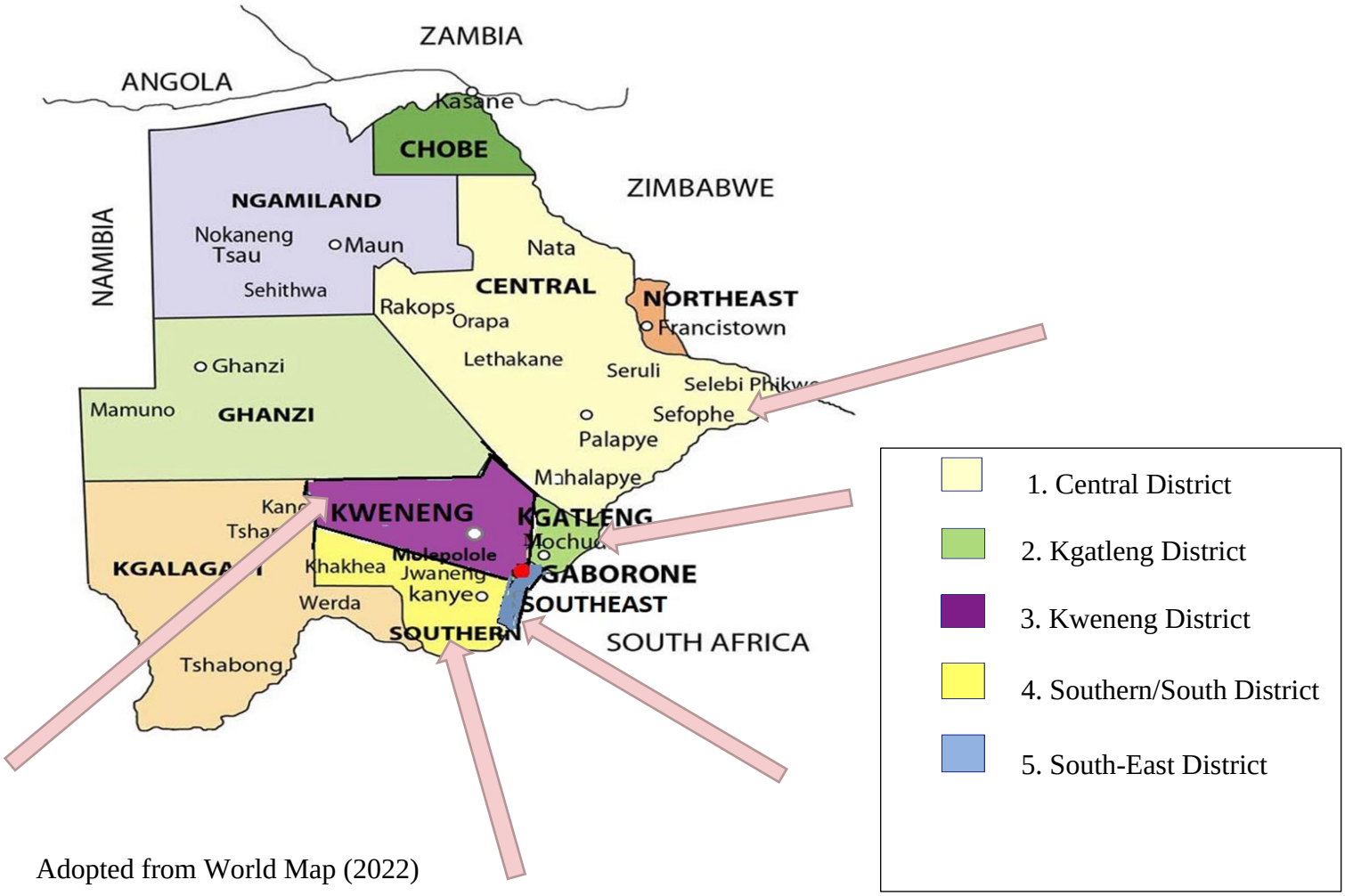
The second phase of the study viewed the study from the qualitative lens of adopting an interpretive stance of data derived from participants' subjective experiences and stories and not from the researcher's philosophical worldview (Aarons et al.,2012; Brady & O'Regan, 2009; Morgan,1998).

3.2 Population and Sample of the Study

Participants were drawn from the following 5 districts out of the 10 districts of Botswana:

Figure 9

The Map of Botswana Showing Selected Districts



Adopted from World Map (2022)

The purpose of this mixed methods research was to explore the knowledge, attitudes and practices of clinical supervision among counsellors in Botswana.

Since counselling is a fairly new phenomenon in the country, the study aimed to determine the level of clinical supervision access, assess counsellors' knowledge of clinical supervision, examine counsellors' attitudes towards clinical supervision, determine the clinical supervision practice, investigate ethical principles

that guided clinical supervision of counsellors as well as examine possible strategies towards improving the clinical supervision of counsellors.

This section of the study focuses on the sample and population; and describes the population sample of the research study, the details of the instrumentation of research tools, operational variables, study procedures, ethical assurances and the data collection process. The key impetus to align a quantitative perspective and qualitative methodology was to enhance the ecological and external validity that is considered invaluable for this study. The same guided the sampling procedure. The sampling procedures in the behavioural sciences can be probability or non-probability; the sampling research population can also be a sample of convenience and mixed methods sampling (Tansey,2007; Teddlie & Yu,2007). Probability sampling techniques are used primarily in quantitative studies where participants are randomly selected in a large number of units from a targeted population so that due to the probability of inclusion, every member of the particular community is determinable with the aim being to achieve representativeness and the ability to generalize the findings.

This was done such that the sample becomes representative of the entire population (Schreuder et al.,2001; Teddlie & Yu,2007). The study used probability stratified random selection and purposive sampling by conveniently selecting accessible districts whilst organizations from the districts were randomly selected to form different strata from varied environmental settings offering counselling from each of the five (5) districts; every institution offering counselling had an equal probability of being sampled.

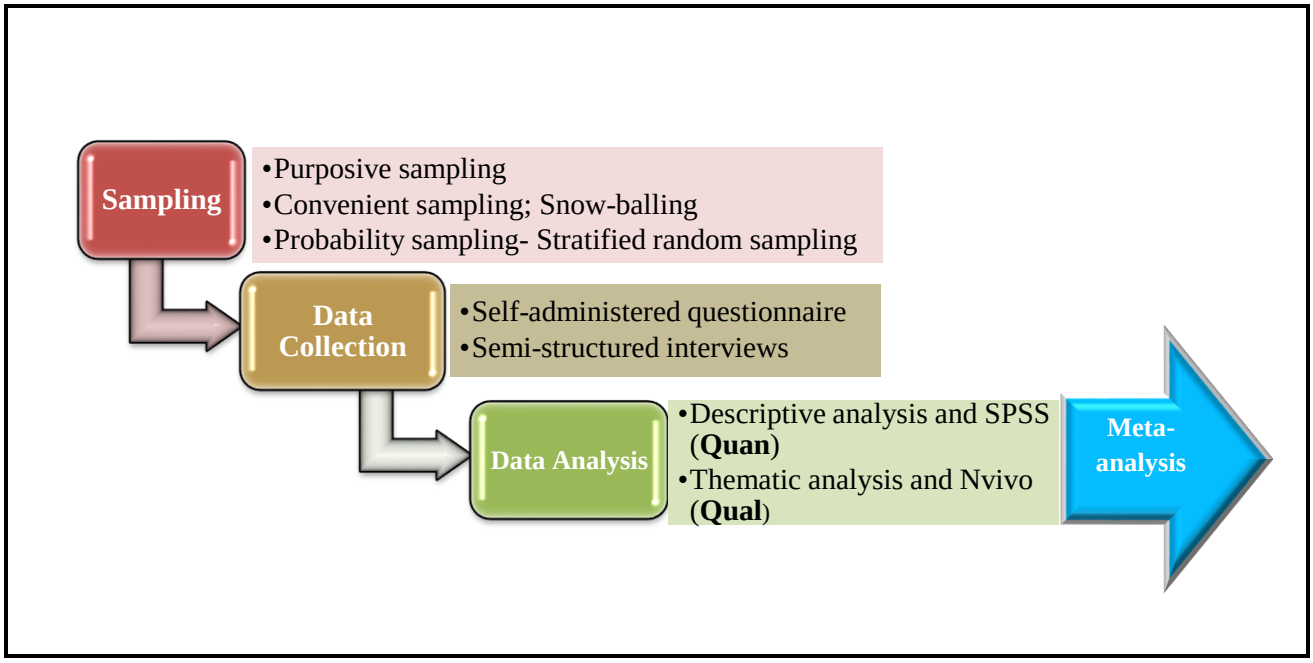
The study also deployed Purposive sampling as it targeted a specific group of professionals practising counselling. As Teddlie and Yu (2007) assert, purposive sampling techniques are compatible with qualitative data collection methods and allow for the selection of a specific unit of people based on specific purposes that relate to answering the questions of a given study. Therefore, in this purposive sampling method, practising counsellors from different environmental settings were purposefully selected for data that could not be obtained from any other set or unit of participants.

Apart from purposive sampling, convenience sampling was utilised in the selection of districts to draw the sample population from, and that allowed for snowballing where possible. However, inaccessible remote

areas were excluded. The study sampling, data collection and data analysis sequence followed the following process:

Figure 10

Showing the Sampling, Data Collection and Analysis Process



Adapted from Low (2018, p.51)

The criterion for inclusion in this study was that participants had to be practising counsellors with not less than three years of experience aged between twenty-five and sixty-five years old.

This study collected data from multiple sources, from different environmental settings to help establish the pattern across the board. The target population for the study was drawn from five (5) Regional districts; urban, semi-urban and rural out of the 10 districts of Botswana; the sample frame included governmental educational institutions, private educational institutions, non-governmental organizations, tertiary institutions and privately owned organizations offering counselling and clinical supervision.

Two hundred and Fifty (250) counsellors from different environmental settings were randomly selected from the conveniently sampled 5 districts and invited to participate, only two hundred and ten (210) consented and took part hence making the sample population of the study.

These comprised of guidance and counselling teachers who are portfolio holders of "Senior Teacher 1 – Guidance and Counselling" from public schools; both Primary and secondary schools and School counsellors

from privately owned schools (Primary and Secondary), Participants were also recruited from government-owned and privately owned tertiary institutions, mental health/counselling regulating organizations, privately owned companies offering counselling, non-governmental organizations (NGOs) and health facilities.

Counsellor supervisors responded to semi-structured interviews and were from counselling regulating bodies, the Ministry of Basic Education's Department of Special Support Services (DSSS); Counsellors at the policy development level and Counsellor-educators. DSSS officers from the five (5) sampled regional districts responsible for the coordination, coaching, and mentoring of school counsellors and monitoring the implementation of the Guidance and Counselling programme in schools, Centre managers and directors were included in the study as respondents to semi-structured interviews. The study targeted a total sample of 50 interviewees but only thirty-eight (38) consented and participated; supervisors were from different environments such as tertiary education (counsellor educators), practising counsellors involved in policy-making, clinical supervisors from government, non-governmental, schools and private practice as informed by the results of quantitative data analysis for explanatory purposes and corroboration of data.

According to Cohen et al. (2009), "small-scale research often uses non-probability samples because, despite the disadvantages that arise from their non-representativeness, they are far less complicated to set up", are considerably less expensive, and can prove perfectly adequate where researchers do not intend to generalize their findings beyond the sample in question." Purposive and Probability sampling were therefore used in this study drawing a sample of two hundred and ten (210) respondents from only five (5) districts out of the ten (10) districts in Botswana for quantitative data and 38 supervisors for qualitative data (interviews) making a total of 248 respondents.

This sample was considered representative as it was drawn from multiple environmental settings representing the views of counsellors from diverse settings having characteristics of the communities they operated in, and thus representative of the overall population group of counsellors in the country hence the study findings were considered generalizable to the population.

3.2.1 Sampling

The sampling strategy deployed in this study was intended to maximize efficiency and validity, it was aimed at being consistent with the objectives to be achieved by this mixed methods study to gain an in-depth understanding of the phenomenon, whilst at the same time quantitatively achieving breadth of understanding (Palinkas et al.,2016).

Probability and Purposeful sampling methods were deemed appropriate (Sandelowski,2000; Tansey,2007; Teddlie & Yu, 2007). Conveniently, sampling districts that were accessible whilst randomly selecting schools, NGOs, tertiary institutions and private companies from the selected districts was a process followed in the sampling of counsellors who were engaged as research participants in this mixed methods study.

The sampling technique used was to purposefully select the targeted population of counsellors for purposes that they could relate well to answering the questions the study aimed to investigate (Tansey,2007; Teddlie & Yu, 2007). The probability and non-probability sampling approaches provided an opportunity to corroborate what counsellors said through questionnaires with what those who were interviewed from different environmental settings were saying (Tansey,2007). This eventually was able to facilitate inferences to be made, and all this is synonymous with probability and non-probability purposive sampling (Tansey,2007).

The study sampled two hundred and ten (210) practising counsellors in Botswana aged between twenty-five and sixty-five years with more than three years of experience in the field of counselling from different environmental settings.

For the Qualitative phase of the study, 50 participants were approached from the 5 districts. Respondents were Counselling Centre Coordinators/clinical directors, case managers or in some places heads of centre. These were drawn from both governmental and non-governmental entities, private practice, District Health Management Teams overseeing counsellors under health, Heads of Addiction centres, MOBE Regional District heads of Pastoral care (DSSS- PEOs) supervising School Counsellors (Guidance Teachers) and/or overseeing the implementation of the Guidance and Counselling programme in schools, vocational training centres, counsellor educators in tertiary institutions as well as tertiary institutions career counselling centre coordinators and counselling regulating bodies.

Out of 50, only 38 consented and took part in the interviews. The face-to-face interview and telephone response rate were estimated at 70%, however, 76% was achieved, surpassing the target estimated percentage by 6% (Badger & Werrett (2005); Kelly et al.,2003; Sappleton & Lourenço,2016).

To reduce data biases, the interview sample population was not part of the questionnaire participants.

3.2.2 Purposive and Probability Random Sampling

Purposive sampling of counselling service providers included practising counsellors and those who provide clinical supervision such as school counsellors (Guidance teachers), counsellors from different mental health settings such as those in private practice, health facilities, tertiary institutions, non-governmental organizations (NGOs) and counselling regulating bodies, for as Palinkas et al. (2015, p.534) assert, "Purposeful sampling is a technique widely used in qualitative research for the identification and selection of information-rich cases for the most effective use of limited resources", and this study having mixed methods used both the quantitative and qualitative approach and hence the use of probability (stratified) and non-probability (purposive) sampling techniques.

The purposeful sampling strategy targeted the people believed to be in a position to provide the much-needed information, for as Creswell and Plano Clark (2011) pointed out, purposive sampling "involves identifying and selecting individuals or groups of individuals that are especially knowledgeable about or experienced with a phenomenon of interest".

Botswana has 10 Regional districts; the sample was drawn from only 5 out of the 10. It is believed that the use of questionnaires and interviews reduced the issue of bias in the study. The University of Botswana as the custodian of counsellor education was equally engaged; especially counsellors from the University Careers and Counselling Centre and educational foundations' Counsellor Education department. The study purposively approached two hundred and fifty (250) potential respondents, however ended up with a sample of Two hundred and Ten (210) respondents taking part in questionnaires. The parameters of generalizability in this type of sample are very possible as the target population and the country population are relatively small, and counselling is relatively new in Botswana; "at the infancy stage" (Msimanga & Moeti,2018; Muchado,2018).

Face-to-face interviews were specifically conducted for clinical supervisors/counsellors, clinical managers, and counsellor educators following the questionnaire that was administered. This was to help clarify some issues and probe some of the issues that emerged from the questionnaire responses and results.

Though Botswana has approximately 207 Juniors Secondary Schools, 33 Senior Secondary Schools and about 754 Primary Schools, and each one is supposed to have a Guidance teacher/school counsellor; in some schools that was not the case; and for some due to regular regional and national transfers they remained without any replacement. Out of 994 counsellors, 735 counsellors were located in the sampled 5 districts. Therefore, with the target population of 735, the study took into account a margin error of 5% and, an estimated confidence level of 95%, and therefore 250 potential respondents were approached for the study drawn from different environmental settings from the 5 districts.

With consideration of the possible response rate of approximately 80%, 250 invitations were sent out to potential participants to form part of the study questionnaire respondents, and only Two hundred and Ten (210) consented and took part. Similarly, fifty (50) counsellor supervisors were invited to participate in semi-structured interviews, and only thirty-eight (38) agreed and took part. Since the population sample of counsellors was drawn from diverse environmental settings for the study to explore this phenomenon, this sample (248) was considered representative enough to allow saturation and generalizability to the larger population of counsellors in the country; 210 questionnaire respondents plus 38 respondents for interviews gave the total response rate of 82.6 (83%) surpassing the estimated response rate by 3%. The sample size influences the data and the study's credibility and trustworthiness; therefore, this sample is considered representative as it sufficiently captures various issues, and this data drawn from different settings helped to adequately explore the variables in this study, rather than sampling from only one group of people or one environmental setting (Bowen,2008; Hennink et al.,2017; Mason,2010).

The characteristics of research participants were male and female practising counsellors aged between 25 and 65 years, with not less than three years of experience sampled from various environmental settings within the five (5) selected Districts.

Counsellors were identified and recruited through their regional directors, Heads of Schools for those working in schools, whilst others were equally recruited by emails, and phone calls followed by formally written letters to heads of departments and/or directors of organizations, others were recruited through snowballing. Recruitment and sampling were carried out before the data collection process following approval by the Unicaf University Research and Ethics Committee (UREC) and local research approval bodies (Berg,2017). Before data collection, Informed consent forms were sent to potential participants requesting consent to participate in the study. Questionnaires were administered first, analysed then followed by semi-structured interviews. Recruitment of participants was done by sending emails followed up with telephone calls and vice-versa. The sample for this study mirrors the characteristics of the target population and the size of the country's population, and hence their views were used to represent the views of the target population; especially because the sample was drawn from diverse environmental settings (Fink,2003).

3.2.3 Instrumentation of Research Tools

The Instrumentation of the study started with a deductive process followed by an inductive process of identifying the knowledge, attitudes, and practices of CP among counsellors by determining the level of Access, their knowledge, attitudes, practice, ethical principles, and possible strategies for improvement.

The questionnaire was used, followed by interviews as research instrumentation to obtain data from practising counsellors and counsellor supervisors, and since a standardised data collection tool appropriate for this study could not be found, a self-developed questionnaire was designed for purposes of quantitative data collection in line with Ajzen's (2006) guidelines on how to construct a "Theory of Planned Behaviour (TPB) questionnaire" and step-by-step guidelines on designing KAP(knowledge, Attitude and Practice) surveys and questionnaires (Andrade et al.,2020; OECD,2012; USAID,2011), the same were used to guide the development of semi-structured interview guidelines which was later reviewed as informed by the results of the quantitative data.

The self-developed instrument comprised 36 items seeking information on the six variables; Access, Knowledge, Attitudes, Practice, Ethical principles guiding and Strategies towards improving the clinical supervision practice in Botswana.

The development of the specific instrument for this study was in line with Landon's (2016) and Thielsen and Leahy's (2001) work wherein they had to conceive and develop Rehabilitation Counsellor Supervision Inventory (RCSI) specifically for their studies as a standardised instruments were unavailable. Benchmarking from Ajzen (2006); Andrade et al. (2020); OECD (2012) and USAID (2011) on designing KAP surveys, the instrument for this study was developed and piloted before data collection.

The first part of the questionnaire was to collect demographic data that included age, gender, level of education (qualification), work environmental setting, district and years of work experience to establish background information in conducting and accessing clinical supervision. The second part was 5 Likert response structured questions eliciting information on the key variables. The instrument was piloted in institutions based in Gaborone first to help establish the validity and reliability of the instruments before the actual data collection. The instrument was designed to establish the knowledge, attitudes and practices of CS among counsellors by examining the level of access to clinical supervision, the knowledge of clinical supervision, their practice of CS, guiding ethical principles used to guide their clinical practice and strategies for improvement of the clinical supervision practice by Counsellors in different community settings such as; Schools, NGOs, private practice, counselling regulating bodies and tertiary institutions.

The instrument also established how often counsellors accessed individual, peer and group clinical supervision, what their views were on clinical supervision; what they perceived to be the benefits of the clinical supervision, as well as what ethical principles guided their clinical practice.

To obtain quantitative data the study used a 5-point Likert scale Questionnaire with responses ranging from "strongly agree" to "strongly disagree"; Strongly Agree =5, Agree =4, Somewhat agree/neutral =3, disagree =2 and strongly disagree =1.

3.3 Validity and Reliability

Validity refers to the accuracy of an instrument; whether or not it measures what it is supposed to measure because an instrument may be reliable without necessarily giving a valid measure (Drost,2011). Bashir et al. (2008) and Golafshani (2003) view validity as the accuracy of an assessment; whether or not it measures what

it purports. It is the extent to which a measure is close to representing the concept it claims to measure. On the other hand, reliability defines the consistency of a particular test, procedure or tool such as how a questionnaire can produce related or similar results in different circumstances assuming no other changes occur (Collins et al.,2006,2007). It refers to the degree to which an instrument yields consistent results; it is normally measured through internal consistency, test-retest, and inter-rater reliabilities (Johnson,2014).

To ensure the reliability of the instrument used, the instrument was reviewed and piloted under the premise of trustworthiness, genuineness, objectivity and quality separated from researcher biases and authentic acceptance of constructive and objective feedback from the research project supervisor, peers and experts who took part in the content evaluation and/or construct validity testing process. Reliability has to do with the consistency of a measure of a concept (Johnson,2014; Tenuche,2018). This implies that the instruments used must be thoroughly examined and ensured that they are consistent with the research objectives, research questions aims and the main purpose of the study. Hence, for this study, a 36-item questionnaire was developed as there was none available for adaptation. The questionnaire used 5 Likert scale with clear instructions.

Participants had to choose their level of agreeing or disagreeing with the given statements measuring perceptions and looking at seven variables of demography, Access, knowledge, attitude, practice, principles and strategies for improvement of the clinical supervision practice.

The language used was the one that clinical practising counsellors would be able to understand in their day-to-day work and to reduce biases and ensure validity, the wording, phrasing and arrangement of the question items for the structured questionnaire and semi-structured interviews were assessed at the development stage to establish whether they described the concept being assessed.

The items were also shared with the research project supervisor, peers and some experts in the field to validate if the items were appropriately measuring the intended construct. This exercise helped with the assessment of the instruments before being used for the study. The items were revised and those that did not meet the requirement were deleted or rephrased. Neutrality also played a part in preventing the use of leading

questions (Conroy,2021; Collins et al.,2007; Johnson,2014; Onwuegbuzie, & Johnson,2006; Tenuche,2018). Piloting of the instrument to test for reliability was conducted at a two-week interval to assess if the tool would yield the same results.

Thirty-six (36) participants were selected to pilot the instrument to assess the reliability of the tool, The internal consistency of the instrument was tested on IBM SPSS 26.0 using Cronbach's Alpha for all the variables, and the test indicated a relatively good internal consistency, Therefore, the items and variables were considered reliable based on their Cronbach Alpha value that ranged from .728 to .924 (Taber,2016; Tenuche,2018) as indicated in the table below. Alpha is commonly reported for the development of scales intended to measure attitudes and other affective constructs, literature shows that it is considered an indicator of the quality of an instrument and/or an indicator of instrument scale reliability or internal consistency.

Table 1

Showing Cronbach's Alpha for testing Reliability and the validity of the 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 Principles	*36*	*5*	*.699*
Strategies	*36*	*6*	*.924*

It is important to note that the participants of the pilot phase did not form part of the actual research study sample population.

3.4 Operational Definition of Variables

The proposed instrument of data collection was developed in line with Ajzen (2006); Landon (2016) Andrade et al. (2020); OECD (2012) and USAID (2011) as a process to adopt in a situation where a suitable standardized instrument is unavailable. The instrument was pre-tested among randomly selected counsellors in Gaborone to assess the language of the instrument and suitability for the study, The instrument focused on establishing the level of access, knowledge, attitudes, practice of clinical supervision, examined ethical principles used and elicited for possible strategies to be adopted for the improvement of clinical supervision intervention. All these variables were nominal; for demographic data and the rest were ordinal and helped to unearth the perceptions of counsellors towards clinical supervision.

Variable 1: Demographic information gathered nominal data; no hierarchy exists for Gender which requires respondents to indicate in writing the gender they identified themselves by (Male/ Female or prefer not to say) and the data was calculated in percentages and was also coded as 1= Male. 2 = Female and 3 = Prefer not to say. On the other hand, the issue of age inclusion in the study was for people aged 25-65 years, which is incremental and ordinal ranging from 25-35 years, 36 - 45 years, 46-55 years, and 56-65 years and measured in percentages. The number of years of experience ranged from 3 years to 40 years, also Ordinal data ranged from 1= 3-10, 2 =11-15, 3 =16-20, 4 =21-30, 5 = 31- 40, and qualifications had a value to them and/or order and hence ordinal data that allowed for calculation of percentages as well; and data was captured as 1 = certificate, 2 = Diploma, 3 = Bachelor's degree, 4 = Master's degree and 5 = Doctorate.

The indication of the district was nominal (string rather than numeric) as respondents had to name any of the 5 districts they were located, whilst the rest of the items in the questionnaire collected ordinal data, participants had to choose their responses from different statements using different responses ranging from; "strongly agree", "agree", "somewhat agree/neutral", "disagree" to "strongly disagree".

The demographic data was collected from both the questionnaire and the semi-structured interviews, and descriptive analysis was used to work out the percentages on gender, age, years of experience, qualifications and the varied responses to the variables in this study. Demographic data was nominal and possible to measure in percentages, the rest of the questionnaire collected ordinal measurable data which was quantifiable as was

collected through a structured questionnaire to assess counsellors' perceptions towards clinical supervision in terms of Access, knowledge, attitudes, practice, ethical principles and strategies that could help improve the clinical supervision, the 5-point Likert scale Responses ranged from 1= Strongly disagree, 2= Disagree, 3 = somewhat agree/neutral, 4 =Agree = and 5 = Strongly Agree.

Participants had to give their opinion on a given statement, and their level of agreement or disagreement with the statement, and each of the variables had six items/statements to respond to; for example, one item/statement on the variable intended to establish the level of access to clinical supervision was: "I have access to clinical supervision at my workplace", of which participants had to choose from 1= strongly disagree, 2 = disagree, 3= somewhat agree/neutral, 4 = agree or 5 = strongly agree. The same was the case for the statement; "I only have access to clinical supervision once a year" and for the rest of the statements.

Variable 2; "Access" in this study referred to participants' ability to attend and receive clinical supervision, mentorship, coaching, case review, clinical assessment as well as professional developmental support by engaging with a senior and more experienced member of the same profession (Clinical supervisor).

Accessing the clinical process helps to address ethical dilemmas that counsellors as practitioners may encounter in their provision of counselling services. This variable enabled the calculation of ordinal numeric measurement as respondents had to select their responses from 5 Likert scale ranging from 1 = Strongly disagree, 2= disagree, 3= Somewhat agree/Neutral, 4=Agree to 5=Strongly Agree to the given six statements such as "I only have access to clinical supervision once a year", "My clinical supervision session takes 60-90 minutes", "I only have access to individual supervision" and so on.

Variable 3: was on Knowledge and sought to determine the knowledge of clinical supervision by counsellors, it was also an ordinal measurement variable that enabled the calculation of ordinal data as participants also had to select Responses from" strongly agree" to "strongly disagree" for statements such as; "I have knowledge of clinical supervision as a requirement in counselling", "I am trained in clinical supervision", "I can competitively provide clinical supervision". This variable was intended to determine the level of respondents' knowledge of clinical supervision.

"Knowledge" in this study is a concept that refers to possessing relevant information, a state of knowing something, understanding and having an awareness about a construct, a practice, and that knowledge often is accompanied by the ability and competencies to perform the intended action or behaviour and in this case clinical supervision. Hunt (2003) views it as acquired information resulting in behaviour modification; "Learning has the concept of knowledge being defined as the relatively permanent modification of the behavioural potential of an organism which accompanies practice."

Variable 4 examined the attitudes of counsellors towards clinical supervision. This is equally an ordinal data item with six statements eliciting responses from; "strongly agree" = 5, "agree" = 4, "neutral" = 3, disagree = 2 to "strongly disagree" = 1 given statements like; "I believe Clinical Supervision enhances counselling skills", "I am interested in learning more about clinical supervision", I believe clinical supervision is a good intervention". The analysis of ordinal data gathered in this study through the questionnaire was descriptively analysed.

The concept of attitudes according to Schwarz and Bohner (2001) is; "a mental and neural state of readiness, organized through experience, exerting a directive and dynamic influence upon the individual's response to all objects and situations with which it is related"; clearly, attitudes can greatly have an influence on how an intervention is perceived and/or appreciated; either favourably or negatively; and if positively, the outcome and implementation may be different as compared where attitudes towards the intervention (Clinical supervision) are negative. This variable sought examining attitudes counsellors had towards the intervention.

Variable 5 intended determining Practice by counsellors. This was equally an ordinal data item with six statements eliciting responses; "strongly agree", "agree", "neutral", "disagree" or "strongly disagree" concerning their clinical practice; linking theory to practice. The given statements for example included; "I am confident in providing clinical supervision", "I can use supervision skills within ethical and legal boundaries", and can articulate and practice confidentiality in clinical supervision" and so on.

Practice in this study refers to any action or an omission by a counsellor that another may reasonably consider being part of a counselling service, or that which could cast doubt upon the ability and competence to practice as counsellor(s), and outside counselling, it may be that aspect which harms public trust in the

discipline or the profession of counselling, and in the capacity as a counsellor to provide credible clinical counselling and/or supervision (Australian Counselling Association,2019,2022). Having a theory and knowledge of a construct may not always equate to the application of behaviour in practice.

Variable 6 was equally an ordinal data six-itemed variable that sought to investigate principles that guided counsellors in their clinical supervision practice. This ordinal data item also had six statements related to ethical principles and elicited the following responses; "strongly agree" = 5, "agree" = 4, "neutral" =3, "disagree" =2 and "Strongly disagree" =1.

Statements included; "Protecting clients' issues and records in my practice is important", "I practice unconditional positive regard in my practice", "I am affiliated to a counselling regulating body/Association" and "I use ethical principles for a regulating body/association". It is essential to point out that Mental health professions and many other professions dealing with human subjects are guided by ethical principles to ensure safety, justice, confidentiality, non-maleficence and prevent malpractice as well as protect the image and credibility of the profession. Hence, this variable examined counsellors' clinical ethics.

Variable 7 was equally a six-item ordinal data variable that sought to elicit possible strategies that could be deployed towards improving clinical supervision in Botswana. This ordinal data item had statements related to possible strategies and elicited responses ranging from "Strongly agree" to "Strongly disagree" Such statements included: "Training counsellors in clinical supervision could help improve clinical supervision", "making clinical supervision mandatory is a good strategy to enhance the clinical supervision practice", "establishing an accreditation and licensing body could greatly improve clinical supervision", "A good strategy for improving Clinical supervision will be to have regular planned clinical supervision sessions in Botswana" as well as; "instilling a good practice of documenting, ethical and legal compliance can go a long way towards improving clinical supervision in the country".

These survey items were followed by data analysis and the results were used to guide the second phase of the study i.e.; collecting qualitative data through the use of semi-structured interviews using open-ended questions for purposes of corroboration, gaining more insight and explaining.

Every set had to be cleaned, coded and uploaded into SPSS for statistical descriptive representation and NVivo for analysis (Daniel,2021; Field,2013) was derived from the raw data percentage and frequencies of the responses to each survey item, then qualitative data was also analysed using NVivo, thematic and content analysis and the two data sets results were merged and meta-analysis used to triangulate the findings to establish convergence and divergence.

3.5 Study Procedures and Ethical Assurances

Approval was sought and obtained from the UNICAF University Research Council, from Botswana's Department of Educational Planning and Research Services Unit within the Ministry of Basic Education (DEPRS-MOBE Headquarters) and from various corporate entities before the collection of data for this study. Similarly, permission was also obtained from the five (5) Regional Districts DEPRS (MOBE) units.

