COMMENTARY

Deconstructing Risk Management in Psychotherapy Supervision

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In the ongoing controversy over how much regulation and standardization to impose on clinical practice and research, it is not surprising that the activity of psychotherapy supervision should be swept up in the drive for uniformity. The managers amongst us want to regulate and institutionalize all aspects of practice. In opposition, many clinicians resist the relentless march toward the safety of uniformity travel alongside managerial imposition of regulations. Psychotherapy supervision's method of a close apprenticeship relationship between supervisor and trainee and its focus on the process and ethics of professional interaction stand at the humanistic core of what is otherwise becoming an increasingly mechanistic model of providing care to persons with mental illness. Our commentary picks up on these themes as it reviews the work by Mehrtens *et al.* about strengthening awareness of liability in psychiatry residency training programs. We argue that the practice of psychiatry is overburdened by documentation requirements. In imposing further record-keeping on psychotherapy supervision, we lose much more than we gain. We recommend that the supervisory process focus on the characterological virtues essential to functioning as an ethical therapist. We also argue that self-protective rules place restraints on possibilities for imaginative insights and innovations in psychotherapy.

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For the letter kills, but the spirit gives life. II Corinthians 3:6

Mehrtens *et al.*[1] state that the goal of their article was to explore the current supervision practices of psychiatry training programs with the intent of reducing potential liability risk that is inherent in all medical activities involving supervision of trainees. The authors developed a 24-item questionnaire, based on recent articles,[2–4] that examines the thoroughness with which psychotherapy supervision programs include safeguards and discussions of risk management principles and strategies to lower the potential liability involved in therapy