During the process of this study, various counselling Association research ethical codes were consulted such as American ([ACA],2014), Australian counselling ([ACA],2022,2019), BACP (2018-19) as well as Botswana Data Protection ACT of 2018 to ensure adherence to confidentiality, privacy and protection of research participants, their data and safe storage of the obtained data.

All permissions for approval of the study were sought through formal application forms that were completed and submitted to the relevant research approval authorities; both from the university (UREC) and the country of data collection (Botswana); hence research approval requirements were fully met and data was collected from counsellors in different environmental settings through structured questionnaires and semi-structured interviews from August 2022 to February 2023.

3.5.1 Ethical Assurances

Research ethical assurances helped to guide the researcher and protect research participants. These are guidelines that ensure compliance and professionalism in research conduct. History has indicated how unethical research undertakings could be harmful to research participants, therefore the study ensured ethical compliance and responsible conduct during the undertaking of this study ([ACA],2014; p.15-17). This was ensured through adhering to confidentiality, anonymity and consent participation by research participants,

voluntary participation, debriefing before and after the data collection process as well as seeking research approval from the relevant authorities.

3.5.1.1 Risks

The potential ethical considerations in the study included the possible risks breaching of confidentiality and data storage, these were reduced by ensuring that participants responded anonymously to the data collection instruments, signing the consent form, and not coercing potential into taking part, as well as by using a coding system to prevent responses from being easily traced back to the respondents. For the safety of the gathered data, storage was a password-enabled external device which could not be hacked and was securely stored in lockable storage.

Potential risks towards respondents' participation in this study were considered to be low. Similarly, regular consultations, guidance and debriefing were sought from the UNICAF School of Doctoral Studies, the research project supervisor, and the University Research Committee (UREC) process. Respondents were free to withdraw if they so wished without any negative consequences. The study presented no risks to participants, excluded under-age individuals and those with mental disabilities.

3.5.1.2 Confidentiality

Participants were debriefed before research data collection and were reassured of their privacy and protection of their identity. This included explaining the purpose of the research, the empirical benefits of participating in the study, assurance of privacy through anonymity in responses and data coding.

The assurance given also covered data protection and safe storage of the information they shared. Similarly, their right to withdraw from the study if they desired was also explained, and potential respondents were made aware that their withdrawal from the study would not require explanation or attract any negative consequences towards them in any way. Participants were also assured that in the event they pulled out of the study, their data would be excluded from the study and deleted. Research participants were not coerced, manipulated, deceived or incentivised to participate in the study in any way; there were no monetary incentives awarded to attract participation.

Similarly, there was no hierarchical relationship or any other relationship between the researcher and the participants. Participants were also reassured that the data they gave would not in any way be traceable back to them due to anonymity in responding to the questionnaire. Participants were also cautioned not to write any identifiers on their questionnaire papers.

Their consent to participate was sought before the data collection process through the signing of the "informed consent form" which detailed the purpose of the study and requested their participation, their right to withdraw and confidentiality

3.5.2 Role of the Researcher

The role of the researcher involved being responsible for the whole research project and its processes under the mentorship of the research project supervisor.

This included data collection activity, development of the data collection instruments, data analysis, examining of the views and values as well as ensuring credibility of the study outcome. This was a critical aspect of the credibility of the overall study. The researcher identified as a Motswana female who shared a similar professional identity with the research participants as a former school counsellor, Guidance and Counselling officer, counselling policy developer and implementor, counsellor educator, and clinical counsellor supervisor with a passion for the strengthening of clinical supervision in Botswana.

However, despite the researcher's background, biases were reduced by adhering to ACA (2014,2022,2019) research ethics and using mixed-methods approaches. Biases synonymous with "interviewer bias" were also reduced as most interviews were conducted by telephone. Moreover, interview guiding questions were UREC-approved together with the questionnaire instrument before data collection. Additionally, questionnaires were reviewed by peers from local universities and record-keeping and maintenance of research processes also helped to reduce bias.

3.6 Data Collection and Analysis

This study was predominantly quantitative through the use of a self-developed well-structured questionnaire followed by semi-structured open-ended interview questions.

The Questionnaire sought to determine the demographic data, access, knowledge, attitudes, practice, ethical principles and strategies for improvement of clinical supervision by Counsellors in different community settings such as; Schools, NGOs and Private practice, Counselling regulating bodies and tertiary institutions**.** School counsellors, counsellors from non-governmental organizations and those from tertiary institutions responded to questionnaires, whilst supervisors from Ministry headquarters, centre directors, regional education offices, Private Practice, counsellor education, Counselling regulating bodies and a few from schools and NGOs responded to semi-structured face-to-face or telephone interviews**.**

Data was sequentially gathered; quantitative data was collected first through a questionnaire, followed by qualitative data collected through semi-structured interviews (Creswell & Clark, 2017; Low,2018; Onwuegbuzie &Collins,2007). The interview data was then utilised to corroborate, compare, cross-check, explain, augment and/or refute the findings derived from the survey data (Collins et al.,2006; Creswell & Clark,2017; Onwuegbuzie &Collins,2006). Therefore, in this hierarchical order and process, there was an unequal priority as the data collection started with questionnaires as a major data collection instrument. Interpretation of the mixed methods findings necessitated for sequential data triangulation process wherein the major findings from the questionnaires, and those from the interviews were compared to identify data convergence; patterns and data divergence or data conflict through meta-analysis.

3.6.1 Participants Recruitment

Recruitment of participants started after the UREC and local research permit approvals. Participants for the study were recruited by sending invitations by email with informed consent forms which had to be signed if agreeing to participate in the study, Consent forms and answered questionnaires were then emailed back to the researcher. However, some questionnaires were hand-delivered and collected in person.

The purpose and significance of the study as well as guidelines; ethical assurance, confidentiality, data protection and identity protection were fully explained. Emailing addresses and contact details were obtained from the government website portal for government institutions, from the Ministry of Basic Education headquarters and regional offices, whilst for other organizations contact details were obtained from the national telephone directory, and regulating organizations. Participants were also recruited through telephone calls.

3.6.2 Operational Constructs

The following constructs addressed associated with the research topic of this study as were operationally defined for purposes of this study and the proposed data analysis techniques.

Variable 1: Demographic information gathered nominal data; no hierarchy exists for Gender which required respondents to indicate in writing the gender they identified themselves by (Male/ Female or prefer not to say) and the data was coded 1= Male, 2 = Female and 3 as "prefer not to say" which was calculated in percentages. On the other hand, the issue of age inclusion in the study was for people aged from 25-65 years, which is incremental and ordinal ranging from 1 = 25-35 years, 2 = 36-45years, 3 = 46-55years, 4 = 56-60+ years and measured in percentages. The number ranged and also coded thus; 1 = 3-10, 2 = 11- 15, 3 = 16-20, 4 = 21-30, 5 = 31- 40 for years of experience.

The highest level of education had a value to them and hierarchical order, and therefore, ordinal data allowed for the calculation of percentages; and were also coded as follows; 1 = certificate, 2 = Diploma, 3 = Bachelor's Degree, 4 = Master's degree and 5 = Doctorate. The collection of indication of district data was nominal (non-numeric, but string) using SPSS, whilst the rest of the items in the questionnaire collected ordinal data as participants had to choose their responses from different categories of responses; "strongly agree" =5, "agree" =4, "neutral" =3, "disagree" =2 and "strongly disagree" =1. Similarly, these ordinal data were used to calculate percentages.

Demographic both questionnaire and descriptive analysis were used to work out the percentages on gender, age, years of experience, qualifications and the varied responses to the variables in this study. The demographic

data was nominal data and possible to measure in percentages, the rest of the questionnaire collected ordinal measurable data which was quantifiable, and was collected through a structured questionnaire to assess counsellors' perceptions towards clinical supervision in terms of access, knowledge, attitudes, practice, ethical principles and strategies that could help improve the clinical supervision, the 5-point Likert scale Responses; 5 = "strongly agree", 4 = "agree", 3 = "Somewhat agree/neutral", 2 = "disagree" and 1= "strongly disagree".

Participants gave their opinion on a given statement and each of the variables had six statements to which they responded; for example; one item on the variable intended to establish the level of access to clinical supervision was; "I have access to clinical supervision at my workplace", of which participants had to choose from; 5 = "strongly agree", 4 = "agree", 3 = "somewhat agree/neutral", 2 = disagree, or 1= "strongly disagree". It was the same for the statement; "I only have access to clinical supervision once a year".

Variable 2; "Access" in this study referred to the counsellors' ability to attend or receive clinical supervision for professional developmental and clinical support by engaging with a more experienced member of the same profession (Clinical supervisor).

This variable enabled the calculation of ordinal numeric measurement as respondents had to select their responses from 5 Likert scale ranging from "strongly agree"=5, "agree"=4, "somewhat/neutral"= 3, "disagree" = 2 to "strongly disagree"= 1 from given six statements: "I have access to clinical supervision at my workplace", "I only have access to clinical supervision once a year", "My clinical supervision session takes "60-90 minutes", "I only have access to individual supervision", "I have access to group supervision only" and "I only access peer-to-peer clinical supervision".

Variable 3: was knowledge which sought to determine the knowledge and/or competencies of counsellors of clinical supervision, It was also an ordinal measurement variable, and enabled for calculation of ordinal data as participants also had to select responses from" strongly agree" to "strongly disagree" for statements such as; "I have knowledge of clinical supervision as a requirement in counselling", "I am trained in clinical supervision", "I can competitively provide clinical supervision".

"Knowledge" in this study is a concept that refers to possessing relevant information, a state of knowing something and having an awareness about a construct, a practice, with such knowledge accompanied by the ability to perform the intended action or behaviour such as competently facilitating Clinical Supervision. Hunt (2003) views it as a piece of acquired information resulting in behaviour modification; "Learning has the concept of knowledge being defined as the relatively permanent modification of the behavioural potential of an organism which accompanies practice."

Variable 4 sought to examine the attitudes of counsellors towards clinical supervision. This is equally an ordinal data item with six statements eliciting responses given statements that included; "I believe Clinical Supervision enhances counselling skills", "I am interested in learning more about clinical supervision", I believe clinical supervision is a good intervention", and "I enjoy attending clinical supervision sessions".

The analysis of ordinal data gathered in this study through the questionnaire was descriptively analysed. The concept of attitudes according to Schwarz and Bohner (2001) is; "a mental and neural state of readiness, organized through experience, exerting a directive and dynamic influence upon the individual's response to all objects and situations with which it is related"; attitudes can have a great influence on how an intervention is appreciated and evaluated either favourably or negatively, and if positively evaluated the outcome and implementation may be different as compared to if the attitudes towards the intervention are evaluated negatively. This variable sought to examined attitudes counsellors had towards CS.

Variable 5 intended to investigate counsellors practices. It was equally an ordinal data item with six statements eliciting responses ranging from "strongly agree" to "strongly disagree" concerning their clinical practice, linking theory to practice. The given statements for example included; "I am confident in providing clinical supervision", "I can use listening and paraphrasing skills in clinical supervision", "Empathy and working alliance are important in my clinical supervision", "I can use supervision skills within ethical and legal boundaries", "I can maintain eye contact and open body posture in clinical supervision sessions", and "Can articulate and practice confidentiality in clinical supervision".

Practice in this study referred to any action or an omission by a counsellor that another may reasonably consider being part of a counselling service or that which could cast doubt upon the ability and competence to practice as counsellor(s), and outside counselling, it may be that aspect which harms public trust in the discipline or the profession of counselling and in the capacity of a counsellor to provide credible clinical counselling or supervision (Australian Counselling Association,2019,2022; Braid,2021; Hood & Milson, 2021).

Variable 6 was an equally ordinal data six-itemed variable that sought to investigate the principles that guide counsellors in their clinical supervision practice. This ordinal data item had the following six statements related to ethical principles and eliciting responses ranging from "strongly agree" to "strongly disagree":

"Protecting clients' issues and records in my practice is important", I practice unconditional positive regard in my practice", "I am affiliated to a counselling regulating body", "I use Botswana Counselling Association ethical principles to guide me", "I use principles for a different regulating body", "am not aware of any ethical principles that guide clinical supervision".

Mental health professions and many other professions dealing with human subjects are guided by ethical principles to ensure safety, justice, confidentiality, and non-maleficence to prevent malpractice and protect the image and credibility of the profession. Thus, this variable examined ethical principles guiding counsellors in their practice of clinical supervision.

Variable 7 was also a six-item ordinal data variable that elicited possible strategies that could be deployed towards improving clinical supervision in Botswana. This ordinal data item had the following six statements related to ethical principles and eliciting responses ranging from "strongly agree" to "strongly disagree": "Training counsellors in clinical supervision could help improve clinical supervision", "Making clinical supervision mandatory is a good strategy to enhance the clinical supervision practice", "Establishing an accreditation and licensing body could greatly improve clinical supervision", "A good strategy for improving Clinical supervision will be to have regular planned clinical supervision sessions", "Creating awareness on

clinical supervision services can help improve clinical supervision in Botswana", "Instilling a good practice of documenting, ethical and legal compliance can go a long way towards improving clinical supervision in the country". The variable on demographic data was quantifiable by first coding and assigning values and measurements to possible responses and some sections were nominal data measurable by use of scales and/or range. The quantitative data had to be cleaned up, coded and downloaded into statistical descriptive representation whilst NVivo and thematic analysis were used for qualitative data (Daniel,2021).

The survey items were followed by data analysis and the results were used to guide the second phase of the study which involved collecting qualitative data through the use of semi-structured interviews through open-ended questions.

The following data analysis techniques were deployed as deemed suitable in this mixed-method study.

3.6.3 Data Analysis Techniques

Quantitative data sets were analysed first followed by qualitative data. Techniques appropriate for the two types of data sets were used. Suffice it to say that, data triangulation allowed for data corroboration between the data sets collected through quantitative instrumentation and data gathered through qualitative tools; the results from approaches used helped. Data analysis employed the use of descriptive statistical analysis by using frequencies and percentages which were calculated for each of the major variables of the study.

This was then presented in frequency tables which included a bar graph for demographic data. These techniques aligned well with the research questions and provided evidence to indicate that the research questions were adequately answered.

In semi-structured interviews the responses were analyzed using interpretive content analysis which allowed for thematic groupings and auto-code themes (word cloud), word frequencies and coding of ideas according to their conceptual similarity (Berg & Lune, 2017). Each grouping was given a name that reflected the key theme, then inferences made to adequately address the questions of this research study; "Integration of

quantitative and qualitative data maximized the strengths and minimized the weaknesses of each type of data" (Low,2018).

3.6.3.1 Quantitative Data Analysis

This section articulates various data analysis techniques that were used in analysing sets gathered using a self-developed thirty-six-item questionnaire tool approved by UREC, whilst semi-structured interview guiding questions were equally approved by the same and guided by the outcome of quantitative analysis.

Quantitative data sets are quantifiable and hence descriptive statistical analysis methods were utilised, the selection of techniques was based on what was aimed to establish. On these grounds, the analysis focused on descriptive statistics; frequencies and percentages for purposes of better understanding the phenomenon; "through the use of a systematic collection of numerical data and its interpretation" (Lecture notes, UNICAF, 2022 Sept, 16)**.** As Burns and Grove (2005) posit, the statistic is a numerical value derived from a given sample used to estimate the parameters of a population, in this case, the sample in question being that of counsellors across different environmental settings in Botswana.

Descriptive statistics were used to describe the basic features of the data collected on the perceptions of counsellors towards clinical supervision by way of examining the following variables; "Access, Knowledge, Attitudes, Practice, Principles and possible strategies for improvement of clinical Supervision, as well as the demographic data; location (Districts), age, years of experience, environmental setting and level of education to establish if they had any influence in access, knowledge, attitude and the practice of Clinical supervision in any way.

3.6.3.2 Qualitative Data Analysis

The qualitative data collection approach yielded a massive amount of information extracted through interviews, and the information was derived from explanations, justifications, and elaborations hence providing an extensive amount of qualitative data. This type of data was challenging to analyse, however, with appropriate qualitative data analysis techniques the data adequately helped to explain the quantitative data in

this mixed-method research. The qualitative data provided interpretive and corroboration to help explain quantitative data.

Qualitative data in this study was collected through the use of face-to-face and telephone interviews. Through this data collection strategy, a voluminous amount of data in the form of self-reports, explanations, elaborations, justifications, suggestions and so on were gathered. This type of data was not numeric and therefore not easily quantifiable, it could mostly be interpreted thematically (Attride-Stirling,2001; Braun & Clarke,2006). Though different approaches can be used to analyse, interpret and make sense of qualitative data sets, in this study deductive and inductive approach was more suited and deployed, therefore, deductive coding, indexing and identifying themes and patterns were essential in this qualitative data analysis process. Additionally, NVivo and content analysis were also done to form a foundation for high-quality analysis, whilst the research questions, theoretical framework and literature review girded the deductive thematic coding and what followed was to further identify any codes that inductively emerged through the use of NVivo to achieve a hybrid approach in qualitative data analysis; allowing the codes to develop out of the data and then comparing them with codes that were intentionally developed deductively (Fereday & Muir-Cochrane,2006) further enabled data analysis triangulation.

3.6.3.2.1 Thematic Analysis

Thematic analysis has proved to be effective in helping to establish themes and codes as well as establishing patterns. Qualitative data usually unearths massive amounts of narrative data derived from interviews, focus group discussions and observation (Clarke, Braun and Hayfield,2015) and in this study, semi-structured interviews were used.

Therefore, it was that same qualitative data that was analysed by using a hybrid approach wherein both deductive and inductive approaches were deployed to examine the data from differing approaches to see what the data would yield. Data was coded and thematic network analysis was done followed by content data analysis to give depth and understand the emerging themes and patterns to gain insight into the phenomenon being explored (Clarke & Gray,2017; Clarke,2017; Evans,2018).

All this was done in line with Clarke and Braun's (2017, p.297) view that; “Thematic analysis is a method for identifying, analyzing, and interpreting patterns of meaning (‘themes’) within qualitative data”, hence the process was considered beneficial to the whole data analysis process in this study. Moreover, as Cassell and Symon (2004) opined; thematic analysis involves well-laid-out steps of processes or activities that include coding of basic themes, identifying sub-codes and continuing to organise the codes into conceptual basic themes, and global themes, as well as further performing the thematic mapping and interpreting the thematic data and process to be able to make deductive and inductive inferences. Attride-Stirling (2001) asserts that; thematic network analysis has certain “core features” found to be compatible with most qualitative data analysis approaches intended to explore and understand the phenomenon better.

NVivo is a software used to analyse qualitative data and it was used in this study to establish major themes, generate a word cloud, and auto-generated web codes this was followed by the adoption and utilization of Braun and Clarke’s (2006) coding and thematic mapping approach for qualitative data analysis.

3.6.3.2.2 Content Analysis

Content analysis was also utilised in this study because it facilitates flexibility in helping to understand qualitative data. It is considered to be “a research tool used to determine the presence of certain word frequencies, themes, or concepts within some given qualitative data” (Berelson,1952; Berg & Lune,2017). The technique was conveniently utilised for corroboration and validation of what emerged from qualitative thematic network analysis results, the techniques helped to add a slight quantitative aspect to a qualitative analysis by assessing the patterns that existed within the respondent's excerpts through identifying the content frequency of particular ideas, phrases, statements and words that were frequently used by respondents during interviews and helped in establishing underlying interpretations and meaning. Therefore, the use of content analysis facilitated quantification and analysis of the presence of meanings linked or associated words and the existence of patterns between certain words, themes and concepts (Hsieh & Shannon,2005; MacNamara,2005).

There are three approaches used under content analysis and each fulfils a specific need within the data analysis.

There is the conventional approach, the directed approach and the summative approach. The conventional approach works best with a study design aimed to simply describe a phenomenon whilst the directed approach is mostly used when seeking to validate or extend a theoretical framework or theory in content analysis; it offers an additional description of an existing theory regarding the phenomenon being explored. On the other hand, summative approach analysis starts by evaluating frequencies by identifying and quantifying certain words, or examining text content to understand the contextual usage of words in the narrative research data (Hsieh & Shannon, 2005). For this study, the latter was perceived to be adequate for that purpose.

3.7 Data Presentation

Research data can be massive and challenging to analyse and represent the results, and often it even becomes challenging to know how best to portray the results. It is from this viewpoint that it is better to deploy various forms of descriptive representation and/or presentation such as; pie charts, histograms, graphs and tables. It is on this grounds that graphic descriptive data is popularly utilised for easier interpretation and visibility, hence the same have been used in this study.

3.7.1 Data Analysis Procedure

This study data analysis occurred sequentially, the study sequentially followed separate data analysis processes and techniques for each data set. Quantitative was collected using a questionnaire, it was analysed first and qualitative data followed after. Data was cleaned, coded and analysed then meta-analysis used to identify convergence and divergence. Meta-analysis allowed for identification of common patterns across variations, allowed for comparisons and contrasts, similarities and differences to be identified where they existed. Data comparison enabled the merging of results (Creswell & Clark, 2017). In this study, the qualitative data provided insight and interpretation of the quantitative data results.

IBM SPSS is considered an effective software for analysing quantitative data, therefore, the quantitative data obtained through questionnaires that were collected from the different groups of respondents was carefully

categorised, cleaned, coded, and captured for descriptive statistical analysis to numerically understand phenomenon from responses to questionnaire.

NVivo was used for qualitative data to generate codes and themes (Kriukow,2020; Field, 2013). The data was transcribed, carefully coded and uploaded into NVivo12 for auto-generation of codes and themes. Thematic analysis was also done manually develop and establish themes to get an interpretive understanding of how supervision is being experienced by respondents. Thematic and qualitative content analysis techniques were considered suited (Moustakas, 1994).

Suffice it to say that for easier and timely data analysis SPSS and NVivo software were used, IBM SPSS for quantifiable data and NVivo12 for narrative data to establish patterns, codes and word cloud themes. Descriptive tables and graphs were generated and representative of the data input into IBM SPSS version 26.1.

Data analysis process and procedure included data cleaning, importing the data, naming variables, checking the accuracy, coding and examining missing data (Daniel, 2021; Kriukow,2020). Descriptive statistics frequencies and percentages were used to understand research variables; knowledge of clinical supervision, attitudes towards practices of supervision, principles used, their practice and strategies for improvement of clinical supervision. The study followed the underpinning theories; the social constructivist theory helped to understand that the data collected from participants were based on lived experiences and hence caution on using data coding to protect participants' privacy, and anonymity.

The process was through theoretical lens of underpinning theories of this study that purports an individual is influenced by their intention and subsequently influence perceptions, perceived control beliefs, on attitudes towards the behaviour and subjective norms; thus, the counsellors' intentions to perform, access, provide and have the desire to know more about the clinical supervision intervention.

The data analysis procedure and all the study processes were grounded on the theoretical framework that also facilitated understanding of counsellors' and supervisors' behaviour towards clinical supervision across different environmental settings. Clinical supervision herein is perceived as a planned behaviour. Under this

consideration, the study captured and analysed data in line with variables, examining the knowledge, attitude and practices of CS given perceived behavioural norms and perceived behavioural control.

This was intended to better understand what knowledge, attitudes and practices of CS were present, and if their practice of the intervention was influenced by their perceived behavioural control because the literature shows that knowledge, attitudes and competencies could influence the motivation and intention to perform the planned behaviour (CS). As Ajzen (1991,2006) opined, human behaviour is often inspired by various factors such as; perceived benefits to be derived or consequences and past experiences associated with the planned behaviour in consideration of "behavioural beliefs and "normative beliefs" influenced by normative expectations, the behaviours and expectations from significant individuals. Therefore, according to TPB, behavioural beliefs may be favourable or unfavourable, positive or negative towards the planned behaviour, and if positive, chances act on the planned behaviour or do the opposite if the behaviour is negatively perceived as influenced by behavioural beliefs, perceptions and attitudes.

Similarly, normative beliefs may lead to perceived social pressure (subjective norm) whilst control beliefs may trigger perceived behavioural control, self-efficacy and the perceptions that one has of the confidence and competence to diligently execute the expected behaviour; in this case clinical Supervision. Suffice it to say, that attitudes towards behaviour and subjective norms influence perceptions one has on behavioural control and individual's intention to perform the behaviour in question.

This understanding of the underpinning theories and purpose guided questionnaire development and semi-structured interview guiding questions utilised in this study data collection (Ajzen, 2006).

The data analysis procedure was also underpinned by the social constructivist theory and therefore qualitative data was analysed with this in mind, through interviews respondents shared their lived experiences, and were given a voice and an opportunity to construct their meaning of the phenomenon as only experienced and understood by them first hand hence the use of open-ended questions in semi-structured interviews (Guiffrida, 2015).

3.7.2 Limitations of the Study

Credibility of data may have been the major limitation because both data sets were self-reported and obtained through self-administered questionnaires and self-reporting through an interview. According to the literature, it is common that information derived from self-reporting is prone to data bias as participants control the amount and nature of information to disclose, as such the data given may have been influenced by several factors such as how much they were willing to genuinely disclose and how they perceived the national benefits of the study. Therefore, there could have been other influencing factors and variables. The other possible limitation could have possibly been the population sample size and that may have impacted the generalizability. Similarly, the researcher's background as a professional counsellor trained in counsellor supervision and having to interview other counsellors could have possibly clouded objectivity.

Convenient purposive sampling was used in this study targeting specifically practising counsellors and supervisors, therefore the use of convenient sampling and purposive selection of geographically accessible districts to draw participants from for this study excluding the remotest inaccessible areas was another possible limitation. These limitations may have had implications on the outcome of the study. Drawing a larger sample population size and including inaccessible remote districts may have possibly led to different outcomes.

Purposive selection of respondents who met clearly defined and predetermined criteria such as the years of experience, specified age limit, specific experience of the investigated phenomenon and having to be based in a specified location may have contributed to the exclusion of other significant groups such as the beneficiaries of the outcome of clinical supervision, those who receive services from supervisees.

Another possible limitation could have been sample bias from the use of purposive sampling and snowballing. This could have affected the representativeness of the sample, therefore, sample size limitation, data collection bias and sample bias were possible limitations (Petrovski & Pestana,2017).

3.7.3 Delimitation of study

The research design; conceptual framework, methodology, research topic, research questions and target population provided the necessary delimitation parameters and guided instruments. The study purposefully targeted a specific group of professionals (practising counsellors) who possessed specific characteristics as

research respondents as they had the potential to provide relevant and much-needed data. The use of the two methods; quantitative and qualitative was intentionally meant to achieve depth and breadth in this mixed methods study and give a balanced perspective of the phenomenon being researched.

The recruitment of participants from different counselling environmental settings rather than drawing from one particular sector was considered a strength and a delimitation aspect that also created the generalizability and replicability of the study. The sample size was also deemed adequate for saturation.

Summary

Gave description of method, population sample size, characteristics of respondents and the sampling techniques used. The section also described the instrumentation; the type of research tools (questionnaire and semi-structured interviews), operational definitions of variables, construct variables, study procedures, ethical assurances; confidentiality, privacy, data protection process, procedures was given of sequential phases of research in data, and role of researcher in the study. The limitations and delimitations of the study and how the underpinning theories guided the whole research process were also herein articulated.

The next chapter discusses the research findings from the two phases, a comparison of the two datasets, results discussion, implications, recommendations for application and future research.

CHAPTER 4: FINDINGS

Chapter Introduction

Mixed method study investigated Knowledge, Attitudes and Practices of Clinical Supervision (CS) among counsellors in Botswana. Since counselling is a fairly new phenomenon in the country, existence of CS in the counselling profession in Botswana though a crucial aspect recognised internationally and mandatory in most parts of the world is lagging. This study aimed to determine the level of CS access, determine counsellors' knowledge, examine their attitudes towards clinical supervision, determine practices, investigate ethical principles guiding counsellors' clinical practice and the strategies towards improving the practice. To achieve this purpose, literature was explored to establish the amount of work already done locally and globally in the field. Suffice it to say local literature only revealed the existing dearth of empirical data regarding this phenomenon despite available extensive international literature. There is an evident information deficit on the practices of clinical supervision among counsellors across mental health professions in Botswana. The only available literature is conference and seminal material presented in international conferences by a few lamenting the state of counselling and the missing CS intervention and questioning the quality of counselling services offered in the absence of the CS practice.

World Health Organization ([WHO],2010) conducted a survey involving 147 and established that CS was only practised in 43.5% of the countries whilst in some countries there was no supervision offered. The least supervision was offered in Africa by only 28.8% of countries. This was not surprising as most African countries fall within the low-income economic classification with very few within the middle-income category, therefore they lack "human resources to provide regular supervision". The World Health Mental Health Atlas (2020), reported that in 2019 suicide accounted for an estimated 703,000 deaths worldwide and 11.2% of them were from Africa.

WHO Mental Health Atlas ([WHO],2017) estimated suicide rate in Botswana was 9.3% in 2017, and 16.1% in 2023 per 100,000 people whilst the World Population Review (2023) reported that in 2023 26.3% of reported suicide deaths in Botswana were male. Considering Botswana's small population of approximately

2.2 million, these percentages are alarming. The same report states that only 4 (11%) of African countries reported having suicide prevention programmes and according to Hall et al. (2015), burnout among clinical psychologists working in low-income countries has been reported, yet CS support structures are not available in such countries despite empirical research supporting the benefits of CS for the effectiveness of counsellors, clinical self-care and reduction of burnout among mental health service providers (Morgan & Sprenkle,2007).

Findings begins by discussing the trustworthiness of the data being presented and what strategies were used from the inception of the study to data analysis. Also discussed is the development of data collection tools, research approvals, data collection approvals, validity and reliability of the instrument as well as ethical research assurances, how risks were reduced towards research participants and ethical reporting of research findings. Validity and reliability of research, overall credibility and usefulness of the research were at the centre of the research processes in this study (Zohrabi,2013). To ensure the credibility of the study findings, appropriate activities "fitting" to the methodology, research design, capturing and analysis were deployed.

The presentation begins with quantitative followed by qualitative data. The results are organized by research questions starting with demographic profiles. The presentation of the findings was guided by these that also guided the whole research:

Q1. What is the level of clinical supervision access by counsellors in Botswana?
Q2. What is the knowledge of counsellors towards clinical supervision in Botswana?
Q3. What is the attitude of counsellors toward clinical supervision in Botswana?
Q4. What is the practice of counsellors towards clinical supervision in Botswana?
Q5. What are the ethical principles that guide counsellors in Botswana?
Q6. What are the strategies towards improving clinical supervision in Botswana?

4.1 Trustworthiness of Data

Trustworthiness of data depends largely on the ability to meet the set methodological and ethical research standards of practice, it is linked to research ethics and has a lot to do with credibility, appropriateness of research methods, application of suited research design, and the validity and reliability of the study (Nowell et al.,2017; Rallis & Rossman,2009). Trustworthiness also has to do with data being collected ethically, logically, transparently and systematically conducted with clearly formulated procedures and appropriate approaches resulting in authentic, credible and beneficial findings representative of the reality and experiences on the ground, representative and adequately relating to the experiences of the research participants. Therefore, the approaches utilized in this study rendered the study findings trustworthy. Literature shows that there are various strategies to ensure the trustworthiness of research such as; triangulation of data, methods, and theories, as well as validity, reliability, time awarded to data collection and analysis process, credibility, rigour and ethical reporting.

4.1.2 Triangulation of Methods, Data and Theories

This study followed well-documented, acceptable and appropriate ethical research procedures and protocols to ensure trustworthiness. Research methods, research questions, research design and theoretical framework gave an in-depth outline description of the research processes and triangulation, theories, tools, data techniques further ensured trustworthiness. The triangulation of methods and data collection instruments eliminated reliance on a single data source and single paradigm. Examining the phenomenon from different lenses enabled data triangulation and enhanced trustworthiness.

Triangulating methods (QUAN-Qual) were meant to enhance the trustworthiness of the study findings as the methods addressed any inherent limitations in either one of the two. Similarly, predetermined choices of appropriate data analysis techniques as well as triangulation of research methods and data collection instruments were also intended to address the trustworthiness of data.

The data triangulation allowed for corroboration and validation of results, and was beneficial for addressing inherent weaknesses as each data set could strengthen the other and in so doing validity. Method triangulation, data triangulation and theoretical triangulation strengthened the outcomes of the study as it was viewed from multiple perspectives and limited biased interpretation of the study results likely to happen when using a single research method (Bryman,2006a; Denzin, 2010,2012; Ryan,2021). Denzin (2012,2010,2007), opines that theoretical triangulation allows the use of multiple theories in investigating a phenomenon as it allows for exploration of a phenomenon through differing lenses; from opposing philosophical stances, and the more divergent the theories the more likely to identify different issues in the study.

4.1.3 Credibility

As earlier stated, the study sample was counsellors recruited from different counselling settings that produced data from multiple sources. This enabled data triangulation to ensure data credibility by not relying upon a single data type; for the data to be representative of mental health service providers in Botswana, it had to come from diverse counselling environmental settings with practising counsellors to determine the knowledge, attitudes and practices of clinical supervision among counsellors across the different sectors and establish uniformity in the clinical supervision practice. Therefore, recruiting respondents from varied environments provided the needed corroboration, validation and elucidation of data to further build trustworthiness and make the study findings credible and possibly transferable, generalizable and authentic.

Regular consultations with the project supervisor and peers through doctoral research groups provided feedback, a learning forum and an audit trail platform for the improvement of the study to further ensure the credibility of the research processes and research findings.

4.1.4 Dependability

To ensure trustworthiness, the study had a logical, concise research process with clear research questions, objectives, research design, theoretical framework, data collection and data analysis techniques clearly outlined to guide the whole research process. Each process was cross-checked, verified and thoroughly checked by the research project supervisor.

The intended approaches for exploring the phenomenon were very clearly laid out, and ethical research ethics standards were maintained. With the Quantitative research approach, trustworthiness was anchored towards ensuring the validity and reliability of the processes; the data collection tool was pre-tested for validity and reliability, and the appropriateness of the instrument was assessed by the research supervisor and revised until deemed fit for use and authenticated by UREC.

Similarly, the research design and data analysis techniques were submitted for approval before utilization. In the collection of qualitative data, trustworthiness was addressed by having clear evidence, traces and elements of transferability, credibility, dependability and conformability in the research; attention was not only given to the validity, reliability and but to rigour of the quantitative data. Giddings and Grant (2009) assert that, in mixed-method research, trustworthiness is about validation of data, reliability, credibility, appropriateness of methods, instrumentation and the integrity of the whole research process.

Rigour means different things in approaches; the rigour is all about used data collection, whereas in the qualitative method, rigour is about the trustworthiness of the study; whether the research was ethically conducted and if the findings closely represent the experiences of the research participants. There are different principles used for determining rigour in quantitative and qualitative studies, hence in this mixed methods research, these were addressed separately (Bryman,2006b,2008b; Saxby,2016).

The dependability of this research was secured through adopting mixed methods; data ensured dependability as it allowed for corroboration. Dependability was also secured through audit trials; peer checks through doctoral group feedback, supervisor feedback and triangulation; all of which helped to enhance the study findings (Anney,2014; Nowell et al.,2017; Peel,2020).

4.1.5 Ethical Research and Reporting

Research participants were briefed on nature, significance, issues of confidentiality and consented by signing Form as a way of agreeing to take part in the study. There was adherence to counselling Research ethics ([ACA],2014, p.15-16).

Similarly, data collection approvals were sought and obtained from UREC, local authorities and organizational gatekeepers before the data collection process. Respondents were not coerced, deceived or given any monetary incentives; participation was purely anonymous.

Respondents were made aware of the implications and assured of confidentiality. Therefore, they willingly gave their consent to take part in the study. Participants were also made aware that they were at liberty of not participating if they so wished, and were assured that, in the event they chose to withdraw, their data would be deleted and excluded from the study.

The identities of all participants were not disclosed in the research findings and reporting. Data coding was maintained on SPSS for the anonymity of participants; therefore, responses could not be linked to any specific respondent; was maintained in qualitative data and in reporting the research findings (Bryman,2009; Rallis & Rossman,2009).

Trustworthiness of the study in data reporting also had to be secured through authenticity, data triangulation, and credibility through multiple peer-checking, research groups, constant meetings and consultations with the research supervisor, whilst transferability of authentic data reporting was ensured for the target population to be able to relate and compare their lived situations to the research findings (Bryman,2008a; Petrovski & Pestana,2017).

The use of appropriate approaches, research design, conceptual framework, constant consultation and engagement with the research project supervisor, and research council as well as obtaining informed consent from the research participants before data collection was deployed to ensure credibility, ethical research practice and research integrity. There were no risks involved towards respondents and no use of deception. Integrity in research; especially in reporting is very essential for confirmability. Conformability implies the ability to rely on data to make interpretations without allowing the researcher's beliefs, and assumptions to influence the reporting; it allows a clear demonstration of how conclusions were reached based on the data.

Since conformability is equally linked to credibility, dependability and transferability, the study's auditability or audit trial was secured through the use of peer checks, and incorporating the feedback from the research supervisor, doctoral research groups and progress update reports to the UNICAF University School of Doctoral Studies. Similarly, for conformability, research processes were adequately articulated; methods, theoretical framework, procedures, techniques instrumentation for collection.

Methodological limitation could be attributed to the fact that certain aspects were not easily quantifiable, and the sample size could have possibly impacted the credibility of the data since data was derived from the use of a self-administered questionnaire and self-reports from the interviews. All these had possible implications as the data given depended largely on what the respondents chose to share with the researcher; it is a well-established fact that self-reporting has inherent biases that could easily influence the outcome of the data and findings.

Questionnaires were well structured and it is a known fact that closed-ended questions tend to be limiting as are designed from the researchers' positivist paradigm with researcher-provided responses for respondents to choose from using the Likert scale. Therefore, in both data sets, respondents' authenticity or lack thereof, willingness and desire to give genuine information could have influenced the outcome of the study one way or the other.

The study population sample size may have possibly affected the potential to generalize the study to a larger population, but instead may only be generalizable to the sample groups from which the participants were selected (practising counsellors). Similarly, the researcher's professional and academic background may have somehow impacted the study as a trained clinical supervisor and a practising professional counsellor; these characteristics could easily have clouded the researcher's objectivity and affected the data analysis and results. The use of convenient sampling and snowballing could have also had implications for the study (Choy,2014; Heinrich & Klein, 2021; Petrovski & Pestana,2017).

These possible limitations were addressed through delimitation approaches derived from the use of mixed methods, consultation with supervisors and peers, thorough scrutiny of data capturing, data cleaning and data analysis, deployment of appropriate data analysis techniques and data collected methods, seeking expert advice, triangulation of theories to view the phenomenon from different perspectives and review of literature. Introspection and regular reflection on the possible influence of the researcher's beliefs, values, and epistemological paradigm and assumptions were also done as a delimitation aspect (Bryman,2006a,2008a).

4.1.6 Prolonged Period for Data Collection

There was a prolonged period enough awarded towards the whole process as the districts selected for the data collection process were geographically vast apart. The amount of time allocated for the preparatory process for data collection and the actual data collection exercise was from July 2022 to February 2023, and this gave enough time for a credible, ethical and proper data collection process. This prolonged time of data collection helped to minimize errors and provided adequate time.

The time frame helped to avoid a rushed and flawed research undertaking. During the whole process, a codes notebook and journalling of the processes and stages were kept to ensure an ethical and credible systematic process. Similarly, a tentative schedule for data collection was drafted and sample frames were well tabulated to avoid a haphazard process.

4.2 Statistical Assumptions

There are various common assumptions associated with statistical tests including the issue of independent observation where observational methods are used, though this study did not use the observation method for data collection, this assumption was deemed not applicable. However, the assumption was that the instrument was self-administered under similar conditions with the respondents answering the questionnaire in their respective sites. Similarly, the pilot study respondents were independent of questionnaire participants. Moreover, the questionnaire was administered in different environmental counselling sites and districts, and

this was done to ensure that participants did not influence each other's responses to the questions. It was important to eliminate the possibility of group influence on the study results.

Interviews were conducted separately and respondents engaged independently from others. The interview respondents had not participated in the questionnaires or the pilot study to avoid data bias. Moreover, individuals were interviewed at separate scheduled times by telephone and where possible in a face-to-face setting in their respective counselling sites. Due to this arrangement, there was no respondents' influence on each other on how to respond to the interview questions.

The statistical assumption of homogeneity of variances was considered to be only applicable in situations where there was a need to compare data from various groups, therefore was not considered applicable in this study. The assumption was that the characteristics of respondents answering the questionnaire were similar and it was taken under similar conditions, whilst for qualitative data collection the respondents were supervisors with similar characteristics. The variables' constructs were tested using the Cronbach's Alpha test which confirmed the internal consistency of the questionnaire. Likert responses were provided for the questionnaires and presented a high possibility of influencing the respondents' answers, this could be considered a weakness synonymous with surveys, however, to address the issue, the instrument language was scrutinized for appropriateness and used the language familiar to practising counsellors regardless of location and district.

To ensure data quality, anonymity and transparency in data coding were used to protect respondents' privacy. The data coding also enhanced the validity of the research data. Data interpretation has the potential to be affected by the researcher's competency in interpretation, computation errors, and misinterpretations may be challenging to identify if the researcher's data analysis skills are handicapped. Hence data scrutiny for errors, missing data, and incomplete data had to be consistently done and accordingly resolved. To ensure data quality and accurate interpretation, there was a need for a series of reviews and revisions based on the feedback from peer research groups, professional experts and the project supervisor (Choy, 2014; Heinrich & Klein,2021).

This study had two hundred and forty-eight respondents; 210 for quantitative and 38 for qualitative and the sample was considered adequate considering the diverse environmental settings they were drawn from and the small population of the country. Limited resources may have influenced the study as resources have the potential to render large-scale research impossible. Similarly, limited data analysis competencies had the potential to affect data analysis evaluation, however, it was addressed through regular consultations with the research supervisor and other skilled research mentors (Heinrich & Klein,2021).

The qualitative data collection process was time-consuming as should be expected. Therefore, extra caution was paid to avoid overlooking any significant aspect of the process. However, since human error in the interpretation of data is always a possibility where there are limited computation skills, more attention was given to the process.

There was possible research bias due to the researcher's background; personal professional experiences, knowledge and training as an educator, counsellor, qualified and practising therapist and clinical supervisor, so these characteristics had the potential to influence interview, data collection, interpretation of data and conclusions. Respondents controlled the amount of information to disclose in the open-ended interview and qualitative data analysis proved to be a time-consuming exercise with a series of activities such as interviews, categorizing data, data transcribing, data cleaning, developing codes and establishing themes as well deploy qualitative content analysis (Choy,2014).

4.3 Reliability and Validity of Data

Quantitative data results informed the qualitative semi-structured interview questions and the qualitative results added complementarity, corroboration and explanatory aspects to the study; from the constructivist interpretive stance.

Questionnaire instrument was tested for validity and internal consistency using Cronbach's Alpha before data collection, the tool was reviewed and refined several times until it was considered suitable for use and

approved by the UNICAF University Research Council (UREC). It was also checked by relevant local gatekeepers and authorities before being allowed.

4.3.1 Validity

Bajpai and Bajpai (2014) assert that validity should be understood from the context of assessing and measuring the quality of a study, and be seen as a measurement of a research tool and what the said instrument claims. Validity can be Internal or External; Internal validity measures what instrument is intended, whilst external validity is concerned with the generalizability of study findings to the target population. Both Internal and External validity are important for establishing the benefits, innovativeness, usefulness and meaningfulness of the research findings.

The content validity was assessed through multiple assessment reviews and checks by the research supervisor, professionals in the field of counselling and academic peers. The process ensured that the questions used in the questionnaire and the Likert scale Responses were representative, appropriate and consistent with the content construct being investigated and adequate to measure the concept before being used in data collection (Bolarinwa,2015; Drost,2011; Onwuegbuzie & Johnson,2006). All these processes were intended to achieve content validity in measuring the construct of clinical supervision. Therefore, through expert advice and judgment; peer input, the research supervisor's expert advice, and research questions that were considered ambiguous were corrected or deleted, and through the same process face validity was met.

4.3.2 Reliability

Reliability addresses the overall consistency of a research study's measurement instrument. Reliability was tested for the data collection instrument before it was used for quantitative data collection. The instrument was tested using Cronbach's alpha. According to Wyllie (2018, p.7), "reliability refers to the consistency or dependability of a measurement technique and/or instrument; it is concerned with the consistency and/or stability of the score obtained from a measure", whether the instrument is reliable in testing what it is intended to measure.

Test-retest was used to assess the reliability of the instrument at the pilot phase to assess how reliable the instrument was, and whether it would produce similar results if repeated under similar situations on the same sample within a set space of time interval; not too soon after the first administration, and not too long a duration after administration to the population sample. The Pre-test took place before using the instrument. “It is important in research for an instrument to be valid as well as reliable; if it does not measure what it purports, then it is not valid, and if it cannot produce similar results when re-tested upon the same sample it is not reliable, both attributes are essential for dependability of the study” (Wyllie,2018). It is upon this understanding that the questionnaire used in this study was developed under Ajzen's (2006) guidelines on how to develop a theory of planned behaviour questionnaire and the step-by-step guidelines on designing KAP (knowledge, Attitudes and Practice) surveys and questionnaires by Andrade et al. (2020); OECD (2012) and USAID (2011) and piloted on a small sample population of thirty-six (36) counsellors. The responses were computed to test for the validity and reliability of the instrument before data collection on IBM SPSS 26.1 using Cronbach’s Alpha. According to Taber (2016) and Tenuche (2018), any instrument with .70+ is considered a good measurement of reliability.

The Alpha in this study is between .728 and .924; the reliability analysis yielded high alpha results of $\alpha = .92$, indicating adequate level of reliability. In measurement, certain issues may compromise the validity and reliability of measurement and possibly affect the whole study, such as; systematic errors arising from poorly developed questionnaires.

Therefore, the study instrument underwent a series of checks, reviews and thorough assessment by the research supervisor and by UREC until it met the recommended standard. Random errors were prevented by keeping journals, reports, and the code book, data cleaning, accurate data capturing, data checking, recording every questionnaire that arrived, cross-checking entries on SPSS and appropriately coding “missing data” (Bryman,2009). Similarly, the instrument piloting was administered under similar conditions.

The presentation of the quantitative data results starts with the demographic background of the research participants.

4.4 QUANTITATIVE ANALYSIS

Descriptive statistics was the first to analyze quantitative data gathered through the questionnaire from 210 participants, this process was performed on each study variable, The data was first cleaned, coded and scrutinized for missing values before performing descriptive analysis to establish frequencies and percentages. The questionnaire also gathered relevant background information of research participants such as gender, age, number of years of experience, the highest level of education, professional field, district location and counselling environmental setting. This data was significant for providing contextual information about the respondents.

4.4.1 Descriptive Statistics

Demographic Data

Table 2

Descriptive Demographic Data Showing Characteristics of Participants: Gender, Age, Years of Experience, the Highest level of Education, District, Counselling Environmental Setting and Professional Field of Expertise (N=210)

Variable		***N***
GENDER		*210 (100%)*
MALE	*48 (22.9)*	
FEMALE	*162 (77.1)*	
AGE		
25-35	*60 (28.6)*	*210(100%)*
36-45	*71(33.8)*	
46-55	*62(29.5)*	
56-65	*17(8.1)*	
Years of Experience		
3-10	*110 (52.4)*	*210(100%)*
11-15	*61 (29.0)*	
16-20	*16 (7.6)*	
21-30	*18 (8.6)*	
31-40	*5(2.4)*	
Highest Level of Education		
1.Certificate	*1(.5)*	*210(100%)*
2. Diploma	*12(5.7)*	
3. Bachelors'	*145 (69.0)*	
4. Masters'	*44(21.0)*	
5. Doctorate	*8(3.8)*	

District		
Central	*36(17.1)*	*210(100%)*
Kgatleng	*27(12.9)*	
South-East	*57(27.1)*	
Kweneng	*25(11.9*	
South	*65(31.0)*	
Counselling Environmental Setting		*210(100%)*
Governmental Institution	*9(4.3)*	
NGO	*35 (16.7)*	
Private Practice	*14 (6.7)*	
Private School	*10 (4.8)*	
Public School	*125 (59.5)*	
Tertiary Institution	*17(8.1)*	
Field		
Counselling	*57(27.1)*	*210(100%)*
Early Childhood	*7(3.3)*	
Guidance & Counselling	*49(23.3)*	
Humanities	*26(12.4)*	
Primary Education	*24(11.4)*	
Psychology	*25(11.9)*	
Social Work	*22 (10.5)*	

Table 2 shows the characteristics of the quantitative research study participants; the frequencies and percentages of the participants by Gender; (48,22.9%) Males and (162,77.1%) females. A significant percentage of the questionnaire respondents was female, a small percentage was male, though the option; "prefer not to say" was provided none of the participants chose that option. The table also shows the age range, years of experience, the highest level of education, the respective Districts participants were drawn from, their counselling environmental settings and the field of expertise.

Table 2 further shows participants' years of experience in frequencies and percentages, Participants' years of experience in counselling differed; a significant number (110,52.4%) of counsellors reported having 3-10 years of experience, (61,29.0%) reported having 11-15 years of experience. Similarly, (18,8.6%) of counsellors reported having 21-30 years of experience, whilst (16,7.6%) indicated having 16-20 years of experience. The lowest number came from a bracket of 31- 40 years of experience with (5,2.4%).

Table 2 further shows participants' education from Certificate, Diploma and Doctorate. As can be seen from the table, the lowest level of education was a certificate (1,.5%), whilst the highest level of education reported was a doctorate (8,3.8%). The majority (145,69.0%) of counsellors reported having a Bachelor's degree and

(44,21.0%) of counsellors reported having a Master's degree. The table also shows descriptive data on the location of participants from which they were recruited per each of the 5 sampled districts. A significant number of counsellors came from the South District (65,31%), followed by the South-East District (57,27.1%), Central District (36,17.1%), Kgatleng (27,12.9%) and the least participation came from Kweneng with (23,11.9%) participation.

Regarding counselling environmental settings, a significant number of participants came from public schools (125,59.5%), followed by NGOs (35,16.7%), whilst the least came from governmental institutions (9,4.3%).

Participants' areas of speciality revealed various mental health professions offering counselling services. The areas included counselling (57,27.1%), Guidance and Counselling (49,23.3%), Psychology (25,11.9%) and Social Work (22,10.5%). Some reported being from the educational field; such as Early-Childhood-Education (7,3.3%), Humanities (26,12.4%) and Primary Education (24,11.4%).

It can be concluded from Table 2 that there were more female participants than males and that the majority of respondents were trained in mental health-related professions, particularly in Counselling, Guidance and Counselling and Psychology with more than three years of experience who participated in the study from 5 districts.

Figure 11 also gives the visual descriptive representation of the demographic information capturing all the necessary attributes and categories.

Figure 11

Participants' Demographic Data: Field, Years of Experience, District, Level of Education, Age, Environmental setting and Gender (N=210)

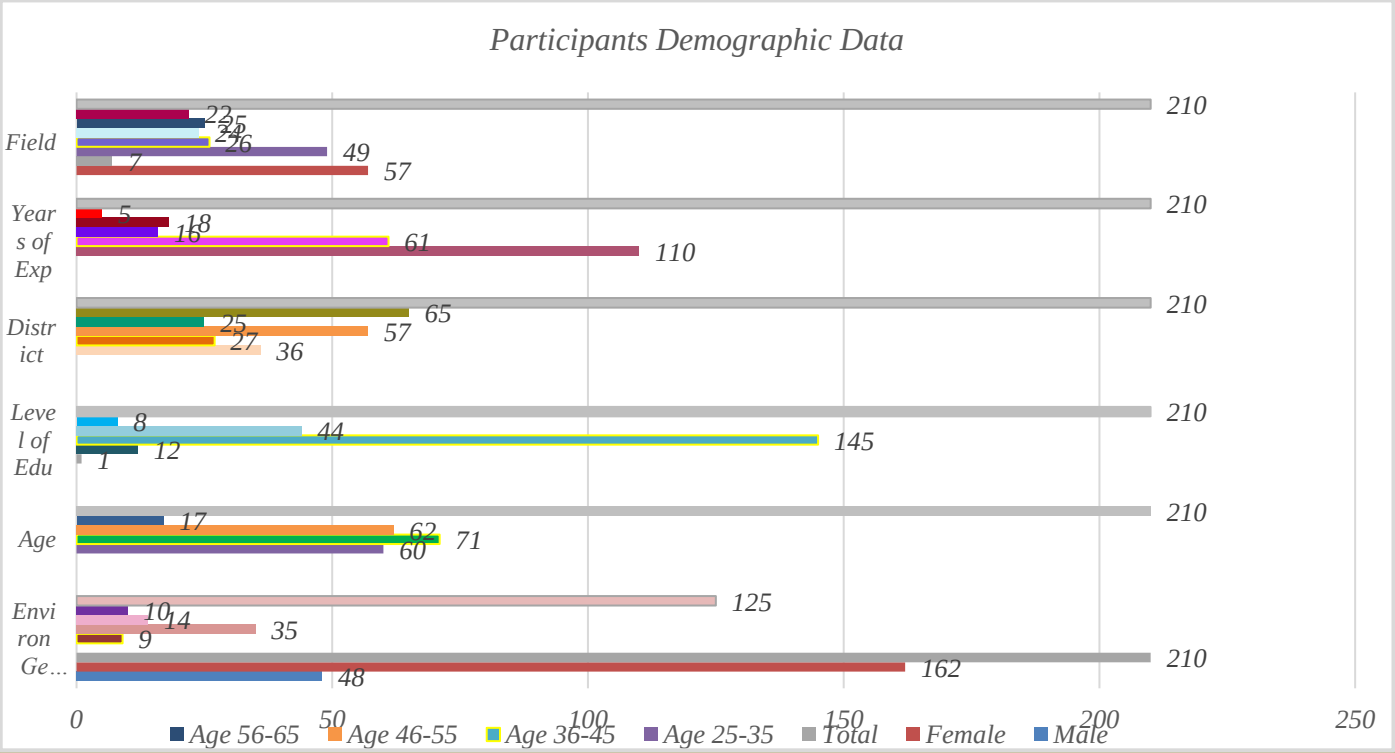


Figure 11 mirrors Table 2 and shows that the largest number of participants came from the millennials age bracket 36-45 years old (71,33.8%), followed by Generation Z and X age group 46-55 (62,29.5%) and 25-35 years (60,28.6%) respectively. The least participation came from the Baby Boomers age group (17,8.1%). The majority of the participants were largely a combination of the Millennials, a few from Generation X and Generation Z with a total of (91.9%) combined (Beresford Research,2023; Hecht,2023,2022; Colby & Ortman,2014; Wikipedia,2023).

Having established the demographic characteristics of the participants, the questions that followed were geared towards establishing participants' level of access to CS, their CS knowledge, their attitudes toward clinical supervision, their practice of CS, their guiding ethical principles and possible strategies they thought could improve the Clinical Supervision practice in the country. This was done by presenting one research question after another as the results are portrayed below.

4.4.2 RESEARCH QUESTIONS

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

Table 3

Descriptive Data on Participants' Level of Access to CS in Frequencies and Percentages (N=210)

Item	*Strongly Disagree*	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*
1. I have access to clinical supervision at my workplace	*48(22.9%)*	*22(10.5%)*	*91(43.3%)*	*28(13.3%)*	*21(10%)*
2. I only have access to clinical supervision once a year	*79(37.6%)*	*40(19%)*	*81(38.6%)*	*5(2.4%)*	*5(2.4%)*
3. My clinical supervision session takes 60-90minutes	*36(17.1%)*	*45(21.4%)*	*93(44.3%)*	*29(13.8%)*	*7(3.3%)*
4. I only have access to individual supervision	*101(48.1%)*	*46(21.9%)*	*35(16.7%)*	*17(8.1%)*	*11(5.2%)*
5. I have access to group supervision only	*103(49%)*	*57(27.1%)*	*32(15.2%)*	*9(4.3%)*	*9(4.3%)*
6. I only access peer-to-peer clinical supervision	*41(19.5%)*	*34(16.2%)*	*111(52.9%)*	*17(8.1%)*	*7(3.3%)*

Significant percentage (91, 43.3%) of participants chose to be neutral, whilst (70,33.4%) indicated not having access to Clinical supervision at their workplace by selecting "strongly disagree" (48,22.9%) and "Disagree (22,10.5%), only a few counsellors (49,23.3%) confirmed having access to CS at their workplace by choosing "agree" (28,13.3%) and "Strongly Agree" (21,10%).

On the issue of annual access to clinical supervision, the majority of counsellors (119,56.6%) disagreed with accessing CS once a year, (79,37.6%) selected "strongly disagree" and (40,19%) chose "disagree", (10,4.8%) agreed; (5,2.4%) and strongly agreed (5,2.4%) to accessing Clinical Supervision once annually, whilst (81,38.6%) remained neutral. A significant percentage (99,44.3%) chose to remain neutral on the issue of duration of their CS session, whilst (81,38.5%) disagreed, and only (36,17.1%) confirmed having a Clinical Supervision session lasting between 60-90 minutes in duration.

A significant percentage (70.0%) confirmed not accessing individual CS, (101,48.1%) chose “Strongly Disagree” (46,21.9%) chose “Disagree”. However, (35,16.7%) chose to remain neutral, whilst a small percentage (28,13.3%) agreed to access individual Clinical Supervision.

Table 3 also shows participants’ information regarding access to group supervision. A significant number (103,49.0%) of counsellors “strongly disagreed” with accessing group supervision, and (57,27.1%) “disagreed”; giving a total of (160,76.1%). Only (18,8.6%) reported having access to group supervision, whilst (32,15.2%) were neutral. A significant number (111,52.9%) of participants chose “Somewhat agree/Neutral” on the issue of peer-to-peer CS, (41,19.5%) chose “strongly disagree”, (34,16.2%) “disagree”, whilst only a very small number “strongly agreed” (7,3.3%) and “agreed” (17,8.1%) to accessing peer-to-peer clinical supervision.

It can be concluded from Table 3 that the level of access to Clinical Supervision by counsellors in Botswana is extremely low or poor.

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

Table 4

Descriptive Data Summary of Participants' Knowledge of Clinical Supervision (N=210)

Item	*Strongly Disagree*	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*
1. I have knowledge of clinical supervision as a requirement in counselling.	*19(9%)*	*60(28.6%)*	*16(7.6%)*	*36(17.1%)*	*79(37.6%)*
2. I am trained in clinical supervision	*112(53.3%)*	*16(7.6%)*	*22(10.5%)*	*33(15.7%)*	*27(12.9%)*
3. I apply theoretical knowledge to client's real-life situations in supervision.	*74(35.2%)*	*33(15.7%)*	*41(19.5%)*	*29(13.8%)*	*33(15.7%)*
4. Am aware of confidentiality issues in clinical supervision.	*6(2.9%)*	*5(2.3%)*	*79(37.6%)*	*44(21%)*	*76(36.2%)*
5. I know how to competently address ethical dilemmas in supervision.	*61(29%)*	*44(21%)*	*31(14.8%)*	*34(16.2%)*	*40(19%)*
6. I know the importance of building rapport in clinical supervision.	*56(26.7%)*	*3(1.4%)*	*46(21.9%)*	*41(19.5%)*	*64(30.5%)*

Table 4 shows the number of counsellors' responses on the issue of knowledge of Clinical Supervision starting with CS as a requirement in counselling; training, theoretical application in practice, confidentiality, competency in handling ethical dilemmas and building rapport in CS. A significant number (115,54.7%) of counsellors "strongly agree" (79,37.6%) and "agree" (36,17.1%) to know CS as a requirement in counselling, (19,9%) "strongly disagree" and (60,28.6%) "disagree" to knowing, (16,7.6%) "somewhat agree" and/or were "neutral". Only (22,10.5%) chose to remain "Neutral" whilst, (33,15.7%) "Agreed" and (27,12.9%) "strongly agreed" to being trained in Clinical Supervision.

A significant number (112,53.3%) “strongly disagreed” and (16,7.6%) “disagreed” with being trained in CS; (128,60.9%) counsellors reported being untrained in clinical supervision, (62,29.5%) respondents reported having the ability or competency to apply theoretical knowledge to clients’ real-life situations in their clinical practice, (41,19.5%) chose to be neutral, whilst more than half (107,50.9%) counsellors chose “strongly disagree” (74,35.2) and disagree (33,15.7%).

Similarly, (76,36.2%) “strongly agreed” and (44,21%) “agreed” to be aware of confidentiality issues in clinical supervision giving a total of (120,57.2%) in agreement; whilst (79,37.6%) remained neutral and only (11,5.2%) “Strongly disagreed” (6,2.9%) and “Disagreed” (5,2.3%). The data shows a significant percentage (57.2%) of respondents indicated having an awareness of confidentiality in CS, whilst (37.6%) were neither aware nor unaware of the confidentiality issues in CS, and only a percentage (5.2%) disagreed with being aware. It can be concluded from Table 4 that the majority of counsellors are aware of confidentiality issues in clinical practice.

Table 4 further shows a significant number (61,29%) of respondents “strongly disagree”, (44,21%) “disagree” with having competencies to address ethical dilemmas in Clinical supervision, half of participants (105,50%) reported lack of competencies in supervision, whilst (34,16.2%) “strongly agree” and (40,19.0%) “agree” that they have the necessary competencies to address ethical dilemmas in clinical supervision, a total of (74,35.2%) counsellors admitted having relevant competencies to handle ethical dilemmas, leaving only (31,14.8%) of counsellors neutral; neither confirming nor disagreeing. Concerning knowledge of rapport building, half of the respondents (105,50.0%) were aware of the importance of rapport building, (41,21.9%) were neutral, whilst (59,28.1%) indicated not knowing the importance of building rapport in CS by choosing “Strongly disagree” (56,26.7) and “disagree (3,1.4%).

It can be concluded from Table 4 that the knowledge of Clinical Supervision among counsellors is limited and therefore they lack the competencies to apply theoretical knowledge in clients’ real-life situations.

Research Question 3: What is the Attitude of Counsellors Towards Clinical Supervision in Botswana?

Table 5

Descriptive Data of Participants' Attitudes Towards CS in Frequencies and Percentages(N=210)

Item	*Strongly Disagree*	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*
1. I believe clinical supervision enhances counselling skills.	*2(1%)*	*0(0%)*	*64(30.5%)*	*49(23.3%)*	*95(45.2%)*
2. I am interested in learning more about clinical supervision.	*3(1.4%)*	*0(0%)*	*2(1%)*	*111(52.9%)*	*94(44.8%)*
3. I believe clinical supervision is a good intervention.	*1(0.5%)*	*0(0%)*	*59(28.1%)*	*60(28.6%)*	*90(42.9%)*
4. I enjoy attending clinical supervision sessions.	*63(30%)*	*9(4.2%)*	*44(21%)*	*29(13.8%)*	*65(31%)*
5. I feel comfortable working with my clinical supervisor.	*76(36.4%)*	*35(16.7%)*	*32(15.3%)*	*32(15.3%)*	*34(16.3%)*
6. I don't like clinical supervision.	*151(71.9%)*	*45(21.4%)*	*5(2.4%)*	*2(1%)*	*7(3.3%)*

Table 5 shows that the majority of the counsellors (144,68.5%) believe that CS enhances counselling skills as indicated by their responses in choosing "strongly agree (95,45.2%) and "Agree" (49,23.3%), (64,30.5%) were neutral, whilst only (2,1.0%) "strongly disagreed". Therefore, an insignificant percentage (1.0%) of participants did not perceive Clinical Supervision as enhancing counselling skills.

Table 5 also shows that the majority (205,97.7%) of counsellors "strongly agreed" (94,44.8%) and "agreed" (111,52.9%) to be interested in learning more about CS, only (3,1.4%) "strongly disagreed", whilst (2,1.0%) "somewhat agreed" and/or were "neutral". Suffice it to say; that an overwhelming percentage (97.7%) of respondents confirmed having an interest in learning more about clinical supervision.

Data further indicates that a significant number and percentage (150,71.5%) of respondents believe that CS is a good intervention; (90,42.9%) chose "Strongly agree" and (60,28.6%) chose "agree whilst (28.1%) chose to remain neutral and only .5% percentage disagreed. Moreover, though (72,34.2%) respondents

disagreed and strongly disagreed to enjoying clinical supervision by selecting “strongly disagree” (63,30%) and “disagree” (9,4.3%), (44,21.0%) remained neutral, only (29,13.8%) agreed and (65,31%) “strongly agreed” to the statement. Hence, it can be concluded that many counsellors do not enjoy the intervention.

Similarly, half (111,53.1%) of the participants reported not being comfortable with their clinical supervisors;(76,36.4%) “strongly disagree”, (35,16.7%) “disagree”, (32,15.2%) remained neutral, whilst only (66,31.6%) agreed to be comfortable working with their clinical supervisors. Table 5 also shows that an overwhelming number (196,93.3%) of counsellors do not agree with disliking CS. This is evident in that (151,71.9%) “strongly disagree” and (45,21.4%) “disagree” whilst (5,2.4%) were neutral, and only a few (9,4.3%) “agree” (2,1%) whilst (7,3.3%) “strongly agree” to disliking clinical supervision.

It can therefore be concluded from Table 5 that there are positive attitudes towards clinical supervision among the majority of counsellors.

Research Question 4: What is the Practice of Counsellors Towards Clinical Supervision in Botswana?

Table 6

Descriptive Data Summary in Frequencies and Percentages of Participants' CS Practice (N=210)

Item	*Strongly Disagree*	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*
1. I am confident in providing clinical supervision.	*85(41.9%)*	*22(10.8%)*	*31(15.3%)*	*35(17.2%)*	*30(14.8%)*
2. I can use listening and paraphrasing skills.	*9(4.3%)*	*25(11.9%)*	*66(31.4%)*	*44(21%)*	*66(31.4%)*
3. Empathy and working alliance are important in clinical supervision.	*8(3.8%)*	*4(1.9%)*	*90(42.9%)*	*29(13.8%)*	*79(37.6%)*
4. I can use supervision skills within ethical and legal boundaries.	*9(4.2%)*	*86(41%)*	*32(15.2%)*	*39(18.6%)*	*44(21%)*
5. I can maintain eye contact and open body posture in sessions.	*4(1.9%)*	*6(2.9%)*	*83(39.5%)*	*36(17.1%)*	*81(38.6%)*
6. Can articulate and practice confidentiality in supervision.	*9(4.3%)*	*64(30.5%)*	*33(15.7%)*	*32(15.2%)*	*71(33.8%)*

Table 6 shows the number and percentages of participants who admitted to having the Confidence to provide clinical supervision to other counsellors. Half (52.7%) of the respondents admitted not having the confidence to conduct clinical supervision;(85,41.9%) selected "strongly disagree", whilst (22,10.8%) chose "disagree". (31,15.3%) chose neutrality, whilst (65,32.0%) agreed to have the confidence to provide CS by selecting "Agree" (35,17.2%) and "Strongly agree" (30,14.8%) respectively.

As can be seen in Table 6, more than half (110,52.4%) of the participants "agree" (44,21%) and (66,31.4%) "strongly agree" to having the skills, whilst only a few (9,4.3%) "strongly disagree" and (25,11.9%) "disagree". A good number (66,31.4%) chose neutrality.

Similarly, a significant number (108,51.4%) of respondents reported that they believe empathy and working alliance are important in clinical supervision; (79,37.6%) chose “strongly agree” whilst (29,13.8%) “agree”. (90,42.9%) remained neutral whilst a small number (12,5.7%) disagreed by choosing “strongly disagree” (8,3.8%) and “Disagree” (4,1.9%).

The table further shows that a good number (95,45.2%) of participants “strongly disagree” (9,4.2%) and “disagree” (86,41%) with having the ability to use clinical supervision skills within ethical and legal boundaries, whilst (32,15.2%) remained neutral, (83,39.5%) “strongly agree” (44,21%) and “agree” (39,18.6%) to have the ability to operate within the confides of ethical and legal practice. A significant cumulative percentage of 45.2% indicates that 95 participants reported not having the ability to use supervision skills within the ethical and legal boundaries, a cumulative percentage of (39.5%) shows that (44,21%) respondents “strongly agree” and (39,18.6%) “agree” with being able to use clinical skills adequately. Only (32,15.2%) counsellors chose to remain neutral.

Table 6 also shows that more than half of the respondents (117,55.7%) reported the ability to maintain eye contact and open body posture in their sessions, (83,39.5%) participants remained neutral, whilst only a small number (10,4.8%) “disagree” (6,2.9%) and (4,1.9%) “strongly disagree”. A significant cumulative percentage (55.7%) of respondents strongly agree and agree to have the ability to maintain eye contact and open body posture in their clinical supervision sessions. There is also a significant number (103,49.0%) of respondents who “strongly agree” (71,33.8%) and “agree” (32,15.2%) to have the ability to articulate and practice confidentiality in CS, whilst a cumulative (73,34.8%) disagree as (9,4.3%) chose “strongly disagree”, disagree (64,30.5%) and (33,15.7%) remained “neutral or somewhat agreed”.

It can be concluded from Table 6 above that there are poor and ineffective practices of clinical supervision among many counsellors as there is a lack of confidence and skills to provide CS.

Research Question 5: What are the Ethical Principles that Guide Counsellors in Botswana?

Table 7

Descriptive Data Summary on Ethical Principles Guiding Counsellors' Clinical Supervision (N=210)

Item	*Strongly Disagree*	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*
1. Protecting clients' issues and records in m practice is important.	*4(1.9%)*	*0(0%)*	*2(1%)*	*93(44.3%)*	*111(52.9%)*
2. I practice unconditional positive regard in my practice.	*4(1.9%)*	*2(1%)*	*60(28.6%)*	*62(29.5%)*	*82(39%)*
3. I am affiliated with a counselling regulating body/ Association.	*32(15.2%)*	*84(40%)*	*32(15.2%)*	*19(9%)*	*43(20.5%)*
4. I use the Botswana Counselling Association's ethical principles to guide me.	*53(25.2%)*	*75(35.7%)*	*30(14.3%)*	*23(11%)*	*29(13.8%)*
5. I use principles for a different regulating body/ Association.	*22(10.5%)*	*61(29%)*	*25(11.9%)*	*61(29%)*	*41(19.5%)*
6. Am not aware of any ethical principles that guide clinical supervision.	*79(37.6%)*	*57(27.1%)*	*58(27.6%)*	*10(4.8%)*	*6(2.9%)*

Table 7 shows that a significant number (204,97.2%) of counsellors agree they value clients' confidentiality and privacy of records in their clinical practice; (111,52.9%) "strongly agree", (93,44.3%) "agree", whilst (2,1.0%) were neutral and (4,1.9%) "disagree". A significant number (144,68.5%) of participants admitted practising unconditional positive regard in their practice; (82,39%) "Strongly agree", (62,29.5%) "agree", whilst (60,28.6%) participants were neutral, and (6,2.9%) "disagree" (2,1%) and (4,1.9%) "strongly disagree" to practising unconditional positive regard (UPR) in their practice.

A significant number (116,55.2%) of counsellors indicated not being affiliated to a local counselling regulating body, (32,15.2%) were neutral on the issue, whilst (62,29.5%) admitted affiliation to a counselling regulating body; (43,20.5%) “strongly agree”, (19,9%) “agree”, and (32,15.2%) were neutral.

On the use of Botswana Counselling Association (BCA) ethical principles, as can be seen in Table 7, more than half (128, 60.9%) participants indicated not using BCA ethical principles; (53,25.2%) “strongly disagree”, (75,35.7%) “disagree”, whilst (30,14.3%) remained neutral, and (52,24.8%) indicated using BCA ethical principles to guide them; (23,11%) “agree, and (29,13.8%) “strongly agree”.

As can be seen in Table 7, (83,39.5%) counsellors “disagree”; (61,29%) “disagree, and (22,10.5%) “strongly disagree” with using principles for a different regulating association, (25,11.9%) are neutral, whilst (102,48.5%) agree to use principles for a different regulating body; (61,29%) “agree” and (41,19.5%) “strongly agree”.

As can be seen from Table 7, a significant number (136,64.7%) of respondents do not agree with not knowing ethical principles guiding clinical supervision; (79,37.6%) “strongly disagree”, (57,27.1%) “disagree”. However, (58,27.8%) remained neutral, whilst a very small number (16,7.7%) agreed to not being aware of guiding CS ethical principles; (10,4.8%) “agree” and (6,2.9%) “strongly disagree”.

It can be concluded from Table 7 that there is a lack of ethical guiding principles in the clinical supervision practice in Botswana.

Research Question 6: What are the Strategies Towards Improving Clinical Supervision in Botswana?

Table 8

Descriptive Data Summary on Possible Strategies Towards the Improvement of CS(N=210)

Item	*Strongly Disagree*	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*
1. Training counsellors in clinical supervision could help improve clinical supervision	*6(2.9%)*	*1(0.5%)*	*84(40%)*	*27(12.9%)*	*92(43.8%)*
2. Making clinical supervision mandatory is a good strategy to enhance the clinical supervision practice	*1(0.5%)*	*1(0.5%)*	*7(3.3%)*	*98(46.7%)*	*103(49%)*
3. Establishing an accreditation and licensing body could greatly improve clinical supervision	*1(0.5%)*	*2(1%)*	*74(35.2%)*	*23(10.9%)*	*110(52.4%)*
4. A good strategy for improving clinical supervision will be to have regular planned clinical supervision sessions	*1(0.5%)*	*1(0.5%)*	*56(26.7%)*	*30(14.3%)*	*122(58%)*
5. Creating awareness of clinical supervision services can help improve clinical supervision in Botswana.	*1(0.5%)*	*1(0.5%)*	*4(1.9%)*	*92(43.8%)*	*112(53.3%)*
6. Instilling a good practice of documenting, ethical and legal compliance can go a long way towards improving clinical supervision in the country	*1(0.5%)*	0(0%)	*52(24.8%)*	*37(17.6%)*	*120(57.1%)*

Table 8 shows descriptive data on strategies suggested by the respondents towards the improvement of clinical supervision intervention in the country. A significant number (119,56.7%) of respondents agree that training counsellors in CS may help improve CS; (92,43.8%) “strongly agree”, (27,12.9%) “agree” whilst (84,40.0%) remained neutral and a very small number (7,3.4%) did not agree that training counsellors in clinical supervision may be helpful towards improving the Clinical practice.

A significant number (201,95.7%) agree with making clinical supervision mandatory; (103,49%) “strongly agree”, (98,46.7%) “agree”. Only (2,1%) of participants disagreed; (1,0.5%) “disagreed” and (1,0.5%)

“strongly disagreed”, whilst only (7,3.3%) of participants were neutral about making clinical supervision mandatory.

A significant number (133,63.3%) of counsellors agree that establishing accreditation and licensing body could greatly improve CS; (110,52.4%) “strongly agree”, (23,10.9%) “agree”, whilst a significant number (74,35.2%) remained neutral and an insignificant number (3,1.5%) disagree.

As can be seen in Table 8, a significant number (152,72.3%) of counsellors agree that having regular planned clinical supervision sessions is good for improving CS, (56,26.7%) remained neutral whilst only (2,1%) respondents disagreed with regular planned CS for improving clinical supervision practice.

Table 8 also shows that a significant number (204,97.1%) of respondents “agree”; (92,43.8%) and “strongly agree” (112,53.3%) that creating awareness of CS services can help improve CS in the country, whilst only (4,1.9%) of the participants neither agreed nor disagreed, and only (2,1%) disagreed and strongly disagreed. A significant percentage (97.1%) of participants perceive creating awareness of CS Services as a good strategy for improving CS in Botswana.

The table also show that a significant number (157,74.7%) of respondents believe that instilling a good practice of documenting, ethical and legal compliance can go a long way towards improving clinical supervision in the country, However, (52,24.8%) of respondents neither agree nor disagree; they remained neutral whilst (1,0.5%) strongly disagreed.

It can be concluded from Table 8 that more respondents believe that training counsellors in clinical supervision followed by accreditation and licensure could help improve clinical supervision in the country.

This section of the chapter simply presented the results of the quantitative component of the study without discussion. From the above results presentation, respondents reported having very little or no clinical supervision; little or no access to clinical supervision implies a poor or low level of access.

The results of study 1 on their own do not give a clear picture of clinical supervision status on the level of access, knowledge, attitudes, practice and guiding principles used, therefore, there was the need for follow-up through interviews of supervisors to seek corroboration, validate and explain what the quantitative numbers indicated. Hence, the next section focused on presenting the results from the semi-structured interview responses. The section starts with elaborating all the analysis processes that were involved in the thematic steps, NVivo generated codes and themes, the manual development of initial codes and identifying themes as well as the use of content analysis that was carried out to verify the word frequency queries which were done through NVivo.

4.5 QUALITATIVE DATA

This mixed-method research deployed an explanatory sequential research design to investigate the phenomenon from two distinct paradigms. The first study; which is referred to herein as Study 1 was the quantitative phase of the mixed method research which was anchored on the positivist beliefs that view patterns of behaviour from the stance of objectivity in explaining the phenomenon through the lens of objective mathematical; statistical and scientific causal laws (Bryman,2006a,2008b; Nowell et al., 2017; Saxby,2016). This worldview of the positivist approach in research believes in precise measurements of quantification of data and hence uses quantifiable instruments. According to literature (Attride-Stirling,2001; Bryman,2008a; Saxby,2016), the Positivist approach is deductive mainly for purposes of testing the research study's hypotheses and/or research questions. On the other hand, the qualitative study aspect of this research was considered to be the second component of the whole research "mix".

This part of the research mix adopted the interpretive stance; the inductive aspect of the mixed research that helped mostly with the explanatory role of the quantitative aspect of the research.

Despite the debate that has been ongoing for decades on the appropriateness of the approach, literature shows that it can be successfully applied in social sciences despite being from opposing philosophical

paradigms; literature shows that epistemological compatibility is possible and can be achieved (Attride-Stirling,2001; Braun & Clarke,2006; Creswell & Plano Clark, 2017; Saxby,2016).

Both deductive and inductive perspectives were achieved through triangulation of paradigms, theories, methods, data collection and analysis techniques to adequately respond to the specific research questions. This multiple triangulation approach helped to prevent researcher biases and increased the validity, reliability, credibility and trustworthiness of the study (Nowell et al.,2017; Peel,2020; Saxby,2016). Whilst most researchers refer to this approach of combining multiple methods as methodological triangulation, Tashakkori and Teddlie (2010) termed it methodological eclecticism because it is not limiting but rather allows the researcher to explore the phenomenon from different methodological approaches.

The approach reduced the inherent limitation of relying on a single data source and reduced biases associated with depending on one particular paradigm, a single methodological approach, a single data collection tool and data analysis techniques and a single underpinning theory.

Deploying the use of opposing paradigms; inductive and deductive mindset facilitated the complementarity of one approach to the other; the qualitative method played a complementary role to the quantitative. This attempt gave a much used guided thematic analysis approach (Braun and Clarke,2006).

4.5.1 Thematic Analysis

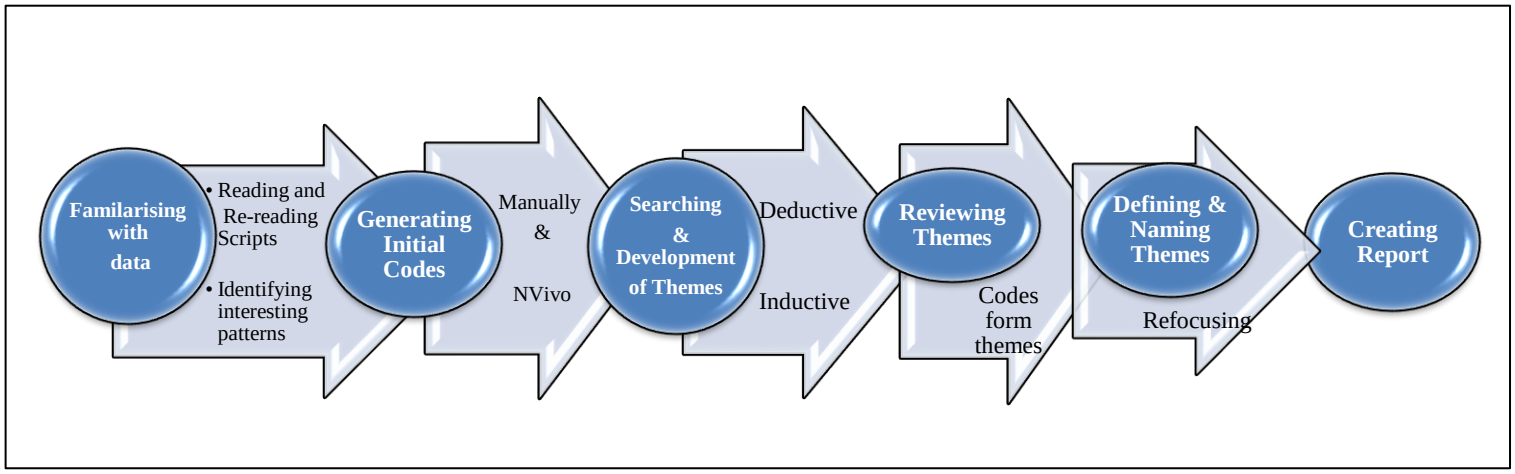
Thematic analysis is “a method for identifying, analysing and reporting patterns (themes) within data. It minimally organizes and describes data set in detail” (Braun & Clarke,2006, p.79). In a nutshell, the thematic analysis helped in this case to identify common ideas that recurred across the transcripts, which helped in developing themes that summarized participants’ responses and views regarding research questions.

According to Kiger and Varpio (2020), “thematic analysis is a method for analyzing qualitative data that entails searching across a data set to identify, analyze, and report repeated patterns”.

The method involved a process of describing and interpreting data through developing and identifying codes that were then constructed into themes for coherent inductive and deductive models and steps deployed as presented in Figure 12 (Braun & Clarke, 2006).

Figure 12

Showing the Thematic Process Followed



i). Familiarization

The first step was to read through the scripts to get familiarised several times and annotate what appeared interesting; accounts helped get acquainted and emersed in the data responses, which allowed for the identification of interesting patterns. According to Braun and Clarke (2006), this process as in this data familiarization, and comments were made in attempts to summarize and make connections between narratives, similar situations that appeared in the scripts were established, and in the process preliminary interpretations emerged. Having developed, next was the attempt to further identify participants' meanings rather than just what was being said. This process involved reading and re-reading the data whilst noting down initial interesting ideas as they emerged (Braun & Clarke,2006; Kiger & Varpio,2020; Kriukow,2022).

ii). Generating Initial Codes/Coding

This involved labelling the data with specific names to reduce the amount of data; to scaling down the volume of data into manageable chunks, it involved grouping the ideas (Kriukow,2022; Varpio et al.,2017).

According to Boyatzis (1998, p63), a code is “the most basic segment or element of the raw data or information that can be assessed in a meaningful way regarding the phenomenon”. Codes were developed, then themes as it was essential in helping to identify what was deemed beneficial in using the data; all about simply describing the story data was telling. Similarly, NVivo was used to auto-generate codes, coding helped in qualitative from transcripts. Codes that shared similar meanings and concepts were then grouped to eventually develop themes. Codes that didn’t seem to make sense were temporarily “shelved”; but not immediately discarded; these were classified under “to be reviewed” whilst salient codes and ideas were identified and noted as themes. This process was repeated until no more new ideas were emerging which was considered an indication of having reached saturation.

iii). Searching and Generating Themes

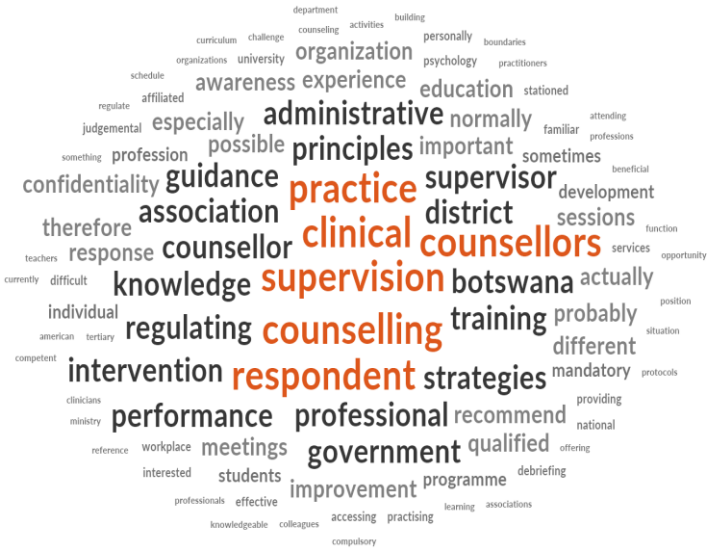
What followed next was reading and re-reading scripts over and over again, codes were established from scripts that formed themes, the identified themes were then developed into abstract ideas that were used to establish participants' conceptualized true meaning. Volumes of data were dissected to make sense and render it manageable to understand participants’ meaning in this process of developing meaningful themes (Kiger & Varpio,2020; Kriukow,2020). Kriukow (2020) posit that there is a need for a clear connection between themes generated from participants’ actual words, though at times some codes and themes may not make sense at first. Therefore, it was on this ground that every excerpt was considered valuable data. The data had to be captured verbatim, cleaned and transferred into one file for easier uploading into NVivo for word frequency, word counts, word cloud, text search, case coding and inductive analysis of responses.

Auto-generated themes served as the guiding framework for the next step as it was compared with respondents’ actual words, this was because trustworthiness in qualitative research has to be demonstrated by capturing and presenting participants’ data and meanings as genuinely intended by the respondents, whilst at the same time maintaining ethical research standards for authenticity, consistency and rigour; not only in data collection but in data analysis as well.

Running the word frequency query on NVivo helped to identify and understand the key themes, and helped to generate the word cloud that showed the most frequent words in the corpus of responses from the semi-structured interviews as indicated below:

Figure 13

Showing Auto-generated Word Cloud from NVivo from Interview Responses



iv). Reviewing and Connecting Themes

Actual themes that emerged or were developed were assessed to establish the connections, an effort was made to establish any new themes; reviewing the initial ones and grouping them to help make sense of narrated phenomenon and to establish patterns in the participants ‘responses and views.

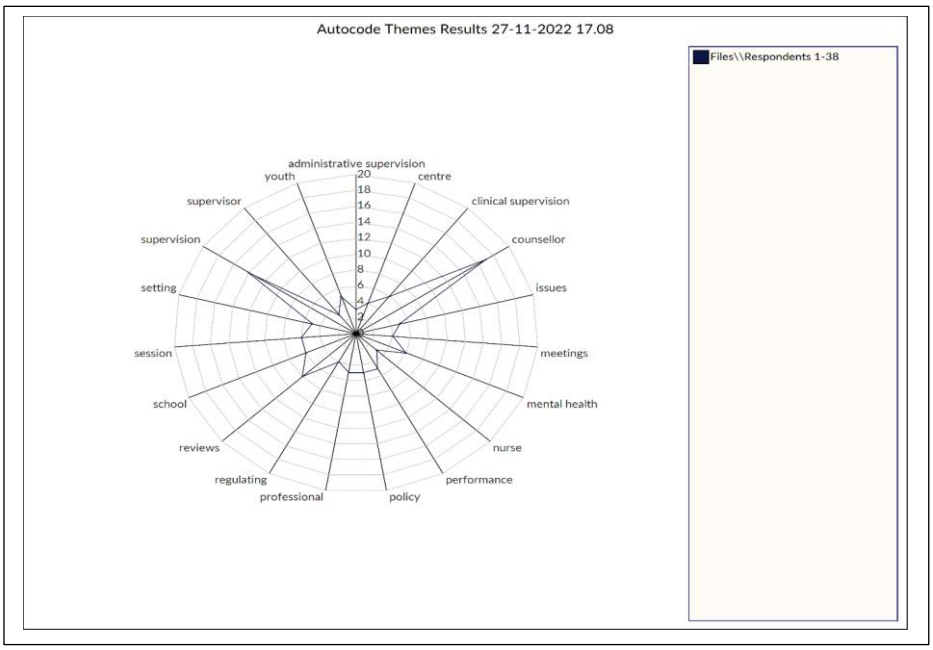
These major themes and sub-themes were then named and captured using thematic network mapping and finally only three main themes were identified as shown in the final thematic map in Figure14.

Data saturation point was reached making counsellors’ narratives of lived clinical supervision experiences repetitive and more similar without any new information emerging. Themes were refined and those that appeared not to have enough support from the data were merged into others, the main idea was to create coherent patterns, assess, refine and establish the validity of the themes and ensure accurate representation of the data.

The process facilitated the retrieval of meaningful themes and created the ability to establish patterns from the data. Initially, "initial coding" was done and initial codes were sorted into provisional codes, through NVivo and manually. Apart from word frequencies that generated the word cloud, NVivo was used to auto-generate web codes as represented in Figure 14;

Figure 14

Showing NVivo-Generated Autocode Themes



Auto-codes

The NVivo-enabled word frequency query provided the ability to understand the themes in the responses and provided summaries of the most frequently occurring words in participants' responses, the codes generated in web representation matched the word cloud, only this time they were merged and reduced. Whilst text searches facilitated specific searches for words to help with creating codes that allowed for retrieval of segments of text that contained such words, using word frequency and text search proved helpful (Elliot,2023).

v). Defining and Naming Themes

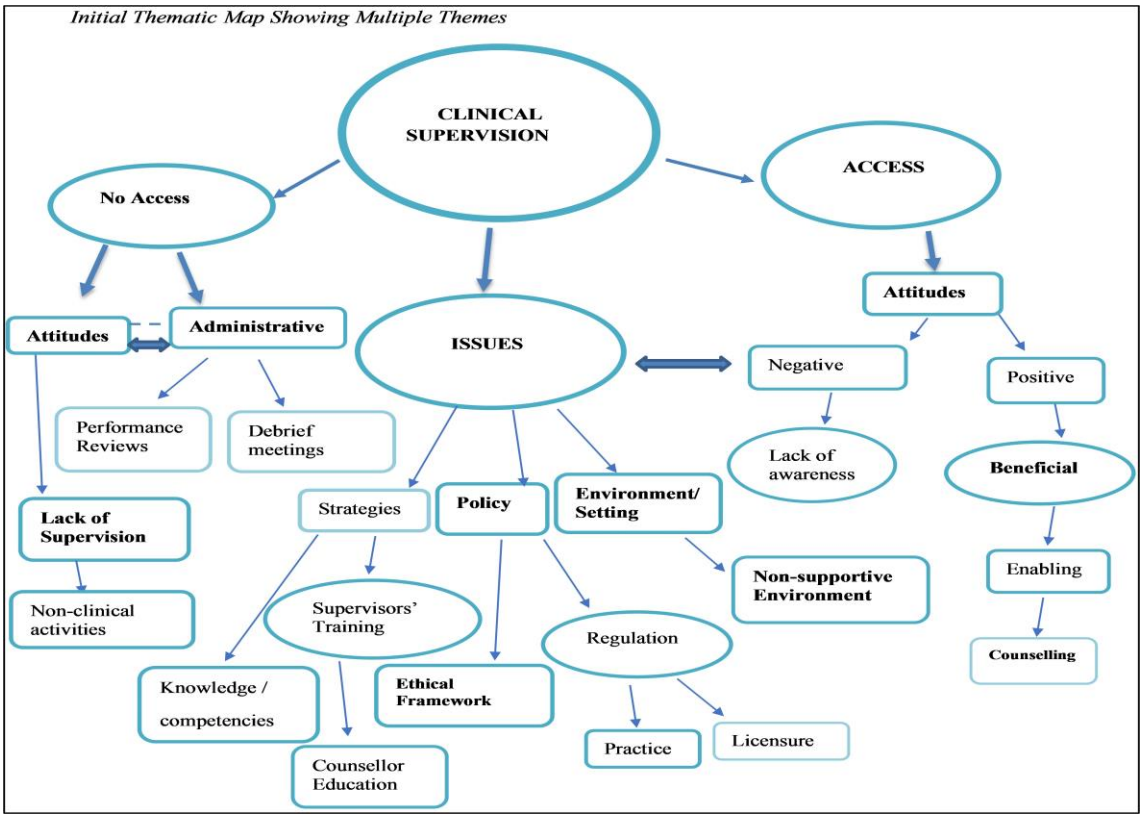
At this stage codes were used to form themes; to re-focus the analysis and move into much broader meaningful themes, it involved the collating of all the relevant coded data extracts within the identified themes

and using the initial codes to form themes. The process allowed for easier identification and establishment of the meaning inherent in each theme; what the theme was really about and linking them with the data.

Themes were defined and further re-defined to be deployed in the analysis of the data (Kiger & Varpio,2020). The developed themes resonated with the NVivo autogenerated themes as can be seen from the web, word cloud and the manually developed themes indicated step by step through thematic maps. The development of thematic maps facilitated the ability to move through different levels of themes, to sub-themes, overarching themes and finally to the major themes as indicated in figures 15,16, and 17 (Braun & Clarke,2006).

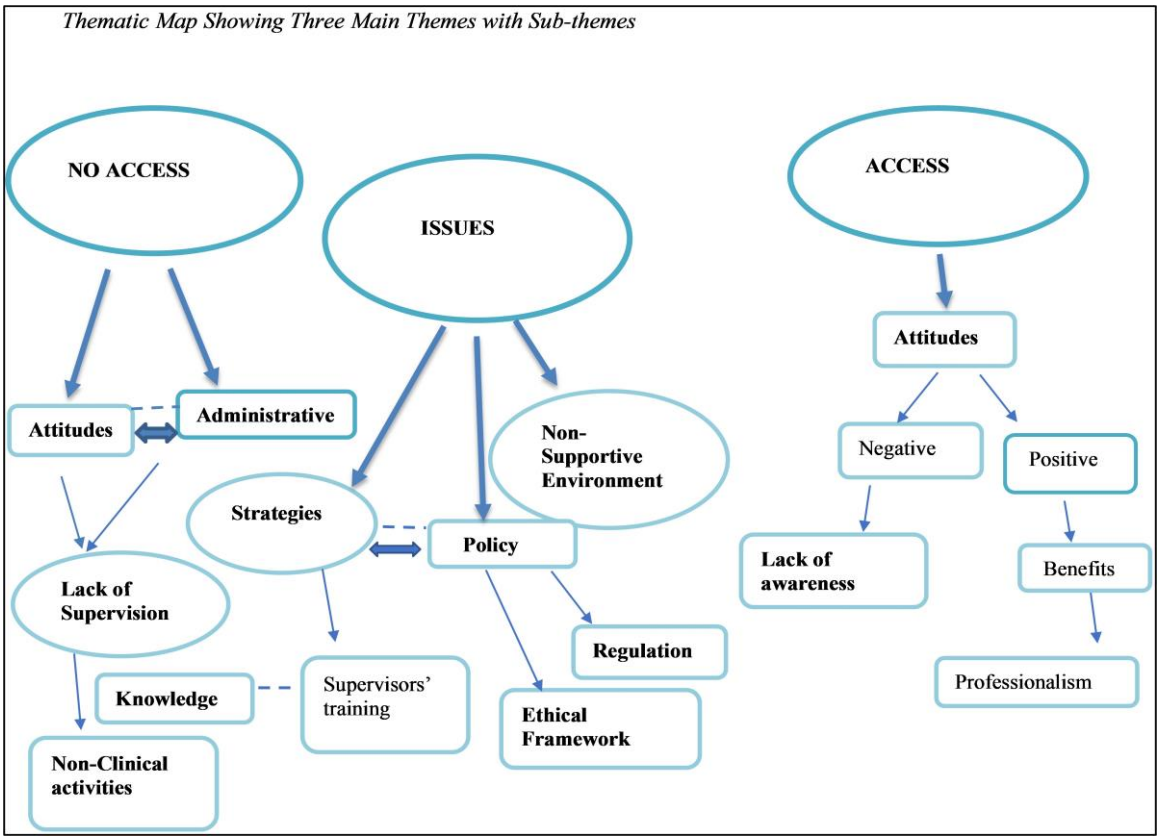
Development of Thematic Maps

Figure 15



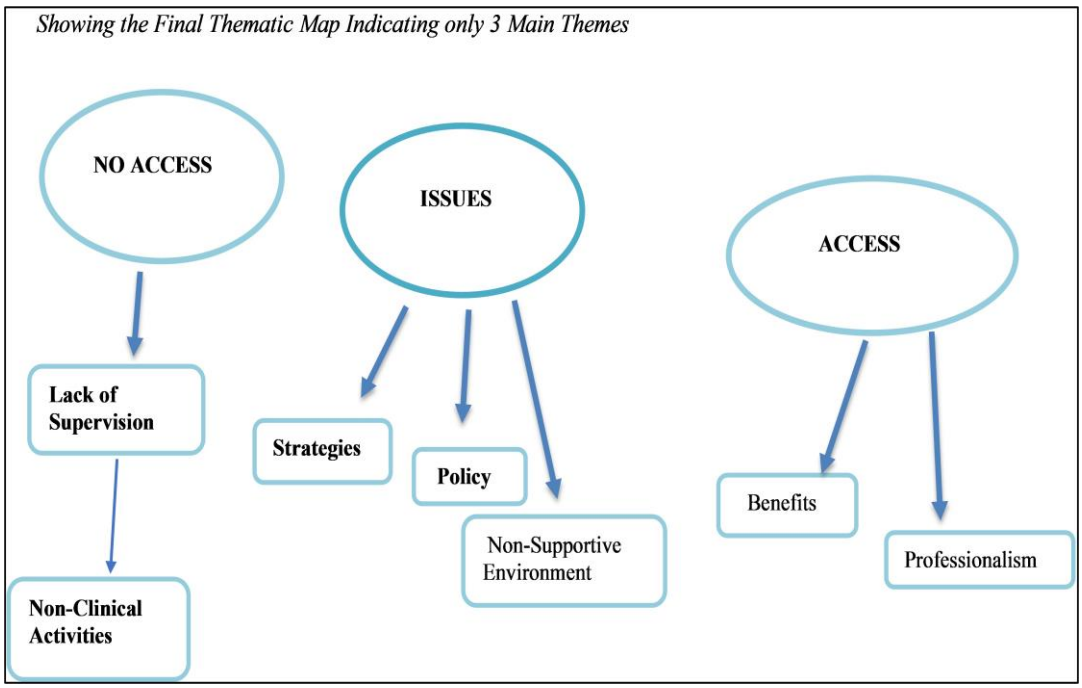
Adapted from Braun and Clarke (2006,p.90-91)

Figure 16



Adapted from Braun and Clarke (2006,p.90-91)

Figure 17



Adapted from Braun and Clarke (2006,p.90-91)

vi). Creating a Report

This write-up was based on the themes that were developed from the data to help explain and show the link between the first study (quantitative data) "mixed methods", and the second (qualitative data). In this portion, data extracts were used to tell the story within and across the themes. A lot of data extracts are used here to show patterns.

4.5.2 Results from Interviews

The interviews started by asking respondents to share their age, background qualifications and their experiences of clinical supervision. The results are presented in line with the themes that emerged under each research question.

Participants' experiences knowledge, attitudes and practices of CS experiences were freely shared regardless of whether considered positive or negative and their functioning as practising supervisors, the duration of their clinical supervision session and to suggest ways in which the practice could be improved.

The researcher personally interviewed the participants in a face-to-face setting and through telephone whilst capturing the responses verbatim on paper and folder, and coding was used to protect the identity of interviewees by numbering them from Respondent 1 to Respondent 38 according to the order in which the interviews were conducted.

4.5.2.1 Interview Participants Population

Using semi-structured interviews was considered appropriate to create the opportunity to engage with clinical supervisors in their respective districts and organizations. 38 Respondents from the provided sample frame consented and were considered suitable to provide the relevant information needed to successfully address the objectives, and purposes of the study. This phase of the study was for elucidation, clarifying and explaining the results of the first study to establish convergence and divergence in the results. The sample was drawn from the different counselling environmental settings across the different mental health professions, the characteristics of the sample were mostly leaders or clinical supervisors of counsellors.

Respondents had a counselling background. This approach was considered beneficial because drawing a different sample that did not take part in questionnaires was intended to increase the validity and reliability of this mixed-method study and reduce biases (Creswell & Plano Clark, 2017).

Focusing on the variables, and in line with the research questions, qualifications, level of access by counsellors in their workplace, their knowledge of CS, their personal experiences of CS, their interest and desire to access CS and themselves as clinical supervisors, and if they would be interested in learning more about it, what framework or ethical principles guided their supervision intervention, as well as whether or not they were familiar with any regulating bodies and affiliated with any regulating organization, and probed on what possible suggestions they could offer for the improvement of clinical supervision practice. The semi-structured interviews had a set of guiding questions that were based on the purpose of making follow-up on the findings of Study 1. The questions were open-ended and allowed for probing to seek clarity.

Table 9

Interview Participants' Demographic Data (N=38)

GENDER	***AGE RANGE***	***YEARS OF EXPERIENCE***	***LEVEL OF EDUCATION***	***PARTICIPANTS BY DISTRICTS***
Male 7	*33-52*	*4-25*	*4 Masters* *3 Bachelors*	*7 Central*
Female 31	*26-63*	*3-27*	*2 PhD* *16 Masters* *12 Bachelors* *1 Dip*	*6 Kgatleng* *5 Kweneng* *17 South-East* *3 South*
Total			**38**	

Seven (n=7,18.4%) out of the thirty-eight interview participants identified as male, whilst the majority of participants (n=31,81.6%) identified as female. Therefore, more than eighty-one percent of respondents were females aged between twenty-six and sixty-three, whilst males were aged between thirty-three and fifty-two. Regarding the years of experience of counsellors, male participants had between four (4) and twenty-five (25) years of counselling experience, whilst their female counterparts had between three (3) and twenty-seven (27)

years of experience in counselling. Participants' level of education also differed; two female participants(n=2,5.3%) had Doctorate degrees, followed by sixteen with Masters Degrees (n=16,42.1%), followed by twelve with Bachelor's degrees (n=12,31.6%) and one with diploma (n=1,2.6%). Out of the seven male participants, four had Master's degrees (n=4,10.5%), whilst three had Bachelor's degrees (n=3,7.9%). These qualifications were in different disciplines; some of which in areas not related to mental health.

Similarly, participants were asked to state which geographical or administrative district they were stationed in, and six reported being in the Kgatleng district (n=6, 15.8%), five in Kweneng (n=5, 13.2%), seventeen stated being from South East (n=7,18,4%), Seven were from Central (n=7,18.4 %), and only three reported being from the South/Southern District (n=3, 7.9%).

4.5.2.2 Areas of Discipline

Table 10

Interview Participants' Field of Training/Area of Discipline of Interviewees (N=38)

Field of Training/Area of Discipline	*Number of Participants*
Human Resource	*1*
Humanities/Sciences: 1 Biology, 1 Maths	*2*
Nursing:1 Psych Nursing,1General Nursing	*2*
Counselling psychology	*3*
Counselling and Human Services	*4*
Social work	*4*
Educational Psychology	*2*
Clinical Psychology	*2*
Guidance and Counselling	*8*
Psychology	*6*
Counsellor Education	*2*
Special Education	*1*
Family and Marriage therapy	*1*
Total	***38***

Participants disclosed being trained in different professional fields, for example; one reported being trained in Human Resource Management (n =1,2.6%), two reported being trained as teachers of Maths and Biology/Humanities (n = 2,5.3%), two in the nursing field (n =2,5.3%), whilst the rest reported being in the following mental health professions: three in counselling Psychology (n=3, 7.9 %), four in Counselling and human services(n=4,10.5%), four in social work (n=4,10.5%), two in Educational Psychology (n=2,5.3%), two

in clinical Psychology(n=2,5.3%), Eight in Guidance and Counselling (n=8, 21.1%), Six in Psychology (n=6,15.8%), two in counsellor education (n= 2,5.3%), one in Special Education (n=1,2.6%) and another one in family and marriage therapy (n =1,2.6%).

4.5.2.3 Environmental Setting

Table 11

Showing Interview Participants' Counselling Environmental Settings (N=38)

Environmental Setting	*Number of Participants*
Tertiary institution	*5*
Public School	*7*
Private practice	*8*
Governmental institutions	*8*
NGO	*9*
The participant did not state the environmental setting	*1*
Total	*38*

Respondents were clinical or counsellor supervisors who reported operating from various counselling environmental settings as follows; five at tertiary institutions (n = 5,13.2 %), seven in Public Schools (n =7, 18.4%), eight in private practice (n= 8, 21.1%), eight in governmental institutions (n= 8, 21.1%), nine in non-governmental Organizations (n = 9, 23.7%) and only one participant did not indicate the environmental setting (n=1,2.6%).

4.5.2.4 Inclusion Criteria

Practising counsellors who were also supervisors and offering and receiving clinical supervision were from various counselling environment settings and governmental and non-governmental organisations had more than 3 years of experience and were drawn from 5 districts. These included counsellor educators, clinical practitioners/directors from private practice and non-profit NGOs, Regional managers of psychosocial support services (governmental) and Case Managers from privately owned counselling centres, centre leaders, regulating bodies leaders and district leaders of counsellors.

4.5.2.5 Exclusion Criteria

Non-practising counsellors, practising counsellors and supervisors in remote inaccessible Districts, practising counsellors and supervisors with experience below three (-3) years were excluded. Clinical supervisors who provided supervision to the researcher and those clinically supervised by the researcher were also excluded from the study, those who participated in the pilot phase of the data collection instrument, those who provided expert advice and mentorship in the development of the instrument for data collection, those under the age of 25 and those with mental disabilities were excluded.

4. 5. 2.6 Context

Counsellors in Botswana provide psychosocial support services to various individuals and groups within the communities they live in, therefore, they are found in different environmental settings, either in governmental or non-government institutions. The Majority of counsellors provide counselling services to learners from different levels of educational institutions; pre-primary to tertiary level whilst some are in non-governmental institutions (NGOs) that largely depend on donors to be able to drive their mandate of providing counselling services to their communities. Similarly, there are those at the policy level, Ministerial level and various governmental departments, whilst a few are in income-generating private practice settings.

Counsellors in these various settings provide counselling services, they may encounter ethical dilemmas, experience burn-out or counsellor compassion fatigue and imposter syndrome hence clinical supervision is a mandatory requirement in many countries to ensure counsellor self-care support, effective and ethical service and credibility of the profession (Morgan & Sprenkle,2007; Msimanga & Moeti,2018; Watkins,2014; Wosket,2016) and this is the clinical service that supervisors are expected to provide to practising counsellors. The thematic analysis was data-based and the research questions focused (inductive and deductive).

4.5.3 RESEARCH QUESTIONS

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

The majority of participants reported not having any access to clinical supervision whilst a few reported having irregular access to clinical supervision lasting between 45 – 90 minutes, some reported accessing supervision either individual, peer-to-peer or group supervision once a year. Most reported that counsellors only accessed non-clinical administrative supervision that focused on performance, time management, administrative duties and teaching in a school setting. Many supervisors reported not accessing CS nor providing it, whilst some indicated being familiar with it but not competent to conduct it. Only a handful expressed having provided clinical supervision as well as having accessed it. On these grounds, there were both positive and negative themes established from the interview data which collaborated with the quantitative study results.

Access to Clinical Supervision

Negative and Positive

There were positive and negative responses regarding access to clinical supervision; a few reported having "Access" whilst the majority remained neutral or reported "No Access" to Clinical Supervision. Responses that could be considered "negative" included segments such as these:

Respondent 1*: "I do not have access to any form of clinical supervision except administrative supervision from my boss which is mainly focused on the HR aspect of my roles, the administrative performance of my duties, punctuality……we call these performance reviews"*

Respondent 2: "*Unfortunately, we don't have clinical supervision, just brief meetings on how best to perform our roles, more like administrative meetings focused on performance".* Respondent 2 continued to elaborate on the nature of the group meetings by saying that the meetings were mostly for case review rather than clinical and developmental needs.

Whilst some appeared not to be sure whether their meetings were CS or not, others reported not having accessed the intervention. One respondent stated*; "I haven't been to clinical supervision of any kind",* whilst

one Clinical Supervisor shared their supervision experience by saying; *"I provide counselling as well as clinical supervision to counsellors. I have been doing supervision for 10 years now, but it is not many counsellors who are accessing the service from my practice".* This emerged as a concern of lack of access to CS by respondents for different reasons as seen from these next segments;

Respondent 5: "*I haven't accessed any form….. and am not quite familiar with it. I think that must be the same as case review.*

Respondent 8: "*The issue of access is a non-starter, the reason I say that is because even during my practicum it was a challenge, it appears not to be taken seriously. I do not have access to clinical supervision…. and schools are also in shift Programme due to COVID-19. I also do not know those who provide the service..."*

Response*15*: *"I rarely access clinical supervision, and I no longer provide clinical supervision but administrative supervision instead.".*

Respondent 23: *"I do not have access to clinical supervision, only performance-related supervision when I go to quarterly reviews…., the counsellors I supervise do not have access to formal clinical supervision, they only give each other advice and support when encountering challenging cases".*

However, these next excerpts show that some respondents reported having access to clinical supervision either at their workplace or outside the workplace and these formed positive themes.

Positives

Despite the majority of responses showing "No Access" to clinical supervision, a few positive ones stated that they have access to clinical supervision and a few clinical supervisors reported having the training and competencies to effectively provide clinical supervision to a few counsellors at their workplace and outside. Some went further to report what they considered to be the benefits of clinical supervision towards enhancing their counselling skills, clinical self-care and effective functioning in counselling. Though some expressed a lack of clinical supervision due to non-supportive environmental settings, many reported accessing administrative supervision in the form of performance reviews or just ordinary staff meetings, and a few reported accessing irregular, informal peer-to-peer, group or individual clinical supervision.

The following were some of the responses given and captured verbatim to help with a true representation of the respondents' narrations:

Respondent 3: *"I access Individual and group supervision. I am also competent in providing Clinical Supervision. It was part of my training at a South African University. I do receive clinical supervision elsewhere..."*

Respondent 13 uttered; *"I do have a clinical supervisor, though I also provide clinical supervision to other counsellors. We meet monthly by Skype as my clinical supervisor is based abroad. Our monthly session usually takes an hour…"*

Another counsellor said*; "I do access clinical supervision, but I do not provide any clinical supervision to anyone. I work in a government tertiary institution. I access a clinical supervisor here at work because I work with other counsellors in the student counselling centre.*

Follow-up questions were asked to establish the duration of their CS sessions, responses differed, for some the duration was between 45 and 60 minutes, whilst others utilized less time as can be seen from the excerpts below:

Respondent 19*:* *"My session usually lasts an hour, but the group sessions normally take 2 hours. The same applies to administrative supervision".*

Respondent 22*: "Our meetings usually take an hour and a half. But mostly it's just a brief 45-60 minutes tops, as a counselling Psychologist I am familiar with clinical supervision, one can't be a healthy counsellor without accessing supervision".*

Respondent 23 expressed*; "I would say my meetings when I review my team and when I am reviewed by my supervisor take close to 45 minutes".*

Question 2 wanted to establish the knowledge of Clinical supervision among respondents. A few reported being knowledgeable and trained in clinical supervision, whilst many reported being just aware, not trained nor experienced, and a few stated not being aware of CS.

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

Respondents were asked to share their lived experiences concerning their knowledge of clinical supervision. A significant number of respondents indicated "not being trained in clinical supervision", This was followed up because "not being trained" may not necessarily imply not being knowledgeable.

Supervisors were also asked how important they believed accessing clinical supervision was to them as practising therapists, what their level of adherence to accessing clinical supervision was, how they accessed their clinical supervision; whether they accessed it in their environmental setting or outside, the duration of

their clinical supervision sessions, how often they accessed it; the amount of time they awarded to the sessions, their knowledge and application of rapport building, the confidentiality issues, Unconditional Positive Regard (UPR), the link to their ability and desire to access CS and what competencies they had in conducting clinical supervision. There were positive and negative responses towards this question; a few appeared to know clinical supervision, whilst the majority expressed having very little or no knowledge at all or only having heard about it. This was evident from the quotes below.

Positive Responses

A small number of respondents reported having the knowledge and competency about clinical supervision, and a few also reported being qualified clinical supervisors and went further to highlight the significance of CS in counselling, however, others expressed being aware of CS but not competent to facilitate it;

Respondent 3*: "I am trained in CS, so I would say I am knowledgeable, I have the awareness and the skills to provide clinical supervision, and I do offer the service to a team of clinicians".*

Respondent 8: *"Yes, I do know about clinical supervision, it is compulsory in certain countries like the USA where counsellors are licensed, unlike here in our country.*

Respondent 30: *"When I go to clinical supervision, it usually takes about 45 minutes to 1hr, and mostly it is peer supervision,".* Respondent 30 went further to say*: "I am definitely familiar with clinical Supervision, and I do provide it to others virtually, but not as frequently as I should due to my busy schedule at the moment.".*

The next quotes are examples of some responses from many who reported not being trained, unaware; not knowledgeable or experienced in clinical supervision.

Negative Responses

Respondent 10: *"I don't have much knowledge about clinical supervision in our environment, because we deal with disabilities, once in a while we can have some benchmark from other schools that offer special education".*

Respondent 24:

"I know very little about clinical supervision, in social work, we are familiar with case reviews and we only do it when there is a need..."

Research Question 3: What is the Attitude of Counsellors towards Clinical Supervision in Botswana?

The majority of clinical supervisors had positive views towards Clinical Supervision; they perceived it as a good, important and beneficial intervention and articulated the benefits they derived or that can be derived from clinical supervision by counsellors. A few expressed having enjoyed accessing clinical supervision sessions and believed it is essential to counsellor efficacy and reducing counsellor burn-out and stress. Many positively described their feelings towards the intervention as good and shared their thoughts, that it enhanced supervisory working alliance and improved their clinical supervision experience. The following responses revealed their attitudes towards the clinical supervision practice;

Respondent 1: "*I would say, everyone who provides counselling has to be informed, trained and aware of clinical supervision."*

Respondent 3: *"I believe it's an important function and part of mental health and counselling, Unfortunately, it's not the case for everyone in our country ……. in Botswana anyone can just set up, no proper regulation, no monitoring, no licensure".*

Respondent 28: *"I value clinical supervision. I always feel refreshed and less stressed after attending a supervision session……, and I wish every practitioner could access it including the "para-professional..."*

Respondent 31: *"I think it could be a helpful intervention and very beneficial if it was available in the country."*

Research Question 4: What is the Practice of Counsellors Towards Clinical Supervision in Botswana?

Having a positive attitude towards clinical supervision and the actual practice may differ, hence, there was a need for follow-up questions to probe and examine how in practice clinical supervision was implemented as opposed to the theoretical aspect of it. Respondents were asked to describe the state of clinical supervision practice from their perspective based on their lived experiences, observations and understanding; to describe how it worked in real-life practice from their experience, how they tracked their activities, proficiency in clinical supervision skills, supervision format used, their guiding principles and what they considered essential in their practice and how they built rapport and maintained therapeutic working alliance within ethically and legally expected boundaries.

Their responses showed differing views that could be classified as either "positive" or "negative"; some reported having the competencies and skills to provide clinical supervision whilst many reported not having the relevant competencies;

Respondent 10*: "I can use supervision skills; apply empathy and I am confident in providing clinical supervision. I always protect my clients".*

Respondent 16*: "In our centre we are non-judgmental, we practice unconditional positive regard, and documenting and ethical adherence to confidentiality is important in my practice and to our clients".*

Respondent 21*: "It's important in CS to connect with supervisees, therefore building rapport is important."*

Negative

Non-Clinical Activities

Many reported non-clinical activities in their respective environments and "non-supportive environments", these appeared to be a constantly emerging theme.

Respondent 8: *"In schools, we just follow the Guidance and Counselling curriculum and G&C Programme implementation policy guidelines. In our country, it's not done, never heard of any of my colleagues even suggesting it or talking of having gone to see their clinical supervisor."*

Respondent 15: *"My mandate requires focusing on performance and monitoring the implementation of G&C curriculum in Schools from primary to secondary."*

These were followed up with a question seeking clarity on whether there was any framework or ethical principles guiding the counsellors' clinical supervision practice.

Research Question 5: What are the Ethical Principles that Guide Counsellors in Botswana?

Respondents were asked to discuss what they used as a guiding framework in their clinical supervision practice, how they addressed ethical dilemmas, how they protected clients' issues and confidential records in their clinical supervision practice, how they applied UPR in their CS, what regulating bodies they were affiliated to and what ethical principles they used to guide their clinical practice.

These probing questions attracted varied responses; a few counsellors reported being aware of the existence of the Botswana Counselling Association (BCA) but not aware of its ethical principles, and many reported not being affiliated with the organization but instead using ethical principles of different international counselling regulating bodies to guide their practice.

A few counsellors gave reasons for having adopted ethical codes from other countries; especially from the Western countries where most obtained their qualifications. Some reported not being aware of the Botswana Counselling Association (BCA) and its ethical principles, whilst others reported not being aware of any local ethical principles available to guide CS and counselling. The Excerpts below are evidence of the varied responses regarding the issue of ethical principles;

Respondent 4: *"I have heard of the Botswana Counselling Association, but I am not a member, I mostly google and refer to Australian Counselling Association ethics."*

Respondent 13*: "Being trained in Australia, I seem to be more comfortable using the ACA (Australia)……, However, I am aware of the Botswana Counselling Association draft guidelines."*

Respondent 8*: "I use ACA (America) ethical codes, but I am aware that Botswana Counselling Association exist; though I am not aware of their ethical codes".*

Negative

Respondent 31: *"As for ethical principles, I have never seen any in this country, so I tend to refer to the ones I used during my studies as a university student, I have heard of the Botswana Counselling Association but I am not a member".*

Respondent 7*: "I am more inclined to use the ACA (American Counselling Association) code of ethics because the Botswana Counselling Association is still at an infancy stage."*

Research Question 6: What are the Strategies for Improving Clinical Supervision in Botswana?

Given the responses from all the previous questions and the results from study 1, respondents were asked open-ended probes to elicit suggestions on the ways that clinical supervision could be improved in the country and what strategies they thought would be helpful towards the development of clinical supervision to positively change the status quo.

Participants were asked to share their observations and thoughts on issues regarding clinical supervision awareness in the country, and any other additional information they deemed necessary to share as suggestions towards the improvement of the CS practice. The majority came up with similar suggestions as can be seen in the positive and negative verbatim quotes given here:

Respondent 26: *"I think it is important for us mental health service providers to know about CS, maybe it will help if the government or our organizations could train us or create awareness around it.".*

Respondent 30: *"I think it should start with counsellor training institutions, if CS is made part of the counsellor-education curriculum, clinical supervision could easily be implemented and appreciated by many."*

Respondent 31: *"I think that because it is not mandatory, clinicians don't seem to think that it is a requirement in our country… it should be made mandatory".*

Respondent 7*: "As a counsellor educator, I would say there is a need to revise our counsellor education programmes at tertiary. In other countries, Clinical Supervision is a specialization…."*

Respondent 21: "*There is a need for an effective mental health regulating body that oversees all mental health professions, CS should be made compulsory for such professions."*

4.5.3 Content Analysis

The use of content analysis was deployed for results validity and validation of the thematic analysis results. Content analysis can be defined as a systematic, replicable technique for compressing many words of text (Krippendorff, 2019,2009). It is also perceived as; "any technique for making inferences by objectively and systematically identifying specified characteristics of messages".

Content analysis was not only restricted to textual analysis, it was applied in coding to systematically sift through the large volumes of interview data with ease (Stemler,2015,2000). It helped to establish and describe the focus of the interviews to establish what appeared to matter; what had meaning and linked to the research participants' exact narratives whilst identifying the actual concerns and issues of the interviewees.

The technique created the ability to make inferences and served as an instrument of corroboration to the results of the first (quantitative) study results.

The content analysis provided the ability to examine and identify the trends and patterns in the interview script data. More importantly, it enabled the systematic reduction of the voluminous data to make it manageable.

This proved to be a very useful and systematic instrument for compressing volumes of words and text into fewer content categories based on the desired and planned coding rules in this phase of the study. The technique "has attractive features of being unobtrusive, and yet useful in dealing with large volumes of data, its usefulness extends far beyond simple word frequency counts" (Drisko & Maschi,2016) and word counts were done through NVivo. Triangulation was deployed at various levels and stages; content analysis involving an eclectic approach of Basic Content Analysis (BCA), Interpretive Content Analysis (ICA) and qualitative content analysis was deductively and inductively used to achieve hybrid content analysis as seen in the results portrayed in Table 12 and Fig 16 below.

4.5.3.1 Qualitative Content Analysis - Interpretive and Basic Content Analysis

Qualitative Content Analysis (QCA) could be conceptual focusing on explicit data; words and phrases as well as frequencies of words, content and context, though quantitative, it remains a qualitative tool for data analysis. Similarly, qualitative content analysis may implicitly focus on relational data searching for meanings, word usage, phrases and interpretation to establish patterns and themes and examine how words are used (Grad Coach,2022). The strength of QCA lies in the unobtrusive data, therefore in this case, it was used on the semi-structured interview data and despite the limitations associated with content analysis, it was worth incorporating as an additional tool in the data analysis process for validation and verification of the thematic analysis results and study 1 findings.

The technique was used for corroboration and not as the sole qualitative data analysis tool. It was possible in this case to make replicable and valid inferences from the text to the context used in the interviewees' and participants' narratives. Through QCA an empirical methodological controlled analysis of text was conducted step by step (Krippendorff,1989,2019,2009). The QCA was carefully utilised to develop specified categories which were revised and refined to ensure credibility and usefulness.

This allowed for replicable and valid inferences from text. QCA of text involved inductive and deductive defining and application of categories to help make sense of the semi-structured interview data focusing on the content and context of what was said by respondents. At the same time, Basic Content Analysis (BCA) which is a hybrid approach involving the coding of unstructured narrative data was useful to understand meaning. The data was reduced and analyzed using descriptive statistics, which though a core aspect of quantitative data provided the ability to deductively (Quant) and inductively (Qual) develop codes that enabled the development of themes.

On the other hand; Interpretive Content Analysis (ICA) used summaries and interpretations rather than just relying on word count, and latent contextual narratives were used inductively to generate code lists, so the different types of content analysis were beneficial to this study. From the content analysis, the following summary in Table 12 was reached based on the 38 respondents' interviews.

Table 12

Qualitative Content Analysis Results of the Interview Responses by the 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)

Table 12 shows qualitative data on positive attitudes towards clinical supervision by supervisors, despite evidence of poor access, limited knowledge, practice and limited awareness and use of ethical guiding principles.

Figure 18

Qualitative Interpretive Content Analysis Results of the Interview Responses by Variables (N=38)

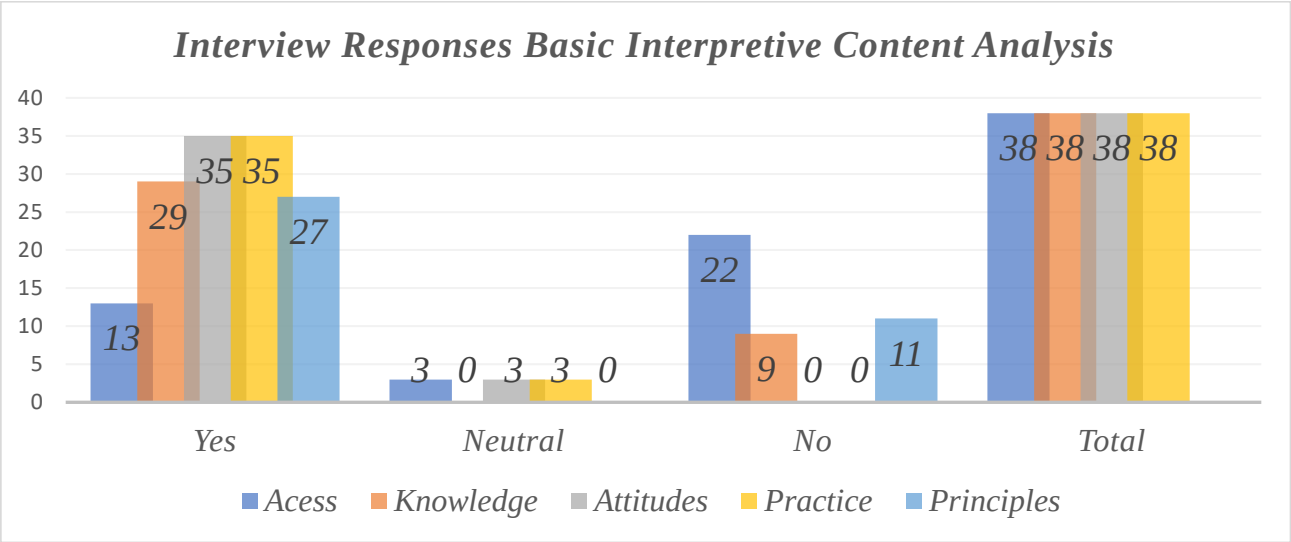


Figure 16 mirrors Table 12 and shows supervisors' positive attitudes as well as negative on other variables.

4.6 Results Summary

Research Question 1 was Intended to Establish the Level of Access to Clinical Supervision

Access and No Access

22 out of 38 (57.9%) counsellor supervisors reported "No Access" to clinical supervision, whilst only 13 out of 38 (34.2%) reported access to clinical supervision, and 3 out of 38 (7.9%) seemed to be undecided and chose to remain neutral. The majority reported a lack of clinical supervision, whilst some expressed being more involved in non-clinical activities. It can be concluded that supervisors reported receiving few counsellors for CS. This summary of findings is based on the semi-structured interview responses from 38 interview responses, The responses indicated that the majority of supervisors reported having no access to clinical supervision due to various reasons including; "unsupportive environment", being in a rural district, lack of qualified clinical supervisors, limited knowledge or awareness, lack of clinical supervision competencies, and lack of well-established facilities overall negatively affected level of access to CS, whilst a small number reported limited access to supervision.

Research Question 2 Sought to Determine the Knowledge of Counsellors on Clinical Supervision

There were no supervisors who were undecided or neutral regarding this question, 29 respondents reported being knowledgeable about CS whilst only 9 gave a negative report of not knowing CS. Many reported a lack of access to CS by counsellors and themselves despite being knowledgeable about it. Some reported not being knowledgeable and expressed the desire to learn more about CS; for example, one said: *"I think we need more training on it, we need to learn more about it".*

Research Question 3 Sought to Examine the Attitude of Counsellors Towards Clinical Supervision in Botswana?

There appears to be a positive talk from the participants about Clinical Supervision. The conversation seemed to be of people yearning for CS, this was evident from some of the quoted narratives captured below.

Positive and Negative, Benefits and Professionalism

An overwhelming number of counsellor supervisors expressed a positive attitude towards CS; 35 out of 38 (92.1%) had positive views about CS, for example, one said; *"I do enjoy accessing clinical supervision, it helps as a sounding board and contributes towards my professional development…"*, whilst another said; *"I value clinical supervision; I always feel refreshed and less stressed after attending a supervision session."* However, 3 supervisors seemed to have a neutral stance whilst none reported negative attitudes about clinical supervision. Some narrated the benefits of CS to their practice; for example, one said; *"I think it is good because it gives us the ability to improve the intervention or improve our counselling skills"* whilst another said; "*I believe clinical supervision enhances counselling skills."*

Research Question 4 was Intended to Determine Practices of Clinical Supervision

Non-clinical activities and Non-supportive Environment

The majority of respondents (25) reported that CS was part of their practice whilst 13 disagreed with the view that clinical supervision was part of their clinical practice; *"As a trained counsellor supervisor, I am*

knowledgeable on clinical supervision, the challenge is not being able to practice." "Well CS as a practice is not done in our country....., I do not offer it and I don't access it…I think it's safe to say that it is non-existent."

On the other hand, a few reported being competent in providing clinical supervision.

Research Question 5 Sought to Investigate Ethical Principles that Guide Counsellors in Botswana

Policy Issues

Most of the respondents (n=27,71.1%) reported being aware of the importance of ethical principles in their practice, whilst only a few (n=11,28.9%) reported not using any guiding ethical principles in their CS practice. Among the majority that expressed being guided by ethical principles, they said they used ethical guidelines from foreign countries; for example, one stated; "*I am more inclined to use the ACA (American Counselling Association) code of ethics, maybe that is because the Botswana Counselling Association is still at an infancy stage…."*, whilst another said; *"As for ethical principles, I have never seen any in this country, so I tend to refer to the ones I used during my studies as a university student."*

Only a few reported being aware of the Botswana Counselling Association (BCA) ethical codes draft, and using them as a point of reference, whilst many were aware of the existence of BCA but reported not being aware of their ethical codes, and not being members of BCA and not using the BCA code of ethics. Content analysis revealed that the interview results were consistent with the results from quantitative data analysis, for example, Table 13 below were responses of supervisors on the question which solicited suggestions towards improving CS practice in the country, and are similar to counsellors' data in the study 1.

Research Question 6: Examined Strategies for Improving Clinical Supervision in Botswana.

Table 13

***Showing Interview Respondents' Suggested Strategies for Improvement of CS* (N=38)**

Suggested Strategy	Number of Participants N (%)
Clinical supervision should be included in the curriculum of counsellors' education and all mental health provision programmes at the tertiary level.	16 (42.1)
Training all qualified counsellors or mental health services providers in clinical supervision.	19(50)
Establishing an active and effective regulating body that provides assessment and licensing of qualified counsellors or mental health service providers.	23(60.5)
Making clinical supervision mandatory/ compulsory for all counsellors or mental health services providers.	23(60.5)
Create awareness of clinical supervision and its importance to counsellors or mental health service providers	18/38(47.4)
Benchmarking in other countries where clinical supervision is thriving then pilot what is culturally focused to the needs of our country.	2/38(5.3)
More research on clinical supervision that bridges the gap.	3/38(7.9)
Set standards and protocols that govern counselling and mental health services provision.	3/38(7.9)

Most respondents (n=23,60.5%) voiced concerns regarding the status of clinical supervision in the country perceived as ineffective or non-existent, lacking regulation; with no regulating body to oversee CS and counselling in general. There appeared to be a consensus on *"Establishing an active and effective regulating body that provides assessment and licensing of qualified counsellors and mental health service providers"*, *"Making clinical supervision mandatory/ compulsory for all counsellors or mental health services providers"* and training all counsellors or mental health services providers in clinical supervision. Most respondents reported CS as non-mandatory in disciplines of mental health in Botswana, perceived it as a novel idea, and counsellors as having limited knowledge and skills and many lacking awareness as a challenge in their respective environmental setting. The other issue that emerged was the need to create awareness to improve counsellor education.

Some respondents further suggested establishing an active and effective regulating body to provide screening and licensing of qualified professional counsellors, whilst most suggested making clinical supervision a compulsory requirement for all counsellors in the country.

It can be concluded from the thematic analysis that there is a poor or low level of access to clinical supervision by counsellors in Botswana, the majority are not trained in CS, and counsellors possess limited knowledge, competencies, skills and confidence to offer CS to other counsellors. The study also concludes that there is a lack of coordination and regulation hence the suggestion by counsellors and supervisors for improvement and the need for a national framework.

4.7 Connecting the Findings with Literature

This chapter briefly presented the results, data analysis shows what findings of the study mean; however, full discussion, interpretation, implications and recommendations are articulated in Chapter 5.

The results fully addressed the research questions, were in line with the theoretical framework and resonated with the literature reviewed. The findings did not come as a surprise given the literature that had revealed little or no presence of practice (Bhusumane,2007; Msimanga & Moeti, 2018; Muchado,2018).

The findings are in unison with the findings from the empirical literature reviewed on clinical supervision, as reported by previous studies where the majority of respondents thought that having access to clinical supervision was beneficial to the counselling practice and ensured ethical and professional service (Bland,2012; Borders et al.,2014; Saxby,2016; Walsh-Rock,2018; Wosket,2016;).

However, just like the literature purported, the majority reported not accessing clinical supervision despite knowing its significance to counselling.

These are herein presented question by question starting with question 1

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

The findings of this study are consistent with local literature (Msimanga & Moeti,2018; Muchado, 2018) that decries the status reported and no access to adequate supervision by counsellors in Botswana. Walsh-Rock (2018, p.3) study posited; "process that requires consistent supervision meetings, usually weekly, for supervisees to process their counselling experiences to bring a higher degree of attention to clinical skills and case conceptualization". Whilst this resonated with the reported responses by those who agreed to access CS and expressed the benefits they derived from the intervention, similarly, speaks to the findings on the responses of those who reported receiving only "Administrative supervision" and terming it "non-clinical activities" and sighting "Performance reviews" as the main focus of their supervision meetings. The same corresponds with literature on the administrative type of supervision whose sole purpose is on organizational administrative roles including time management, the performance of duties, attendance, staff relations, and implementation of organizational protocols and policies (Dollarhide & Miller, 2006; Smith, 2009; Walsh-Rock,2018), this was evident in statements such as; *"The only form of supervision I receive is mostly administrative; performance reviews based on my PDP which is done quarterly and end-of-year appraisals."*

These excerpts resonated with Inman and Ladany (2008) in Watkins (2014, p.267) who posited in their findings that; the "strongest conclusion that we can make about... clinical supervision is that it continues to be a path less travelled". Consequently, as was presented in the literature review (Borders 2005; Inman & Ladany,2008; Inman et al.,2014; Ladany & Inman,2008; Walsh-Rock,2018) where counsellors reported receiving inadequate CS, that correlates with the findings of this study as both counsellors and supervisors reported not accessing the service.

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

Kroeger et al. (2011) and Stockton et al. (2010) raised the same concerns regarding uncoordinated psychosocial support services that were initiated with aims to address HIV and AIDS and related issues in Botswana, wherein lack of appropriate training in counselling and lack of counsellor supervision were also articulated as concerning. The excepts simply show the consistency that was established, literature supports the findings on variables. Literature is consistent with the responses from the majority of participants who reported not being trained in supervision and therefore not knowledgeable about it, whilst others reported having the awareness but not being skilled to provide the service. Many reported knowing very little about CS; for example, one said; *"I have awareness, but I wouldn't say I am knowledgeable enough to provide clinical supervision."*

All this is in line with Herlihy et al. (2002) study findings that found that creates a "cycle of inadequate and ineffective clinical supervision". Moreover, as was opined in the literature review, the presence of qualified supervisors does not guarantee adequate, high-quality clinical supervision due to other factors such as perceptions, time, interest, education and experience in clinical supervision (Benshoff,2008).

Research Question 3: What is the Attitude of Counsellors Towards Clinical Supervision in Botswana?

Despite many reporting a lack of awareness and expressing a knowledge deficit, an overwhelming majority expressed positive attitudes towards the intervention and the desire to learn more about it. Similarly, those accessing it shared the benefits they derive from accessing the supervision;

"I value clinical supervision; I always feel refreshed and less stressed after attending a supervision session. I find clinical supervision very beneficial and I wish every practitioner could access it including the "para-professional" This correlated with literature findings on the studies that attributed counselling efficacy to the benefits of clinical supervision, for example; according to Atzinger et al. (2016), clinical supervision has numerous benefits, mostly linked to providing clinical self-care support to create evidence-based and balanced

professional support to empower the supervisees for professional development and effective service provision and integrity of the profession.

Research Question 4: What is the Practice of Counsellors Towards Clinical Supervision in Botswana?

The majority of respondents reported a culture of non-existent and uncoordinated practice, operating in silos and clinical practice being impacted by a lack of knowledge and skills. Similarly, the World Health Organization ([WHO],2010) 2010 survey involving 147 countries indicated that clinical supervision was practised only in 43.5% of the countries. Falender and Shafranske (2012) also found that; "just because counsellors underwent training and completed their various degrees in counselling and in clinical supervision does not equate to application in practice" supporting segments such as; *"Honestly, in our country, it is not done, never heard of any of my colleagues even suggesting it or talking of having gone to see their clinical supervisor".* Despite the majority echoing this, a few voiced their ability to demonstrate relevant skills in practice

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

The majority of the counsellors reported being guided by ethical principles from foreign countries from where they received their counselling qualifications, and many expressed not being familiar with any local guiding principles and not being affiliated with any organization. Only a few reported being affiliated with the Botswana Counselling Association; *"I mostly Google and refer to Australian Counselling Association ethics or American Counselling Association just to stay on course".* Local literature on the status of clinical supervision in Botswana reported it to be uncoordinated and haphazard due to a lack of an effective regulating body, and lack of a common national framework to guide counsellors on CS, which leads to trial and error implementation by a few who try, and a lack of access to CS for many, leaving professional counsellors and "para-professionals" ineffective, possibly impacting CS, counselling service provision and creating possible harm to clients (Coker & Majuta,2015; Msimanga & Moeti,2018; Muchado,2018).

Research Question 6. What are the Strategies for Improving Clinical Supervision of Counsellors in Botswana?

The majority of counsellors and supervisors suggested making clinical supervision mandatory to help improve the practice; this was evident from excerpts such as; *"I think that because it is not mandatory, clinicians don't seem to think that it is a requirement in our country."*, others suggested that CS should be part of counsellor education, however, literature has revealed that; "it is all too often an inadequately addressed or an entirely missing ingredient in psychology curricula and clinical research" (Falender, 2018, p.1240) . Therefore, suggestions by the majority of respondents to have CS as a mandatory requirement also incorporated into the counsellor-training programme are consistent with the literature.

4.8 Connecting the Results to the Theoretical Framework

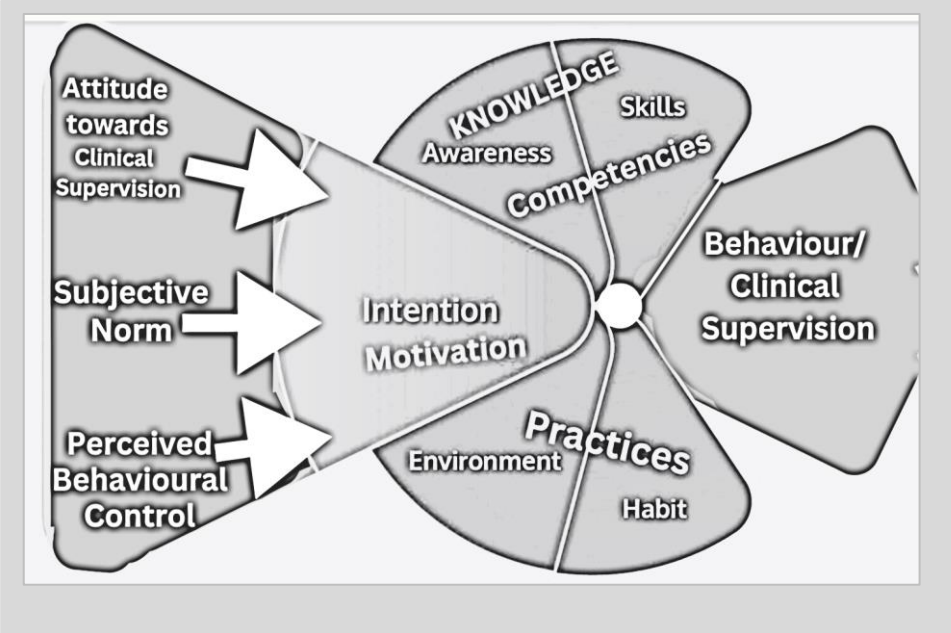
It is worth reflecting on the theories underpinning this study, and how the findings link with the theoretical framework. This is a brief discussion of how the framework that was fully discussed in Chapter 3 ties into these research findings. From the theory of social constructivism respondents had a voice in the study by responding to open-ended questions by way of semi-structured interviews as they freely shared their lived experiences of CS, and constructed their social meaning of the situation in their respective practising environments. This allowed the respondents to give their experiential self-reported disclosures from their understanding of CS. 38 respondents participated, majority of them reported "no access" to CS (Bland,2012; Sano,2019; Saxby,2016). Looking at the study from this lens, and at the rich data that was derived from semi-structured interview responses, the theory of social constructivism proved helpful in the development of the guideline questions for approaching without preconceived notions by the researcher. This enabled open and free disclosure by respondents as evident from their responses. Therefore, the constructivist philosophical paradigm proved to be an efficient instrument that yielded voluminous qualitative data (Adom et al.,2016; Guiffrida,2015; Sano,2019).

The theory guided the full exploration and a large number of counsellors reported a "lack of Clinical Supervision", working in "unsupportive environments", and being involved mostly in "non-clinical activities".

These issues would have probably been difficult to derive from the study without social constructivist theory. The other components of the theoretical framework were discussed in Chapter 3. TRA/TPB assume that individuals' intentions to perform the behaviour are largely influenced by attitude, perceptions and envisaged benefits (Luenendonk,2019**).**

Figure 19

Showing TRA/TPB Model



Adapted from Amalathas et.al (2023)

Both data sets indicated that respondents reported positive attitudes towards CS, and those who reported a lack of training indicated their desire to learn. Therefore, the study findings seem to support the assumption that the desire or intent to practice behaviour is determined by one's attitude and perceptions towards it and PCB (knowledge, competencies, skills and awareness) play a role in influencing the intention as well as social pressures (practices, habits and environment). The expressed expected benefits and interest in learning and accessing CS by respondents imply reasoned intentions.

Those who reported accessing clinical supervision shared its benefits and how they always felt less stressed. They assessed the benefits; and weighed and reasoned out the gains attained from clinical supervision, hence their desire to continue accessing CS seemed influenced by their reasoning on the inherent benefits

derived from CS intervention (Sheppard et al.,1988). Respondents also reported the ability to address ethical dilemmas from accessing clinical supervision, therefore, the theory adequately helped to understand the findings and explained the findings concerning the issue of lack of awareness, knowledge of CS and practices among counsellors. Therefore, the theory was useful in helping to understand counsellors' reasoned actions and motivation towards CS, it made the findings make sense as it facilitated the exploration of counsellors' knowledge, attitudes and practices of CS, and the behavioural intentions to provide and access clinical supervision (Ryan & Carr,2010).

Based on the Perceived Behavioural Control aspect; whether or not they believed they had the knowledge and competencies to provide CS, many disclosed not being confident, competent or knowledgeable to conduct supervision (Sheppard et al.,1988). therefore, the findings show that the majority of counsellors reported not providing CS due to a lack of training and lack of knowledge. Many expressed not accessing supervision as there were no trained clinical supervisors, whilst some indicated having a positive attitude towards the intervention but not accessing it due to lack of trained supervisors or being expected to carry out non-clinical activities and lack of guiding principles. This theory helped to understand the reasons given for the "lack of Clinical Supervision". Relating this theory, study gave an understanding of both the reported CS knowledge and skills.

Theoretical framework helped in making sense of findings from human social perspective. TPB assumes that planned behaviours such as Clinical Supervision are influenced by intentions largely attitudes, behavioural control beliefs, normative beliefs and subjective norms encompassing social pressures, expectations by others and availability of resources for the execution of the behaviour, combined with the perceived behavioural control which involves self-efficacy, knowledge, competencies and skills (Ajzen & Fishbein,1985,1977,1975; Cameron et al.,2012; Cameron, 2010; Ryan & Carr,2010).

The above findings support the deployment of theoretical triangulation of Social Constructivism, under this theoretical framework, counsellors' positive attitude towards accessing and providing clinical supervision was expected to influence their intention to access and provide CS.

However, their actual performance of the intervention, despite the perceived positive benefits of performing the behaviour, did not correlate. Hence, the findings show only a small number of counsellors accessing and conducting supervision CS.

Examining the findings in line with the theoretical framework and from the two opposing epistemological or philosophical paradigms gave strength. Respondents reported positive attitudes towards CS; some reported training, awareness, supportive environments, their desire to learn about CS, the need to be trained in CS, and gave suggestions towards improvement. Therefore, despite positive attitudes and perceived benefits of clinical supervision reported by counsellors, there are subjective norms; social environment (non-supportive environment), policy, trends, regulation, training and other external social influences that appear to have contributed to ineffective and poor clinical supervision implementation by many counsellors (Luenendonk, 2019). This theoretical framework was consistent with the findings and supported the results having helped to unearth counsellors' positive attitudes, limited knowledge, poor level of access, ineffective practices and lack of guiding principles, non-supportive environments, and suggested strategies for improvement. The framework adequately undergirded the investigation and unearthed positive and negative themes surrounding the knowledge, attitude and practices of clinical supervision among counsellors.

4.8.1 Evaluation of Findings

Having attempted to highlight the application of the theoretical framework, next gives detailed study findings and articulates answered questions. The discussion started with the convergence and divergence, the study findings, how the second phase corroborate or elucidate the results of the quantitative data findings. From the two aspects of the study, the majority of respondents reported "not having Access" to clinical supervision, whilst a few reported having "access", Many reported areas of concern including; "lack of Clinical Supervision", whilst others reported functioning in "non-supportive" environmental settings. Nonetheless, some of the respondents expressed their desire to access clinical supervision whilst others gave their reasons for the desire to access CS which they linked to positive outcomes such as; ethical and professional practice.

Those who reported a lack of clinical supervision expressed concerns over; “non-clinical activities” which they attributed to policy and ineffective regulation of the clinical supervision practice in the country. Respondents felt that clinical supervision training was crucial and could contribute immensely towards the professionalization of clinical supervision. Thematic findings are consistent with findings of the quantitative results.

There was consistency and consensus between the results from study 1 (quantitative) and study 2 (Semi-Structured Interviews) results. Viewing these findings from the lens of the theoretical framework or underpinning theories, the researcher believes that there were no surprises or conflicting results between study 1 and study 2 findings. The results were found to be in line with the literature review that had already indicated nor suggested CS presence in Botswana. Therefore, there were no surprises; there was more convergence between the findings of Study 1 (questionnaire) and the responses to Study 2 (interviews). The respondents expressed a positive attitude towards CS but felt that it was foreign and not a regular part of their professional practice. Counsellors expressed concerns over the general state of CS practice in their respective environmental settings, districts, and in the country as a whole and went further to suggest strategies towards improving clinical supervision practice in the country.

In juxtaposition of findings, this mixed methods, literature review findings, conclusion is that if there was a high demand for access to CS, there would be pressure on service providers who also lack knowledge and skills which could lead to clinical supervisors being overwhelmed resulting in poor service, and under such circumstances, the country’s mental health would possibly face challenges. Similarly, if the findings revealed negative attitudes, that was going to negatively impact the counsellors’ responsiveness to CS and its development.

The hypothetical analysis made is that due to a significant percentage of positive attitudes, with findings juxtaposed; if counsellors were knowledgeable, clinical supervisors qualified and CS regulated, there could be considerable access and effective implementation in the country.

There is a substantial convergence data finding, therefore, are significant not likely to have resulted from chance, and therefore hoped to significantly influence Botswana.

Summary

Presented all components of the chapter. Majority of responses show that most counsellors have no access to clinical supervision, few reported having training and knowledge on CS, whilst majority indicated not being trained in CS. However, counsellors perceived clinical supervision as being beneficial for enhancing ethical practice and professionalism. The majority reported working in non-supportive environments and performing non-clinical activities. Respondents suggested strategies towards improving Clinical supervision in the country which included making it mandatory, incorporating it in counsellor education, strengthening regulation and introducing licensing for counsellors and all mental health practitioners.

The next chapter gives a meta-analysis for better understanding, and goes on to give detailed discussion of the findings to indicate areas of convergence and divergence as well as suggest future research.

CHAPTER 5: IMPLICATIONS, RECOMMENDATIONS, AND CONCLUSIONS

Chapter Introduction

The problem investigated by this mixed-method research was the knowledge, attitudes and practices of clinical supervision among counsellors in Botswana. The study used an Explanatory Sequential research design. Counselling is a fairly new and unexplored phenomenon in Botswana; therefore, it seems to be an unfamiliar practice that has never been investigated in the history of counselling in Botswana despite being a significant part of counselling and a mandatory requirement globally. The dearth of local literature revealed very little or no empirical evidence of the existence of the intervention in the country. It was on this basis that there was the need to establish level of clinical access, assess counsellors' knowledge, examine attitudes to determine clinical supervision practices, determine ethical principles guiding their clinical supervision practice, and examine possible strategies that could improve CS among counsellors.

To achieve this purpose, the study explored available literature to establish the extent of research that had already gone into the issue, in the process there was evidence of lacking empirical research in the country despite the intervention being well-established and extensively researched globally. Used quantitative approaches, and for balanced investigation qualitative method was deployed for quantitative data's complementarity, corroboration and explanatory purposes.

The study also triangulated three theories; social constructivist approach, and also attempted the triangulation of data collection tools (questionnaire and semi-structured interview). There was also triangulation of data analysis techniques to ensure the credibility of results, validation and a multidimensional approach to reaching genuine findings from authentic exploration of the phenomenon from the different lenses to reduce biased findings. The lack of empirical local literature inspired the researcher to investigate the phenomenon to establish what the situation was in Botswana regarding CS. There was what appeared to be an alarming deficit of empirical literature on this intervention across mental health professions in the country which triggered the researcher's interest.

Identified limited literature in the form of conference and seminar papers lamented the status of the quality of counselling services reported to be emanating from the lack of clinical supervision of counsellors. There was enough evidence to indicate that Botswana was lagging in research which created questionable clinical practice in the counselling field. This perspective was echoed by local scholars such as Msimanga & Moeti (2018); Muchado (2018); Bhusumane (2007) and Coker & Majuta (2015).

Clinical Supervision (CS) can be described as a therapeutic and developmental helping relationship between a more experienced counsellor (Supervisor), and a less experienced counsellor (Supervisee) for professional growth and clinical self-care (Bland,2012). In this mixed methods research, data was collected through a questionnaire followed by semi-structured interviews. Data was analyzed using multiple techniques to achieve triangulation, corroboration and validation of results.

5.1 Limitations and Ethical Dimensions

This mixed methods study used explanatory sequential research designs, therefore the primary means of collecting data was through a questionnaire which was analyzed and the results were used to inform the next phase of conducting semi-structured interviews to make sense of the numeric data derived from the quantitative method. The study relied on the authenticity of each of the participants to provide credible self-reports of their lived experiences of clinical supervision in their respective environmental settings.

The use of self-report surveys and face-to-face interviews may have been a major limitation of the study as self-reports are synonymous with biases because respondents solely controlled the amount of information to disclose. The use of interviews often leaves room for respondents to share the information that they feel will be pleasing to the researcher; in this case, the interaction may have influenced the authenticity of the data provided. This study was not intentionally gender specific, and that may have allowed for a very small representation of male participants which may have impacted the outcome of the study.

Therefore, the quality and authenticity of the information depended largely on the willingness of the respondents and that may have been a limitation.

This study focused on several variables to establish the knowledge, attitudes and practices of clinical supervision among practising counsellors, in the process, the study revealed that many of the counsellors were not trained, lacked knowledge and were less likely to access the intervention. The inference made is that the situation may be contributing to unethical clinical practices of CS.

Similarly, structured questions for the questionnaire are by nature limiting and leave no room for explanation, hence, interviews had to be used as follow-up to explore areas that indicated possible discrepancies and contradictions. Moreover, the geographical locations from which participants were drawn purposefully selected 5 districts out of the 10 for the study; inaccessible and remote rural areas were excluded due to the time factor and limited resources, therefore, counsellors stationed in such areas who could have shared their unique experiences were excluded.

Generalizing may be possible to similar populations and counsellors with similar characteristics used in this study. It is possible that individual differences are likely to have influenced the results derived from the current research, and may also yield differing results when and if studied under different settings with different populations. Therefore, results from this study may not be applicable in other clinical practice settings where knowledge, attitudes/perceptions, and cultural and ethnic issues may influence the outcome of the study in such situations.

Limitations may have also emanated from the different modes and what may mean to the different participants in the different counselling environmental settings and may have influenced responses. The study showed that counsellors were drawn from counselling, psychology, social work, counsellor education, nursing and education. Therefore, the different environmental settings may have influenced counsellors' participation in the study and influenced the results of the study. Participants reported concerns and experiences of operating in what they termed "non-supportive environments".

The issue of the non-supportive environment was one of the themes or content categories that kept emerging in interviews among counsellors across different environmental settings.

Additionally, the majority of counsellors indicated that they mostly accessed administrative supervision which involved taking part in non-clinical activities, whilst only a few reported accessing either individual, group or peer-to-peer mode of clinical supervision.

The major method for recruiting participants may have been limiting as it was through sending out emails requesting participation consent and questionnaires, for those without internet connectivity the questionnaire was physically delivered though the process was more time-consuming. The same was the case for semi-structured interviews that were done in person (face-to-face); consent forms and guiding questions were sent by email and followed up by telephone.

Rural areas and semi-urban areas, participants mostly had to be reached through emails in places where there was internet, otherwise for many it was by hand delivery of questionnaires and interviews by telephone calls. An accurate return rate for the questionnaires and the consent forms that were sent out was not easy due to inability to ascertain exactly how many counsellors received the invitation as some did not respond to the emails sent, whereas those contacted by telephone for follow-up acknowledged having received the questionnaires and consent forms; but sometimes the same were not returned.

Another limitation may have emerged from the use of ranges for items involving time such as years of experience and age of participants; that may have limited the accuracy of data and delineations within those ranges. Notably, this study was not concerned with cause-and-effect relationships between variables and constructs but sought the expressed views, insights, observations and experiences of the participants. Therefore, semi-structured interviews allowed respondents to express their views at greater length to illicit vast amounts of information which resulted in voluminous data that may have influenced the results during the data analysis process (Ary, et al., 2010).

On ethical dimensions, research participants were briefed on nature, its significance and issues of confidentiality. Respondents signed consent form as a way of agreeing to participate in the study.

There was adherence to counselling research ethics to guide the whole process; this being an essential requirement when dealing with human subjects. Similarly, data collection approvals were sought both from UREC and local authorities.

Participation was voluntary and respondents were not coerced in any way into taking part in the study, there was no deceit used in the recruitment of research participants and no monetary incentives to entice participants; participation was ethical and adhered to the confidentiality and protection of research participants.

Respondents were made aware of counselling field and practice, the objectives and inherent benefits of participating aimed towards value-addition to empirical literature and the practice, the implications of respondents' participation were explained and they were assured of confidentiality and privacy protection through the coding process, therefore, respondents willingly consented. Participants were also made aware they could freely withhold their participation if they wished without having to give account. The respondents were further assured that in such a situation their data would be deleted and excluded from the study. The identities of all were not disclosed in research findings and reporting. To further protect the identity of respondents' data coding was adopted by numbering respondents from 1 to 210 for questionnaires and 1-38 for interviews, the number coding was intended to maintain the anonymity of participants and the same coding system was maintained in the reporting of the research findings (Bryman & Cramer,2009; Rallis & Rossman,2009).

Research processes especially during the data collection stage did not pose risks to the participants, and there was no use of deception in the study. The study relied on the data collected to reach conclusions, possible researcher biases were addressed through peer checks, consultation with the research project supervisor, consequential thinking, mindfulness and the need for credible outcomes. Therefore, personal beliefs and assumptions were regulated not to influence the reporting but to genuinely demonstrate step-by-step how conclusions were reached solely based on data (Bryman,2006,2008).

Methodological and sample size limitations could have influenced the results; the use of purposeful sampling, convenience sampling as well and snowballing may have also impacted the outcome of the study, the data collected was dependent on the willingness of the respondents to provide credible information and data was allowed to do the talking.

Questionnaires are well known for being well structured and limiting as are designed from the researchers' positivist paradigm, and as such, have the potential to influence the research findings. Therefore, to guard against biases, opposing epistemological paradigms were utilized in the study. The study population sample size may have also influenced study and possibly only to the sample from which the respondents were drawn (Heinrich & Klein, 2021; Choy,2014).

This chapter draws together results from the quantitative and qualitative studies and examines the findings concerning the wider literature and collected data. The chapter starts the discussion of the findings with analysis, identify and indicate the convergence and divergence in the study results between the two and the discussion is about the existing clinical supervision literature within the local context and about the global trends.

The chapter also discusses the research limitations and recommendations for application, reviewed literature suggests CS mandatory in mental health professions globally, which is a well-regulated intervention beneficial for the provision of effective and ethical counselling services.

Literature also revealed that it is however novel in middle-income countries and lacking in most developing countries (World Health Organization ([WHO],2010); Hall et al.,2015). The triangulated findings showed that indeed it is a less articulated, less accessed, irregular, not well-regulated intervention that lacks a well-established framework and not a common practice in Botswana (Muchado,2018; Msimanga & Moeti,2018).

5.2 DISCUSSION OF THE FINDINGS

5.2.1 Convergence in the Mixed Methods Findings

There was a need to merge, connect and identify areas of agreement in the mixed methods study between the quantitative study findings and those from the qualitative data because interview responses were used to help explain the numeric data derived from questionnaire responses. This was followed by the identification of areas of divergence. There was a significant convergence than divergence in the findings and this is indicated in Table 14 and Table 15.

Table 14

Meta-Analysis: Convergence

METHOD:		Quantitative	Qualitative
DATA COLLECTION		Questionnaire	Semi-Structured Interview
Research Question:		***1. What is the level of clinical supervision access by the 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	*In 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 stated that:* *"I do not have access to clinical supervision, only performance-related supervision when I go for quarterly reviews."* *"I do not have access to clinical supervision at my workplace…. our regular meetings are administrative in nature"* *"I have been doing supervision for 10 years now, but it is not many counsellors who are accessing the service from my practice".*

Research Question:		**2. What is the knowledge of counsellors on clinical supervision?**	
		I am trained in clinical supervision (SA, A, N, D, SD)	What can you say about your knowledge of CS and 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.*	*A significant number of interviewees reported knowing very little or being aware of CS but not trained or qualified to offer it;* *"I am not trained in counselling so… I know very little about clinical supervision……".* *"I have awareness, but I wouldn't say I am knowledgeable enough to provide clinical supervision."* *"Never heard of any of my colleagues even suggesting it or talking of having gone to see their clinical supervisor."*
Research Question:		**3. What is the attitude of counsellors towards clinical supervision in Botswana?**	
		I believe clinical supervision is a good intervention (SA, A, N, D, SD)	What are your feelings and views about clinical supervision?
Findings	*There is positive attitude towards clinical supervision despite the significant level of neutrality which may be rooted in insufficient knowledge and lack of training in clinical supervision practice.*	*(71.4%) of the population sample "strongly agreed" and "agreed", (0.5%) "strongly disagreed" and disagreed and (28.1%) remained neutral.*	*A significant number of interviewees had a positive attitude towards clinical supervision as an intervention:* *"I value clinical supervision. I always feel refreshed and less stressed after attending a supervision session. I find clinical supervision very beneficial"* *"It is a very beneficial service for counsellor growth, and I wish every counsellor had access to it. I do enjoy attending clinical supervision because, to me, it is empowering, and it helps me to evaluate my service provision, and my competencies, address dilemmas and get to know how best I can always improve. As a supervisor, I also get supervision on the clinical supervision I provide…."*

Research Question:		**4. What is the practice of counsellors towards clinical supervision in Botswana?**	
		I am confident in providing CS service (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 reported being confident in providing CS, majority (52.7%) "strongly disagreed" and "disagreed" to the statement whilst (15.3%) were neutral.*	*Some reported having information on clinical supervision 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 it is non-existent in practice, that's all".*
Research Question:		**5. What are Ethical Principles that guide 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 in the country.
Finding	*No regulating body guides clinical supervision as a practice but the participants are affiliated with other regulating bodies that guide their various practices just not clinical supervision.*	*(29.5%) "strongly agreed" and "agreed", (55.2%) "disagreed", "strongly disagreed" and (15.2%) remained neutral.*	*Majority of interviewees reported awareness of guiding ethical principles but are not affiliated with any local regulating body. A few reported using ethical principles of international counselling regulating bodies:* *"I have never seen any in this country, so I tend to refer to the ones I used during my studies as a university student".* *"I seem to be more comfortable using the ACA (Australia) alongside the ACA (America)codes."* *"I am not a member of any regulating body; I just function according to the government departmental protocols".*

Research Question:		**6. What are strategies for improving clinical supervision in Botswana?**	
		Making clinical supervision mandatory is a good strategy to enhance the clinical supervision practice. (SA, A, N, D, SD)	What strategies would you suggest towards improving clinical supervision?
Findings	*Overall suggestions were that clinical supervision should be made mandatory, an effective regulating body that provides licensing, provide training and include clinical supervision in the school curriculum from the tertiary level. As well as importance of clinical supervision in other mental health professions.*	*(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 and effective regulating body to provide screening and licensing of qualified counsellors. As well as; making clinical supervision mandatory for all counsellors and all mental health service providers:* *"It should start with counsellor training institutions."* *"It's important to have a strong and effective national regulating body that could ensure adherence to counselling principles, as well as ensuring that only qualified people provide such services…"* *"Should also be made mandatory for every practising counsellor, and that can only happen if there is a licensing body.*

5.2.2 Divergence in the Study Findings

There was consistency between study results from the data. Qualitative data results helped to explain the questionnaire results and there was corroboration, confirmation and very little or no divergence in the findings as indicated in the table below:

Table 15

Showing Divergence in the Mixed Methods Findings

METHOD:		*Quantitative*	*Qualitative*
DATA COLLECTION		*Questionnaire*	*Semi-Structured Interview*
Research Question		***Q1. What is the Level of Clinical Supervision Access by the Counsellors in Botswana?***	
Findings		*No divergence was established or found between quantitative results and qualitative data results.*	*There was no divergence found between the narrative results and the results derived from numeric data, instead, the qualitative data results helped explain the numbers from component in mixed method.*
METHOD:		*Quantitative*	*Qualitative*
DATA COLLECTION		*Questionnaire*	*Semi-Structured Interview*
Research Question		***Q2. What is the knowledge of counsellors on clinical supervision in Botswana?***	
Findings		*No divergence between quantitative results and qualitative data results.*	*None divergence established*
METHOD:		*Quantitative*	*Qualitative*
DATA COLLECTION		*Questionnaire*	*Semi-Structured Interview*
Research Question		***Q3. What is the Attitude of counsellors towards clinical supervision in Botswana?***	
Findings		*No divergence between quantitative results and qualitative data results.*	*None divergence established*

METHOD:		*Quantitative*	*Qualitative*
DATA COLLECTION		*Questionnaire*	*Semi-Structured Interview*
Research Question		***Q4. What is the Practice of counsellors towards clinical supervision in Botswana?***	
Findings		*No divergence between quantitative results and qualitative data results.*	*None divergence established*

METHOD:		*Quantitative*	*Qualitative*
DATA COLLECTION		*Questionnaire*	*Semi-Structured Interview*
Research Question		***Q5. What are ethical principles that guide counsellors in Botswana?***	
Findings		*No divergence was found between quantitative results and qualitative data results.*	*There was no divergence between quantitative results and qualitative results only corroboration.*
METHOD:		*Quantitative*	*Qualitative*
DATA COLLECTION		*Questionnaire*	*Semi-Structured Interview*
Research Question		***Q6. What are Strategies for Improving Clinical Supervision in Botswana?***	
Findings		*No divergence was found between quantitative results and qualitative data results.*	*There was no divergence between quantitative results and qualitative results only corroboration.*

5.2.3 Demographic Findings

The findings from the study revealed that there are more female members in the counselling or helping profession than males. The study further revealed that participants were largely from three generations; Millennials, Generation Z and X, with the largest percentage of 71 being from the Millennials age bracket 36-45 years. This was followed by Generation Z age 46-55 at 29.5 percent and Generation X bracket (25-35) years at 28.6 percent, whilst there were very few from the Baby Boomers age group (59-68) with 17.8 percent.

The study showed that the largest percentage of participants were mostly Millennials, with a few from Generation X and Generation Z giving a cumulative 91.9 percent. Counsellors across mental health professions

in the specific generation age group were affected. The study revealed that participants came from the five sampled districts with the majority of respondents being from the South Region with 31 percent followed by South-East with 21.7 percent.

Participants came from different counselling environmental areas across mental health with half (59.5) percent of the population from public schools, followed by NGOs with 16.7 percent. Participants' field of specialization varied from counselling in the majority with 27.1 percent, followed by Guidance and Counselling with 23.3 percent and the third largest being Humanities with 12.4 percent; humanities being Senior Teacher 1 - Guidance and Counselling teachers who specialised in different subjects other than G&C but operating in the office portfolio of guidance and counselling whose function is to provide counselling for learners in the school. Participants from Psychology made up only 11.9 percent, and 11.4 percent of participants were from Primary Education followed by Social Work with 10.5 Percent.

There were related themes that emerged from the results and are discussed in this section of the study findings. Such themes appear to fall into two main patterns; negatives and positives in each of the variables and about the research question that was discussed in Chapter 4. Three major sub-themes were established from the study results and that included; access, no access and issues. Under the "access" theme there were reported benefits and professionalism being the major outcome, and under "Issues", there were patterns on three main concerns raised; policy, non-supportive environments and strategies, whilst concerning the "no access" emerged themes were lack of clinical supervision and non-clinical activities.

This discussion of research findings is systematically carried out per each research question.

5.3 Research Questions

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

i) No Access

The findings revealed access to clinical supervision among the majority of counsellors was poor; a significant 43.3 percent of participants did not disclose whether or not they accessed clinical supervision; they chose to be neutral on this issue of access. Only a small percentage of 33.4 of respondents reported having "no access" to the intervention. This implied that there was a significant percentage of lack of clinical supervision, and this was a common and consistent theme in the study between the two methods mixed in this study. Therefore, from the results it can be concluded that a significant number of participants reported "no access", and in consideration of the sample size, this is a significant percentage worth noting. From the findings, it can be concluded that the majority of counsellors do not provide nor receive clinical supervision and hence the study concludes that there is very low access to it.

ii)Access

On the other hand, only 23.3 percent of the participants reported having access to clinical supervision. It was surprising to see the majority of participants (43.3%) having chosen to be neutral concerning this issue. Those who reported accessing CS went further to volunteer the benefits they derived from the clinical supervision intervention. One mentioned always feeling refreshed, motivated, less stressed and clinically supported after attending supervision sessions. Respondents also expressed accessing different types of clinical supervision ranging from individual, peer-to-peer to group supervision.

Based on the findings, the justification for the overwhelming lack of access to clinical supervision by counsellors and the poor percentage of access inference could be attributed to limited knowledge, lack of clinical supervisors and lack of effective regulation of the CS practice in Botswana. In juxtaposing the narrative, the country's mental health would possibly face challenges if the majority of counsellors were accessing clinical supervision as the situation could overwhelm the few existing qualified clinical supervisors

which could impact the frequency of access and the quality of the service given. Similarly, the situation would have financial implications in efforts to train more clinical supervisors to meet the needs and the demand for the supervision service.

Q2. What is the Knowledge of Counsellors on Clinical Supervision in Botswana?

i) Lack of Knowledge

The findings showed that the majority of respondents' knowledge of clinical supervision was inadequate due to a lack of training and competencies, some reported that not only were they not trained in clinical supervision but they specialised in areas unrelated to counselling; whilst a few reported being unqualified in counselling such as teachers in some schools and yet assigned the responsibilities of providing counselling for learners. Many expressed a lack of awareness of clinical supervision as a requirement in counselling, whilst some stated not being aware of the existence of any trained and experienced clinical supervisors from whom to receive the CS service. Many expressed being qualified counsellors but not trained or experienced to provide clinical supervision which is contrary to the literature review that; clinical supervision has to be provided by experienced and licensed clinical supervisors (Glaes,2010; Bland,2012).

The study revealed three groups of counsellors; those who reported not being aware of clinical supervision and therefore not accessing it, those who reported who were aware of it but not accessing it, and those who are aware, knowledgeable and trained in CS and providing it inconsistently.

With this type of scenario drawn from the study results, the next research question was crucial, as theoretical underpinnings in Chapter 3 had demonstrated that knowledge may impact intentions, motivation, desire and ultimately the attitude towards performing the planned behaviour (clinical supervision).

The inference that can be made from the findings on lack of knowledge of clinical supervision could possibly be due to CS not being part of the counsellor education curriculum. Juxtaposing this situation, it is understandable why there is poor implementation of CS, with limited knowledge supervisees could be exposed to harmful CS, and knowing may not necessarily influence participation in CS. Other factors may have an

influence such as cultural norms, perceived benefits, the perceptions of those around them such as other counsellors, administrators, and managers, subjective norms, individual self-preference, self-skills-evaluation as well and public opinion. This is because attitudes, subjective norms, affect one's intention and motivation to practice a planned or reasoned behaviour.

Naturally, people can process; reason and decide whether or not to practice a behaviour based on their beliefs and the gratification derived from performing it. Hence, despite knowing supervision, it is possible that based on the outcome of their reasoning and what they believe they stand to benefit, some participants may not necessarily act. Lack of knowledge implies that the provision of CS may be done by unqualified and less experienced supervisors, and lack of supervision could be due to not being comfortable accessing supervision from inexperienced or unqualified supervisors for fear of being possibly exposed to a harmful form of supervision. On the other hand, it may be emanating from held attitudes, perceptions and anxieties related to viewing CS as a fault-finding exercise. The Plethora of empirical literature in Chapter 2 alluded to the existence of harmful clinical supervision with incidents of victimization of supervisees in different parts of the world (Walsh,2015; Hendricks & Cartwright,2018; MacNamara et al.,2017).

Q3. What is the Attitude of Counsellors Towards Clinical Supervision in Botswana?

i) Non-Clinical Activities

The study established that many counsellors across mental health professions have positive attitudes towards clinical supervision despite not having access, they believe that it is a beneficial intervention with the potential to improve their clinical skills, enhance their counselling skills and provide an essential platform for clinical self-care and professional development. Some stated their feelings of being "refreshed", less stressed, and empowered following their attendance of clinical supervision sessions. They reported that the intervention enabled them to address ethical dilemmas, self-evaluate and gain the confidence to provide effective counselling and clinical supervision services.

Many respondents expressed valuing CS and desiring for all clinicians to have the awareness and the desire to access it. Therefore, this study has revealed the existence of a knowledge gap that has possibly impacted the practical implementation of clinical supervision (practice), and a possible detachment between theory and practice as evident from the reported "lack of clinical supervision" among counsellors in Botswana.

Consequently, many participants reported being involved in "non-clinical activities" in the form of performance review meetings, project reviews and administrative type of supervision that focused largely on time management, job descriptions, performance indicators, balanced scorecards, time management and staff relations.

However, as was pointed out in Chapter 2; administrative supervision exists to ensure that counsellors are ethically fulfilling their job requirements or job description, record-keeping, legal boundaries, and compliance with organisational policies, whilst clinical supervision exists to ensure the quality of the counselling process through reduction of burn-out, confidence building, sharpening clinical skills, preventing unethical practices and ineffective counselling services (Benshoff,1988).

ii) Benefits and Professionalism

Those who reported accessing clinical supervision highlighted the benefits derived from the intervention, they linked the benefits of clinical supervision to clinical self-care, reduced anxieties, ethical practice, confidence-building, professional development, effective service provision, enhanced counselling skills, ethical practice and overall professionalism.

One respondent stated; "I value clinical supervision; I always feel refreshed and less stressed after attending a supervision session", whilst another reiterated; "I find clinical supervision very beneficial and I wish every practitioner could access it including the para-professional and those new in the field……" Despite clinical supervision being reported to have immense benefits, it is surprising to see that a very small percentage of counsellors access the intervention as revealed by the results of this study. At the same time, based on the literature, these findings did not come as a surprise, they correlate to the literature findings.

Participants reported the duration of their clinical supervision session to be between 45 and 60 minutes and disclosed their desire for CS to be well-planned rather than haphazard, well-regulated and mandatory for the effective and professional provision of counselling services to attain a high level of professionalism, counsellor development and clinical self-care. Consistent literature revealed that; "supervision is to improve client care, develop the professionalism of clinical personnel, and impart and maintain ethical standards in the field" (Msimanga & Moeti,2018).

The justification for the positive attitude of the majority of counsellors towards clinical supervision could be attributed to intentions, motivation and the desire for the professionalization of CS in the country. With the study findings indicating that the majority of counsellors have a positive attitude toward clinical supervision, it would be easy to assume that there would be a reported large number of counsellors with knowledge, competencies and skills of clinical supervision resulting in high levels of access to the intervention but the opposite seems to be the case.

Therefore, it may be inferred that a positive attitude does not necessarily equate to implementation, application or practice. It could be assumed that with the reported limited knowledge and lack of access, the respondents' attitude to clinical supervision would be negative.

Q4. What is the Practice of Counsellors Towards Clinical Supervision in Botswana?

i) Lack of Supervision

What was surprising with the results was the significant percentage of participants who chose not to disclose whether or not clinical supervision formed part of their clinical practice which they accessed or provided in their environmental setting whilst a few reported having clinical supervision in their practice; providing it as well as accessing it at their workplace or outside their working environment.

The results clearly showed that an overwhelming majority of counsellors experienced a lack of clinical supervision as they reported not practising the intervention. It is also evident from the results that though a few reported proving and accessing it, their efforts are irregular and haphazard, whilst the duration of the sessions

also differed from one environmental setting to another. The study indicated that effective coordination is lacking and hence uniformity in practice is unheard of.

Some expressed concerns over time allocated to clinical supervision, they felt that work schedules leave very little time for the supervision, and they reported less time as a result; roughly about 45 minutes. It's therefore worth noting that 33.4 percent reported "No Access"; implying that there is a major concern for the practice. This percentage is despite the literature in Chapter 2 having indicated that clinical supervision is the type of intervention that has to be "intentionally designed to improve the practical application of counselling theories and techniques" (Johnson,2020).

Justification made for these findings is that clinical supervision practice is compromised, ineffective and unplanned in the country. As the literature has indicated, clinical supervision is a process that requires consistent supervision meetings, usually conducted weekly to process counselling experiences (Walsh-Rock,2018).

The issue of Practice links to policy, regulation, accreditation and licensure which ultimately speaks to ethical practice, professionalism and professionalization of clinical supervision in the country. On the other hand, with the reported lack of knowledge and competencies, it would have been a great concern if there was a reported large number of counsellors offering clinical supervision, because; clinical supervision practice is a highly ethical and professional field that has to be offered by well trained, experienced and licensed counsellors as it does not only impact on the supervisees, but ultimately manifest in what goes on in therapy rooms.

Hence, the findings are not surprising as can be assumed that counsellors feel ill-equipped to offer clinical supervision, as literature is replete with evidence of harmful supervision and incidents of "quacks" in situations where unqualified, inexperienced and ineffective supervisors provide supervision to supervisees resulting in possible harm and negative supervisory working alliance (Milne & Reiser,2012).

Q5. What are Ethical Principles that Guide Counsellors in Botswana?

i) Issues

The study showed issues and patterns emerging as themes across the data and such issues included policy, and non-supportive environments said to be hindering the ability to access clinical supervision, and the same contributing to suggestions of the strategies that were felt could be deployed towards improving the CS in the country. The three major common themes in the study included lack of access ("no access"), access, and issues within the intervention.

Sub-themes that emerged under access included perceived benefits and professionalism, whilst under issues emerged non-supportive environments, strategies and policy whilst lack of access and non-clinical activities were sub-themes that emerged under "No Access" to clinical supervision. Many reported lacking clinical supervision services and instead lamented about receiving administrative supervision and being more engaged in non-clinical activities. Many counsellors reported receiving a form of supervision they considered non-clinical from under the perceived "non-supportive environments".

ii) Non-Supportive Environment

Many counsellors reported their environmental settings to be non-supportive to clinical supervision which they claimed contributed to them not accessing any mode of supervision except the administrative type of supervision that was focused mostly on "non-clinical activities". The study showed that respondents felt that their environmental settings were not supportive towards clinical supervision.

Many believe that the situation was due to a lack of policies, a lack of national framework, a lack of guiding principles, ineffective regulation and licensure issues that hinder the ability to have clinical supervision and that the same were hindrances to effective counselling in the country. Also revealed by the study is a lack of training which was reported by many to have resulted in limited knowledge and a lack of competencies to provide supervision, ultimately impacting the ability of many to access CS. Consequently, counsellors could not access or implement that which was unknown to them.

In this study, it was evident that a lack of knowledge and skills had the potential to influence the desire, intention attitudes and/or perceptions of counsellors towards the practical implementation of the clinical supervision practice. These issues, therefore, serve as the major reasons and justification for the findings. Without an effective regulating body and national framework and/or ethical principles to ensure compliance and adherence, these findings are not surprising but rather are evidence that a lot has to be done in the field of counsellor education, ethical practice, professionalization of clinical supervision, counselling profession and mental health as a whole. Literature has also shown that counselling is a psychological profession that requires psychological practice supervision (Watkins,2014).

The fact that the majority of counsellors reported using different ethical principles from differing foreign countries, and very little evidence about the existence of a national guiding framework speaks volumes about the standard of professional counselling, the state of coordination, regulation and counselling in the country. Contrastingly, if ethical principles were in existence, it would lead to uniformity and cause counsellors to comply; which would probably lead to more awareness and more access to clinical supervision. Currently, as the findings have shown, not having ethical principles leaves room for mediocre, unethical ineffective practices and possibly questionable standards of professionalism (Muchado,2018).

Q6. What are Strategies for Improving Clinical Supervision in Botswana?

i) Policy and Strategies

The study revealed a great concern from many counsellors concerning the status of clinical supervision in the country. Consistently echoed the desire for implementation of the intervention and expressed feelings regarding the lack of a guiding national framework, non-existent regulation of the practice and ineffective regulating bodies. 60.5 percent of the participants suggested making clinical supervision mandatory, whilst another 60.5 percent suggested establishing an active and effective regulating body, followed by 50 percent who felt that training all counsellors in clinical supervision will help improve CS, whilst 47.4 percent suggested creating awareness among mental health professionals, and 42.1 percent suggesting the inclusion of

CS in the counsellor-education curriculum. These suggestions aligned with the theme concerning policy and strategies toward the improvement, establishment or professionalizing the intervention in Botswana.

The findings speak significantly to policy issues encompassing the need for effective coordination by an effective organisation with the mandate and authority to regulate what happens in the field, the need for national counselling statutes, national CS framework and ethical principles is evident from the research questions' responses. These are the justifications for engaging policymakers and implementers to tease the issues emanating from this study.

It is without a doubt that the strategies suggested would have financial and policy implications; policy development and training of counsellors in the country, and the establishment of organizations similar to ([CACREP], 2016) if clinical supervision professionalisation in counselling has to happen in Botswana.

5.3 IMPLICATIONS OF THE STUDY

Contributions made by this study are multifaceted and include theoretical, methodological and practical aspects, therefore, the findings add value to empirical information, education, knowledge and practice and subsequently an addition to clinical supervision literature for counsellors working in different environmental settings. The study followed a systematic explanatory sequential research design underpinned by three major significant theories geared towards understanding, and explaining clinical supervision to extend, and go beyond what was already known from previous by other scholars. Study went further to explain the knowledge, attitudes/perceptions and practices of clinical supervision by engaging counsellors from different environmental counselling areas across mental health professions in Botswana.

For thorough investigation and better understanding, the study relied on triangulation of methods, triangulation of theories (theoretical eclecticism), triangulation of data collection tools, and data analysis techniques (Denzin, 2010,2012; Ryan,2021). Using an eclectic theoretical approach allowed multi-methodological lenses that facilitated a better understanding of the major themes surrounding practices of clinical supervision in Botswana.

5.3.1 Implications to Theory

Theoretical and Applied Scientific Knowledge

The findings from this study provide both theoretical and applied scientific knowledge useful for innovative development and improvement. Findings help theory, applied scientific knowledge help counsellors and supervisors to solve the existing real-life problem of lack of CS implementation whilst the theoretical scientific knowledge provides critical information for improved and better understanding of CS in the country. The theoretical empirical knowledge derived from this study will help in the practical application and improvement of the existing situation.

The significance of the study was to stimulate change as applied scientific knowledge always seeks to solve practical problems whilst theoretical scientific knowledge from the study provides the gathered information to serve as a knowledge resource base and information addition to existing empirical and educational material of reference for educational institutions, policymakers, counsellors and clinical supervisors. The findings could be useful in tackling problems related to issues of perceptions towards Clinical supervision, issues of access, knowledge, attitudes, guiding principles and possible strategies for improvement of the intervention. The practice informed this study and the theoretical scientific knowledge derived from these findings is intended to inform the practice for innovative development in the field of CS in the country.

The study revealed a lack of supervision and this has implications for the application and counsellors' ability to put theory into practice. The findings also show that clinical supervision implemented in Botswana lacks a theoretical basis and hence many have adopted CS frameworks from various countries, specifically from countries of training for their acquisition of the various qualifications in counselling, Psychology and social work. Literature shows that most regulating bodies internationally have formulated ethical frameworks and different models of clinical supervision, Botswana has none and this theoretical scientific knowledge provides a starting point towards creating awareness (Borders, 2005,2019; Msimanga & Moeti,2018; Bland,2012).

5.3.2 Implications to Methodology

The present study also contributed to methodology judging due to the eclectic method of data analysis that was adapted in this research approach. There is an existence of empirical literature deficit on this area in the country despite counselling having existed for some time now. Limited previous studies have not considered the use of mixed methods but rather the qualitative approach which is synonymous with most social science research (Hall et al.,2015). Moreover, existing studies targeted only one specific group of counsellors for example; school counsellors, nurses or social workers which do not help to establish a pattern across mental health professions. This study attempted to combine to help explore topic from different perspectives to allow triangulation, corroboration and data validation which was possible through triangulation of data collection and data analysis techniques (Kriukow,2021; Tenuche,2018; Bryman,2008). The results of the study suggest that it is possible to mix research methods for purposes of corroboration of findings. This approach helped to produce well-balanced research findings and its implication was to provide a benchmark for future research.

5.3.3 Implications for Knowledge and Practice

The results of the study suggest that counsellors lack knowledge about CS, the few that know have reported having irregular sessions and often the time awarded is reported to be less than 60 minutes. The majority are most likely to access administrative supervision instead of clinical supervision.

The majority of the counsellors expressed not being familiar with ethical principles that are supposed to guide their practice, whilst a few indicated being aware but preferring to use ethical principles from foreign countries, especially from the countries where they obtained their degrees of qualifications. On these grounds, many of the respondents suggested the need to improve CS by making it mandatory, strengthening coordination and licensure, incorporating clinical supervision in counsellor education programmes, and creating awareness across all mental health professions among practising clinicians in different counselling environmental settings.

The study findings also show that many counsellors have limited knowledge of clinical supervision, and expressed their desire to learn more or to be trained in CS. Participants also raised concern regarding what they reported as a “non-supportive environment”, and expressed the need for supportive environments, the need for

effective regulating bodies and formulation of guiding ethical principles to improve their clinical practice and enhance professionalism.

The study further shows that due to lack of training, the majority reported limited knowledge, skills and competencies to provide clinical supervision, and that has implications on the ability to access or provide clinical supervision. Previous studies show the significance of clinical supervision training towards being able to provide evidence-based interventions (Borders,2019; Muchado,2018; Msimanga & Moeti,2018). The findings of this study add to existing knowledge and provide scientific applied knowledge to enhance practice.

5.4 RECOMMENDATIONS

The study makes the following recommendations for application, future research and possible future research areas in specific reference to counsellors, clinical supervisors, supervisees, counsellor education institutions, policymakers and policy implementers in Botswana across mental health professions.

5.4.1 Recommendations for Application

The current study's findings indicate that overall, very few counsellors access supervision and the situation is causing concern among counsellors because previous studies have shown that CS has a meaningful impact on the efficacy of the counselling service. This study supports previous research studies conducted elsewhere that indicated the importance of clinical supervision to effective counselling. The findings further indicate that although a significant number of counsellors desire clinical supervision, there are challenges emanating from policy, regulation, licensure, training and unsupportive environmental settings.

Implications for practice from this research exist in areas of development of the national framework, strengthening of regulating bodies, sharing common pedagogy across mental health professions, training counsellors and creating awareness of varied environmental practices.

The study points to the desire of counsellors to have coordinated clinical supervision, and their concern is reported clinical; consequently, lack of knowledge, skills and competencies to provide clinical supervision.

There is a need to review counsellor education programs in counsellor training institutions for incorporation of counsellor-clinical supervision for purposes of ensuring ethical and professional counselling service provision across all mental health professions.

The study findings may stimulate the professionalization of clinical supervision and counselling in the country, similarly, there may be a need for awareness and/or in-service-training or re-tooling of existing counsellors in clinical supervision as well as mentorship, coaching, orientation or induction of newly appointed counsellors and adequate clinical supervision of student counsellors during their practicum and internship to enable exposure to clinical supervision. There is a need to align theory through incorporation in actual counselling, through clinical supervision counsellors regularly learn to put theories of psychotherapy into practice and self-evaluate to ensure counselling efficacy and operating within ethical and legal boundaries. To align theory with practice implies the need to establish an effective regulating body, development of a national framework, provide in-service training of counsellors and create awareness among employers of counsellors to help them get an appreciation of the significance of clinical supervision and its importance in the delivery of counselling services, as well as lobby medical aid providers to value clinical supervision as a component of clinical welfare of clinicians deserving medical aid costs covering and essential for the benefit of the beneficiaries of the counselling services.

5.4.2 Recommendations for Future Research

This is an initial study with the sampled population drawn from different environmental settings and strata, it will therefore be beneficial to have replication of the results for purposes of validation of the study. It may be beneficial to further investigate the phenomenon in future with larger populations of counsellors; future research should seek gender, cultural and racial diversity.

Similarly, there may be a need to explore the impact of the different modes of supervision and cultural compatibility in the different counselling environmental settings. Future research may also be interested to see how the results obtained from this study can be generalized to view its usefulness in other contexts.

Furthermore, future studies might want to consider using the conclusions from the present study in a different context, on a different sampling frame using different units of analysis and possibly using a different research method. There may also be a need to improve the theoretical framework used in this study in future studies; data collection methods and epistemological paradigm as well as characteristics of research participants. This study may serve as a stepping stone to provide a research baseline for those desiring to extend and expand further research on this topic. Similarly, future research may also focus on establishing the perceived benefits of clinical supervision by counsellors.

Further inquiry may also be aimed at possibly carrying out further experimental observational studies with control groups; those accessing clinical supervision versus those not accessing it to assess and compare the impact of CS on counsellor efficacy. Most of the previous international studies focused mostly on the link between clinical supervision and counsellor burn-out but none exists locally. This present study will also probably yield different results if considered in a different geographical area, due to personal, social, situational and perhaps cultural norms.

Apart from experimental observational studies, future studies could consider the use of focus-group method research methods, literature reveals that focus-group discussions (FGD) have the potential to unearth rich data due to depth and the ability to expand capabilities and a better understanding of the CS phenomena. According to Puzanova et al. (2023), FGD creates an opportunity to access extensive richer qualitative data derived from varied ideas and opinions of about 15-20 people per group sharing their opinions, views and experiences. Perhaps future studies could consider other areas; and change the scope to apply to a specific group such as Guidance and Counselling teachers, the police force, the army and those in security services due to the nature of their work.

Moreover, researchers may need to investigate whether other factors could be contributing to the “lack of supervision” in the country. Future studies may also consider virtual clinical supervision; the extent of its use and its effectiveness given pandemics like COVID-19 that restricted the assembling and movement of people and future research could explore technology towards services catapulted by advancement in

telecommunication and Artificial Intelligence in the advent of pandemics in the global village we live in, this may be helpful in further establishing the inherent challenges of online/virtual clinical supervision in the third-world countries where technology is still lagging and expensive.

5.4.3 Recommendation of Areas for Future Research

This study provided a baseline for further research, and there are numerous areas for possible investigation in this area of clinical supervision including but not limited to; having an experimental study on benefits, efficacy of counselling by observing and comparing two different groups; those receiving clinical supervision and the group not receiving the clinical supervision intervention.

The perceptions of counsellor educators towards the incorporation of clinical supervision in the counsellor-education and training programme in tertiary institutions, exploring the clinical supervision intervention in Botswana's cultural context, possibly conducting an inquiry on counsellors' effectiveness, exploring the perceptions and challenges facing clinical supervisors and counsellors in rural Districts of Botswana. Similarly, research could be considered among police and army counsellors and investigating the factors hindering clinical supervision in Botswana may also be potential critical research areas to explore in future research.

The study by Schroeder et al. (2009) on cross-racial supervision established that cultural diversity, cultural responsiveness and competency by in large play critical part in CS effectiveness. There may be a need to explore culture on supervision hesitancy by counsellors, The multicultural approach to clinical supervision in Botswana may be worthy of investigation since Bhusumane's (2007) research study showed the significance of utilizing indigenous cultural practices and structures in counselling, whilst Coker and Majuta (2015) study revealed the importance of counsellors' cultural consideration in practice. Similarly, the significance of incorporating clinical supervision in counsellor education programmes in counsellor training institutions may unearth interesting results.

A major recommendation is studies could be conducted using respondents with similar characteristics, deploying the same methodology to assess the knowledge, attitudes and practices of professional counsellors in the mental health professions.

These study findings are significant for value addition to the counselling academic field and are a knowledge resource for counsellor development and the practice. The study revealed poor counsellor CS access and inadequate knowledge of CS and hence ineffective application. The findings are not surprising as literature had already alluded to this fact and lamented the infancy stage of counselling in the country. The study further revealed a lack of regulation, and ethical guiding principles hence many are not affiliated with regulating bodies, while some prefer to use ethical principles from foreign countries. On these grounds, the majority suggested policy formulation, and critical strategies for developing the practice such as; establishing an effective regulating body, the inclusion of clinical supervision in counsellor education and creating awareness about clinical supervision across all mental health professions.

Summary

Consequently, the study established knowledge, attitude practices of clinical supervision among counsellors in Botswana. The findings give a new impetus and professionalisation of CS, the findings have added to the empirical literature and generated a piece of baseline information upon which to conduct further research and gather empirical evidence for CS education in Botswana. The findings adequately addressed the title of the study and adequately responded to the research problem. Chapter 5 showed the results of the entire research to fulfil the aims and objectives mentioned in Chapter 1. The researcher attempted theoretical and methodological triangulation for a better exploration of the phenomenon. The summary in this section gives an overview structure of all the chapters of the entire thesis.

Chapter 1 introduced the research problem, the field of interest and the area of research covered. The chapter explained the purpose, rationale and meaning of clinical supervision drawing from vast available international literature, its benefits, types of clinical supervision and the global trend across mental health

professions as well as the general perceptions of counsellors in other parts of the world and further articulated the main objectives and questions.

Chapter 2 provided extensive literature from various databases on clinical supervision starting with the definition. The chapter provided enough information, clear concept and gave context to the CS practice in the counselling industry. The chapter described the models of supervision, types of clinical supervision, the benefits to counsellor efficacy and the possible harmful side of CS.

Chapter 3 focused on the research methods, theoretical framework; underpinning theories, data collection strategies, and data analysis techniques and further gave justification for the choices of the research methods, theoretical framework, tools, techniques utilised.

Chapter 4 gave descriptive presentation data in tables; figures, frequencies and percentages for quantitative data, whilst qualitative data was appropriately presented in thematic approaches using NVivo-generated web, word cloud, tables and participants' narratives captured verbatim. This was done systematically by research questions and the results indicated that the majority of counsellors do not access clinical supervision, a few are knowledgeable and skilled while the majority are not. Nonetheless, the majority of counsellors and supervisors have a positive attitude towards clinical supervision despite the poor level of access due to reported limited competencies resulting in counsellors' inability to provide the service. These findings speak to the research questions and variables of access, knowledge, attitudes, practice, ethical principles and strategies for improvement.

Chapter 5 gave a full discussion of the research findings, articulated the discussion of the findings per each research question, and discussed the practice. Based from the results, it is evident that there is a need for counsellor training on clinical supervision (Borders,2019; Bland,2012), and a need for clinical national coordination as study revealed a lack of clinical supervision emanating from ineffective regulation, lack of common pedagogy across mental health professions, limited knowledge and competencies impacting the practice. The findings speak directly to the objectives that geared towards establishing attitudes of counsellors

towards CS in Botswana, determining the knowledge of CS, level of access, the practice, guiding ethical principles and examining the strategies for improving clinical supervision in the country.

CONCLUSION

The result prominently indicated that there are positive attitudes towards clinical supervision in the country among counsellors despite unearthed challenges. The study revealed issues contributing to the lack of implementation of clinical supervision such as limited knowledge, lack of training, absence of guiding principles and poor coordination.

The findings also showed that many counsellors receive administrative supervision which focuses on non-clinical activities depending on their respective environmental settings. Few who receive clinical supervision believe that it is beneficial to their clinical practice, clinical proficiency and professional development.

These findings have diverse implications for counsellors across the different mental health professions; policymakers, regulating bodies, counsellor educators and beneficiaries of the counselling services offered in Botswana. It is evident from the findings that there is a need for a clinical supervision national framework for the development of the practice in the country towards the effective provision of counselling services. The study confirmed what was established through literature concerning limited knowledge, ineffective practices, lack of common ethical standards and the need for licensure. The findings adequately addressed the problem; there was a need to explore the phenomenon to inform the practice and the results spoke directly to the CS practice and revealed the existing knowledge gap; the disconnect between theory and practice and the critical need for the development of the practice in the country.

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APPENDICES

Appendix A – University Permissions

UNICAF UNIVERSITY

1st September, 2022

To Whom It May Concern

This letter serves as confirmation that Tshidi M Wyllie with student ID number R1708D3331490 is currently enrolled in the Doctor of Philosophy (PhD) in Education programme of Unicaf University in Malawi.

The student is currently undertaking research for the Dissertation, on the below topic: '*The perceptions of counsellors towards clinical supervision in Botswana*'.

If you require any additional information or clarification, please do not hesitate to contact us in the first instance.

Best regards,

Ms. Selia Masoura

Registrar

Unicaf University:
Unit 1, Shoppers Mall, Area 4, Plot 67, P.O. Box 1420, Lilongwe, Malawi
Email: info@unicafuniversity.com **Telephone:** +265 175533
www.unicafuniversity.com www.unicafuniversity.ac.mw

Letter of Introduction

TELEPHONE NUMBER: +2348034592046
E-mail Address: m.olanrewaju@unicaf.org
Ref: UCF/FOE/ZM/02 Date: 30/07/2022

TO WHOM IT MAY CONCERN
…….
…….
……
Dear Sir/Ma,
I hereby write to introduce TSHIDI M. WYLLIE with Registration Number R1708D3331490 as my Postgraduate project student who is undergoing a research work/project on the topic entitled "**KNOWLEDGE, ATTITUDES AND PRACTICES OF CLINICAL SUPERVISION AMONG COUNSELLORS IN BOTSWANA**"
Your reputable University/Institution is part of the sampled population, kindly assist her in the administration of research instruments, please. Thank you so much for your understanding.

Yours in Service

Dr. K.O. Muraina
Project Supervisor

Provisional Approval - Stage 1

UNICAF UNIVERSITY

UREC Desision, Version 2.0

Unicaf University Research Ethics Committee Decision

Student's Name: Tshidi M Wyllie

Student's ID #: R1708D3331490

Supervisor's Name: Dr Muraina Kamilu Olanrewaju

Program of Study: UUM: PhD Doctorate of Philosophy - Education

Offer ID /Group ID: O39226G39897

Dissertation Stage: 1

Research Project Title: The Perceptions of Counsellors towards Clinical Supervision in Botswana

Comments: No comments

Decision*: A. Approved without revision or comments

Date: 16-Sep-2021

*Provisional approval provided at the Dissertation Stage 1, whereas the final approval is provided at the Dissertation stage 3. The student is allowed to proceed to data collection following the final approval.

Provisional Approval – Stage 3

UNICAF UNIVERSITY

UREC Desision, Version 2.0

Unicaf University Research Ethics Committee Decision

Student's Name: Tshidi M Wyllie

Student's ID #: R1708D3331490

Supervisor's Name: Dr Muraina Kamilu Olanrewaju

Program of Study: UUM: PhD Doctorate of Philosophy - Education

Offer ID /Group ID: O39226G39897

Dissertation Stage: 3

Research Project Title: The Perceptions of Counsellors towards Clinical Supervision in Botswana

Comments: No comments

Decision*: A. Approved without revision or comments

Date: 16-Aug-2022

*Provisional approval provided at the Dissertation Stage 1, whereas the final approval is provided at the Dissertation stage 3. The student is allowed to proceed to data collection following the final approval.

Appendix B

Showing Application Letter to Local Authorities

UNICAF UNIVERSITY

UU_GL - Version 2.0

Gatekeeper letter

Address: The PS,MOBE,P/BAG005,Gaborone,Botswana.

Date: 20-Jul-2022

Subject: RESEARCH PERMISSION

MINISTRY OF EDUCATION & SKILLS DEVELOPMENT
CONFIDENTIAL RMU
22 JUL 2022
NAME:.....TIME:.....
MAIL RECEIVED
P/BAG 005 GABORONE TEL: 3715145 / 44

Dear Sir/Madam,

I am a **doctoral candidate with UNICAF University, Malawi Campus**.

As part of my degree I am carrying out a study on **"THE PERCEPTIONS OF COUNSELLORS TOWARDS CLINICAL SUPERVISION IN BOTSWANA".**

I am writing to request for **permission to recruit school counsellors/Senior Teacher 1-Guidance and Counselling** to participate in this research by answering questionnaires.

Subject to approval by Unicaf Research Ethics Committee (UREC) this study will be using mixed methods approach; collecting quantitative and qualitative data by use of questionnaires and semi-structured interviews.

The Title of the research study is: "The Perceptions of Counsellors Towards Clinical Supervision in Botswana. The aim is to explore the perceptions of counsellors towards the Clinical supervision practice in counselling in terms of access, knowledge, attitudes, practice and guiding ethical principles governing the clinical supervision practice.

This project is supervised by DR.MURAINA KAMILU OLANREWAJU.
Phone: (+234) 8034592046
Email address: m.olanrewaju@unicaf.org

This letter seeks to ask the Permanent Secretary in the Ministry of Basic Education to grant the researcher permission to recruit counsellors,visit and contact the sampled 24 Secondary and 14 primary schools for data collection.

Thank you in advance for your time and for your consideration of this project. Kindly please let me know if you require any further information or need any further clarifications.

Yours Sincerely,

Tmwyl

Student's Name: Tshidi M Wyllie
Student's E-mail: tshidei@gmail.com
Student's Address and Telephone: +267 721 765 81
Supervisor's Title and Name: DR.MURAINA KAMILU OLANREWAJU. Phone: (+234) 8034592046
Supervisor's Position: Research Supervisor
Supervisor's E-mail: m.olanrewaju@unicaf.org

Appendix C

Districts Approvals

Republic of Botswana
Ministry of Education
& Skills Development
Kgatleng Regional Operations

Tel: 5777226
Fax: 5777879
email: mesdkgatleng@gov.bw

Director
Kgatleng Region
Boseja North, Mochudi
P/Bag 199 Mochudi

REFERENCE: KGATL 1/13/1 V (35)

5th August 2022

Tshidi M. Wyllie

Dear Wyllie

PERMISSION TO CONDUCT RESEARCH - YOURSELF

Reference is made to your letter dated **20th July 2022** in which you requested permission to conduct research in Kgatleng Schools on the topic **"The perceptions of Counsellors towards clinical supervision in Botswana".**

This communique serves to grant you permission to conduct the research and you are expected to share the findings of your research with the Regional Education Office **(Principal Education Officer I - Secondary Inspectorate).**

Yours faithfully

Cacius R. Tamaki
For/Director, Regional Operations – Kgatleng

cc: School Heads
- Primary
- Secondary

CRT/lea-lets

BOTSWANA
our pride, your destination

(267) 5920378

FAX: (267) 5920460

Republic of Botswana

TRAINING & DEVELOPMENT
MOLEPOLOLE EDU.
PO BOX 1293
Molepolole

Ref: MEC: 1/14/1 20

Ms. Matshediso Tshidi Wyllie
P.O.Box 4108
Gaborone

12th August 2022

Dear Wyllie

PERMISSION TO CONDUCT RESEARCH.

With reference to your application letter dated 22nd July 2022, your request for a research permit has been granted on the research topic: **The Perceptions of Counsellors towards Clinical Supervision in Botswana.** You are requested to conduct your research between September and October 2022 at the following schools as stipulated in your application letter namely: **Kgari-Sechele Senior, Mogoditshane Senior, Mogoditshane Junior, Moruakgomo Junior, Nare-Sereto Junior, Masilo Junior, Gabane Junior, Boribamo Primary, Gabane Primary, and Borakalalo Primary and Gamodubu Primary.**

This permission also allows you to engage and collect data amongst all your selected participants. You are advised to seek **consent** from the teachers of the above-mentioned school.

Kindly be informed that the head of the concerned institution will be informed. Furthermore, you are advised to concentrate on your study area and adhere to all issues of ethical consideration during the process of data collection. Be advised to submit a copy of your completed research document to Kweneng Region.

Thank you.

Yours faithfully,

Rapula Kgasudi

For/Director- Regional Operations.
Kweneng

TELEPHONE: 4631820/4632325
FAX: 4632324

REFERENCE: 1/13/1 IV (38)

Republic of Botswana

MINISTRY OF BASIC EDUCATION
REGIONAL EDUCATION
OFFICE (CENTRAL)
PRIVATE BAG 091
SEROWE

Ministry of Education & Skills Development
Central Regional Operations

10th August 2022

Ms Tshidi M. Wyllie
P. O. Box 4108
GABORONE

Dear Madam

PERMISSION TO CONDUCT RESEARCH – YOURSELF

Reference is made to your request dated 5th August 2022 in which you are requesting to be granted permission to conduct research on **"The perceptions of counsellors towards Clinical supervisors in Botswana from Moeng College, Lotsane SSS, Swaneng Hill SSS, Bakwena Kgari JSS, Mannathoko JSS, Mmaphula JSS, Mokgalo JSS, Boipuso P. School, Khama Memorial School, Khurumela P. School and Makolojwane P. School.**

By this letter permission is granted. You are therefore advised to liase with the schools listed to seek assent and consent from the School Heads and all participants of your study. Hopefully your research remains bounded by your research ethics at all times. Failure to comply with research ethics will result in immediate termination of this research permit.

You are requested to submit a copy of your final report of the study to the Ministry of Education and skills Development, Department of Educational Planning and Research Services (DPRES) and Regional Education Office upon completion.

Thank you.

Yours faithfully

Ookeditse Johannes
***For*/DIRECTOR, REGIONAL OPERATIONS – CENTRAL**

cc: Chief Education Officers – **Palapye and Serowe Sub Regions**
School Heads – **Moeng College, Lotsane SSS, Swaneng Hill SSS, Bakwena Kgari JSS, Mannathoko JSS, Mmaphula JSS, Mokgalo JSS, Boipuso P. School, Khama Memorial School, Khurumela P. School and Makolojwane P. School.**

/gr

SAVINGRAM

FROM: Director – Regional Operations
Ministry of Education
& Skills Development
South Region

Keneilwe Champane
For/Director

TEL: 5441876

FAX: 5442042/5441880

TO: School Head:
Seepapitso Senior Secondary School
Ngwaketse Junior Secondary School
Tlhomo Junior Secondary School
Makaba II Primary School
Matsaakgang Primary School

REF: SRO 1/15/1 III I (35) 15th August 2022

RESEARCH ISSUANCE OF PERMIT – THE PERCEPTION OF COUNSELLORS TOWARDS CLINICAL SUPERVISION IN BOTSWANA: MS TSHIDI M.WYLLIE

The above subject matter refers.

Permission is hereby granted to Ms Tshidi M.Wyllie to conduct research in your school as per the attached tentative schedule.

She has already been issued a Research Consent and will share information pertaining how she will conduct the research with you.

Accord her the necessary support so that she meets the requirements of PhD.

After completion we expect her to share the findings with us.

Thank you.

BOTSWANA

SAVINGRAM

FROM: Director, Regional Operations
South East Region

A.Z. Ernest
for/Director

TEL: 3972454

FAX: 3972915/3975899

TO: School Head
Gaborone Senior Secondary School
Naledi Senior Secondary School
Ledumang Senior Secondary School
Moselewapula Junior Secondary School
Bonnington Junior Secondary School
Nanogang Junior Secondary School
Tsholofelo Primary School
Lesedi Primary School
Galaletsang Primary Schoool

REF: SER1/15/2XVI (180)

17 August 2022

PERMISSION TO CONDUCT A RESEARCH

Ms. Tshidi M. Wyllie is a **student from Unicaf University** has been granted permission to conduct research study in your schools with effect from August 2022 to August 2023. The research is on **"The Perceptions of Counsellors towards Clinical Supervision in Botswana ".**

The researcher has been advised to contact you directly and also thoroughly brief you on the research. **However, all Covid - 19 Protocols should be strictly adhered to by the researcher.**

Thank you.

MoBE MINISTRY OF BASIC EDUCATION CONTACT CENTRE 16885 5

MINISTRY OF BASIC EDUCATION

TELEPHONE: (267) 3931851
(267) 3972454
FAX: (267) 3975899

Republic of Botswana

Director, Regional Operations
South East
Private Bag 00343
GABORONE
BOTSWANA

REF: SER 1/15/2022 XVI (179)

17 August 2022

Ms, Tshidi M. Wyllie
P.O. Box 4108
GABORONE

Dear Madam,

PERMISSION TO CONDUCT A RESEARCH

Reference is made to your dated 15 August 2022 letter requesting to carry out research in **South East Region** is here by granted. The research will be carried out in **Gaborone, Naledi Senior Secondary Schools, Moselewapula, Bonnington, Nannogang Junior Secondary Schools and Tsholofelo, Lesedi, Galaletsang Primary Schools.** This permit is valid from the **August 2022** to **August 2023,**

Your research is titled **"The Perceptions of Counsellors towards Clinical Supervision in Botswana".** Permission is hereby granted for you to carry out your research as per your request. However, **Covid - 19 Protocols have to be strictly adhered to by yourself.**

NB: Furthermore, you are requested to submit at least one hardcopy and an electronic copy of the report to the South East Region, Ministry of Basic Education within 3 months of completion of the study. Approval is for academic fulfillment only. Copies should be submitted to all other relevant authorities.

Thank you.

Yours faithfully,

A.Z. Ernest
For/ Director, Regional Operations, South East Region

SAVINGRAM

FROM: Director – Regional Operations
Kweneng Region

R. Kgasudi
For/Director

TEL: 5920378

FAX: 5920460

TO: **School Head – Primary &Secondary**
Kgari-Sechele Senior
Mogoditshane Senior
Mogoditshane Junior
Moruakgomo Junior
Nare-Sereto Junior
Masilo & Gabane Junior
Boribamo & Gabane Primary
Borakalalo & Gamodubu Primary

Ref: MEC: 1/14/1 20 12Th August 2022

Permission to Conduct Research –Ms. Matshediso Tshidi Wyllie

This communiqué serves to introduce **Ms. Matshediso Tshidi Wyllie** who is a final year student at UNICAF University, Malawi campus. She is pursuing a Degree of Doctor of Philosophy (Ph.D.) from the university. She has requested to conduct research on the topic: **The Perceptions of Counsellors towards Clinical Supervision in Botswana.** The study will create awareness of the importance of clinical supervision in the area of mental health and lobby for self-care for counselors and safeguard client welfare.

Kweneng region has granted her permission to conduct research in primary and secondary schools and your institution is amongst those selected for data collection. I kindly request your support in facilitating this research by allowing her entry into your institution including permitting her access to research participants who are Senior Teacher 1-Guidance and Counselling. The researcher will be expected to comply with all issues of ethical consideration during data collection. Data will be collected between September and November 2022. Therefore I kindly request that the researcher be given the necessary support and assistance. For further clarification please contact **Mr. Rapula Kgasudi at 71527794 / 5920378.**

Thank you.

Cc: Chief Education Officers- MAA & Mogoditshane Sub-region

Report any corrupt practice @ 0800 700 100
0800 600 990

Appendix D - Consent Form

Informed Consent Form
Part 1: Debriefing of Participant

Student's Name: Tshidi M Wyllie

Student's E-mail Address: tshidei@gmail.com

Student ID #: R1708D3331490

Supervisor's Name: DR. MURAINA KAMILU OLANREWAJU

University Campus: UNICAF University Malawi (UUM)

Program of Study: PhD Doctorate of Philosophy - Education

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

Date:

I am writing to humbly request your participation in this research, hereby approved by the Unicaf Research Ethics Committee (UREC). The study will be using questionnaires and interviews taking roughly 10-15minutes of your time to establish level of access, determine knowledge about clinical supervision by counsellors, examine the attitudes of counsellors towards practice, determine practice, investigate ethical principles guiding counsellors, and examine possible strategies towards improving clinical supervision of Counsellors in Botswana. It is hoped to contribute towards professionalization, encourage ethical compliance to safeguard the welfare of clients and the integrity of the profession as underpinned on the principles of beneficence, justice, non-maleficence and guard against malpractice by counsellors in the country. This project is supervised by Dr. Muraina Kamilu Olanrewaju who can be reached at the following email address: m.olanrewaju@unicaf.org

The above-named Student is committed to ensuring participants' voluntary participation in the research project and guaranteeing there are no potential risks and/or harms to the participants.

Participants have the right to withdraw at any stage (prior to or post the completion) of the research without any consequences and without providing any explanation. In these cases, the data collected will be deleted.

All data and information collected will be coded and will not be accessible to anyone outside this research. Data described and included in dissemination activities will only refer to coded information ensuring beyond the bounds of possibility participant identification.

I Tshidi M Wyllie will ensure that all information stated above is true and that all conditions have been met. Student's Signature: _____

Participant's Informed Consent Form -Part 2

Informed Consent Form
Part 2: Certificate of Consent

Student's Name: Tshidi M Wyllie

Student's E-mail Address: tshidei@gmail.com

Student ID #: R1708D3331490

Supervisor's Name: DR. MURAINA KAMILU OLANREWAJU

University Campus: UNICAF University Malawi (UUM)

Program of Study: PhD Doctorate of Philosophy - Education

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

I have read the foregoing information about this study, or it has been read to me and discussed. I received satisfactory answers to all my questions and I received enough information about this study giving reason for withdrawing and without negative consequences. I consent to the use of multimedia (e.g., audio recordings, video recordings) for my participation in this study. I understand that my data will remain anonymous and confidential unless stated otherwise. I consent voluntarily to be a participant in this study.

Participant's Print name:

Participant's Signature: Date: _____

If the Participant is illiterate:

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had an opportunity to ask questions. I confirm that the aforementioned individual has given consent freely.

Witness's Print name:

Witness's Signature: _____

Date:

Appendix E

Letter of Request to Respondents

TO WHOM IT MAY CONCERN

Hello,

My name is Tshidi M Wyllie, UNICAF University (Malawi Campus) doctoral candidate researching more on the experiences of counsellors. Topic for my research ***Attitudes, Practices Among Counsellors in Botswana,*** current status in different environmental settings mainly to explore knowledge, attitudes and practice of clinical supervision among counsellors in Botswana, and the objectives of the study are to establish the level of clinical supervision access by counsellors, determine the knowledge of counsellors in clinical supervision, examine the attitudes of counsellors, determine clinical supervision, investigate ethical principles that guide counsellors and examine possible strategies towards improving clinical supervision of Counsellors in Botswana.
To achieve this task, I invite you to spare your time to participate in this study by responding to this questionnaire. There are several potential benefits to participating in this research; providing an understanding by sharing your experiences; your knowledge, attitude and practice of clinical supervision. You will also be contributing greatly to the professional development of the clinical supervision literature and baseline data which will help counsellors from different environmental settings such as schools, NGOs, Governmental departments and tertiary institutions more access participation may also create more awareness and professional development for you to have the desire to benefit more from clinical supervision in the future.
For any questions concerning this study please contact me at tshidei@gmail.com mobile (+267) 721 765 81 or contact my academic supervisor Dr. Muraina Kamilu Olanrewaju at this e-mail address m.olanrewaju@unicaf.org

The signed Consent Form and answered questionnaire must be emailed to tshidei@gmail.com

Thank You.

Appendix F

Structured Questionnaire

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

QUESTIONNAIRE

Submitted to UNICAF University in Malawi

in partial fulfilment of the

requirements for the Degree of

Doctor of Philosophy in Education

Tshidi M Wyllie

R1708D3331490

2022

Covering Letter

TO WHOM IT MAY CONCERN

Hello,

My name is Tshidi M Wyllie, UNICAF University (Malawi Campus) doctoral candidate

Researching more about the experiences of counsellors, my research topic is ***Attitudes and Practices Among Counsellors in Botswana*** current status in different environmental counselling settings

mainly to explore the knowledge, attitudes and practices of clinical supervision among counsellors, and the objectives of the study are to establish the level of clinical supervision access by counsellors, determine the knowledge of counsellors in clinical supervision, examine the attitudes of counsellors towards determining clinical supervision, investigate ethical principles that guide counsellors and investigate possible strategies for improving clinical supervision of Counsellors in Botswana.

To achieve this task, I invite you to spare your time to participate in this study by responding to this questionnaire. There are several potential benefits to participating in this research; providing an understanding clinical by sharing your experiences; your knowledge, attitude and practice of clinical supervision. You will also be contributing greatly to the professional development of the clinical supervision literature and baseline data which will help counsellors from different environmental settings such as schools, NGOs, Governmental departments and tertiary institutions more participation may also create more awareness and professional development for you to have the desire to benefit more from clinical supervision in the future.

For any questions concerning this study please contact me at tshidei@gmail.com mobile (+267) 721 765 81 or contact my academic supervisor Dr. Muraina Kamilu Olanrewaju at this e-mail address m.olanrewaju@unicaf.org

Thank You.

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

Instructions

You are invited to anonymously complete the following questionnaire that aims to explore the knowledge, attitudes and practices of Clinical Supervision among counsellors in Botswana. The questionnaire should take only 15-20 minutes of your time. Your honest opinion is important and your responses will not be identifiable.

By participating in this survey, you are indicating that you understand that your responses are anonymous and will not be linked to you in any way. If there is any question you find intrusive or offensive you have the freedom to skip it, but it will help a lot if you could respond to all the questions by placing a tick on the choice response that you agree with, if you are comfortable doing so.

You also have the right to indicate your desire to withdraw your participation from this research at any stage (before or after completing the questionnaire) without having to give any reasons for your withdrawal from the research. Your withdrawal will not attract any negative consequences to yourself and the data you provided will be deleted.

Please complete all the questions and follow instructions per each section and each question and statement.

Questionnaire

SECTION A – THIS SECTION SEEKS DEMOGRAPHIC INFORMATION

A counsellor/practitioner in your respective environmental setting. The questionnaire starts with demographic data. Please write the details required in the respective columns below:

Age	**Gender: you identify by (Male/Female /Prefer not to say)**	**Degree/Qualification & Discipline**		**Counsellor Years of Experience**	**Regional District, Dept / School/NGO/Private Practice/tertiary institution**
		Level of Education	**Discipline**		

SECTION B – SEEKS LEVEL, ACCESS TO

Accessing

The questionnaire seeks information to establish your level of access to clinical supervision as a practising counsellor.

Please answer the following SECTION according to the following order and tick ✓ in each box below only one preference that represents your view for each item (1-6) using the scale 1-5 choice of responses indicated below:

Strongly Agree = 5
Agree = 4
Somewhat/Neutral = 3
Disagree = 2
Strongly Disagree = 1

Item No.	**Statement**	**Tick your Response**				
Rating scale		**5**	**4**	**3**	**2**	**1**
1.	I have access to clinical supervision at my workplace.					
2.	I only have access to clinical supervision once a year.					
3.	My clinical supervision session takes 60-90minutes					
4.	I only have access to individual supervision.					
5.	I have access to group supervision only.					
6.	I only access peer-to-peer clinical supervision.					

SECTION C: SEEKS TO DETERMINE THE KNOWLEDGE OF CLINICAL SUPERVISION

This section seeks information to determine the knowledge you have about clinical supervision.

Please answer the following SECTION according to the following order and tick ✓ in each box below only one preference that represents your view for each item (1-6) using the scale 1-5 choice of responses indicated below:

Strongly Agree = 5
Agree = 4
Somewhat/Neutral = 3
Disagree = 2
Strongly Disagree = 1

Item No.	**Statement**	**Tick your Response**				
Scale		**1**	**2**	**3**	**4**	**5**
1.	I know clinical supervision is a requirement in counselling.					
2.	I am trained in clinical supervision.					
3.	I apply theoretical knowledge to client's real-life situations in supervision.					
4.	Am aware of confidentiality issues in clinical supervision					
5.	I know how to competently address ethical dilemmas in supervision.					
6.	I know the importance of building rapport in clinical supervision.					

SECTION D – SEEKS TO EXAMINE ATTITUDES TOWARDS CLINICAL SUPERVISION

This section seeks to examine your attitudes towards clinical supervision as a Counsellor.

Please answer the following SECTION according to the following order and tick ✓ in each box below only one preference that represents your view for each item (1-6) using the scale 1-5 choice of responses indicated below:

Strongly Agree = 5
Agree = 4
Somewhat/Neutral = 3
Disagree = 2
Strongly Disagree = 1

Disagree Item No.	**Statement**	**Tick your Response**				
Rating scale		**5**	**4**	**3**	**2**	**1**
1.	I believe Clinical Supervision enhances counselling skills.					
2.	Interest in learning more about clinical supervision.					
3.	Believe that clinical supervision is a good intervention					
4.	I enjoy attending clinical supervision sessions.					
5.	I feel comfortable working with my clinical supervisor.					
6.	I don't like clinical supervision.					

SECTION E – SEEKS INFORMATION ON THE PRACTICE OF CLINICAL SUPERVISION

This section seeks information to determine your practice of clinical supervision.

Please answer the following SECTION according to the following order and tick ✓ in each box below only one preference that represents your view for each item (1-6) using the scale 1-5 choice of responses indicated below:

Strongly Agree = 5
Agree = 4
Somewhat/Neutral = 3
Disagree = 2
Strongly Disagree = 1

Item No.	**Statement**	**Tick your Response**				
Rating scale		**5**	**4**	**3**	**2**	**1**
1.	I am confidence in providing the service					
2.	Using listening and paraphrasing skills.					
3.	Empathy and working alliance are important.					
4.	Using supervision skills within ethical and legal boundaries.					
5.	I am able to maintain eye contact and open body posture in sessions.					
6.	Am able to articulate and practice confidentiality in supervision					

SECTION F: SEEKS TO INVESTIGATE ETHICAL PRINCIPLES IN CLINICAL SUPERVISION

This section seeks information to investigate ethical principles that guide your clinical supervision practice.

Please answer the following SECTION according to the following order and tick ✓ in each box below only one preference that represents your view for each item (1-6) using the scale 1-5 choice of responses indicated below:

Strongly Agree = 5
Agree = 4
Somewhat/Neutral = 3
Disagree = 2
Strongly Disagree = 1

Item No.	**Statement**	**Tick your Response**				
Rating scale		**5**	**4**	**3**	**2**	**1**
1.	Protecting clients' issues and records in my practice is important.					
2.	I practice unconditional positive regard in my practice.					
3.	I am affiliated to a counselling regulating body/Association.					
4.	I use the Botswana Counselling Association's ethical principles to guide me.					
5.	I use principles for a different regulating body/association.					
6.	Am not aware of any ethical principles that guide clinical supervision					

SECTION G: SEEKS TO EXAMINE STRATEGIES THAT COULD IMPROVE CLINICAL SUPERVISION IN BOTSWANA.

This section seeks information from you to identify strategies that could be deployed to improve clinical supervision of counsellors in the country.

Please answer the following SECTION according to the following order and tick ☑ in each box below only one preference that represents your view for each item (1-6) using the scale 1-5 choice of responses indicated below:

Strongly Agree = 5
Agree = 4
Somewhat/Neutral = 3
Disagree = 2
Strongly Disagree = 1

Item No.	**Statement**	**Tick your Response**				
Rating scale		**5**	**4**	**3**	**2**	**1**
1.	Training counsellors in clinical supervision could help improve clinical supervision.					
2.	Making clinical supervision mandatory is a good strategy to enhance the clinical supervision practice.					
3.	Establishing an accreditation and licensing body could greatly improve clinical supervision.					
4.	A good strategy for improving Clinical supervision will be to have regular planned clinical supervision sessions.					
5	Creating awareness of clinical supervision services can help improve clinical supervision in Botswana.					
6.	Instilling a good practice of documenting, ethical and legal compliance can go a long way towards improving clinical supervision in the country.					

Appendix G

Semi-structured Interview Open-ended Guiding Questions

INTERVIEW GUIDING QUESTIONS

Semi-structured Interview Questions for Counsellors and Clinical Supervisors

Semi-structured interviews are conversational therefore the interviews always have follow-up questions as the interviewer probes for clarity, therefore these questions were intended to help guide the interviews, however, interviews were based on the results of the questionnaire data analysis. These guiding questions were meant to help answer research questions by exploring the knowledge, attitudes and practices of clinical supervision by examining the level of access, counsellors' knowledge of clinical supervision, their attitudes to CS practice, investigating ethical principles guiding their CS practice as well as examine possible strategies towards improving the practice in Botswana.

SECTION A: Seeks Biographic Data: I will start by asking you about your professional background, this will include; your age, highest qualification, years of experience, your area of speciality and so on:

Age	**Gender: you identify by (Male/Female /Prefer not to say)**	**degree / Qualification and Discipline**		**Years of Clinical Supervisor /Counsellor Supervisor**	**Regional District /Dept / School/NGO/Private Practice/Tertiary institution**
		Level of Education	Discipline		

SECTION B: **Seeks to Establish Counsellor's Level of Access**

1. Tell me more about access to CS in the country?
2. What can you say about the level of clinical supervision access by other counsellors in your Institution?
3. How important is clinical supervision access as a practising counsellor?
4. Explain to me, when you need clinical supervision, and what places are available to you for accessing it.
5. Talk about adherence to accessing clinical supervision and how you maintain that.
6. Normally what is the duration of your clinical supervision session and what clinical supervision format (type) do you usually access it?

SECTION C: Seeks to Determine Counsellors' Knowledge of Clinical Supervision

1. What can you say about the awareness and knowledge of CS by counsellors you work with?
2. Please explain how clinical supervision works in your environmental setting.
3. In what way has knowing clinical supervision impacted your practice?
4. How has your knowledge of rapport-building, unconditional positive regard and confidentiality impacted your clinical supervision?
5. How crucial is it for you as a counsellor to know when to consult or refer in cases that are beyond your Competency?
6. How important is it for you to know when to allocate time for self-care?

SECTION D: Seeks to Examine Counsellors' Attitudes

1. Share your personal experience in clinical supervision?

2. How comfortable were you with the clinical supervision sessions you attended?

3. What do you perceive to be the advantages or disadvantages of clinical supervision?

4. What do you perceive to be important in counselling efficacy?

5. What are feelings towards supervision?

6. What are your thoughts on the supervisory working alliance, and how has it enhanced your clinical supervision?

SECTION E: Seeks to Determine Counsellors Practice

1. How would you describe clinical practice in your country?

2. Concerning the technical and practical aspects, how does clinical supervision practice work?

3. How do you practically keep track of your clinical supervision activities?

4. Please share with me your proficiency in providing clinical supervision

5. What clinical supervision skills and models do you consider essential and use in your practice?

6. Tell me more about how in practice you can create a therapeutic working alliance and function within ethically expected boundaries.

SECTION F: Seeks to investigate ethical guiding principles counsellors adhere to

1. Bearing in mind the issue of ethical principles, how do you address ethical dilemmas?
2. Please share with me; what you have in place to protect clients' issues and records in your clinical Supervision?
3. How does unconditional positive regard apply/work in your clinical supervision and share if there are certain groups of people you cannot work with and why?
4. Tell me about your affiliation with Counselling regulating bodies.
5. What ethical principles guide your clinical supervision practice?
6. What influenced you to adopt the ethical principles (code of ethics) you currently use in your clinical practice?

SECTION G: Seeks to examine possible strategies for improving clinical supervision

1. What strategies would you suggest towards improving clinical supervision?
2. What can you say about the training of counsellors in clinical supervision?
3. Help me understand how accreditation and licensure in clinical supervision work in Botswana and how that improves clinical supervision.
4. What changes could be experienced from having mandatory clinical supervision?
5. How could creating awareness of clinical supervision services help improve clinical supervision in Botswana?
6. What other information would you wish to add or recommend about clinical supervision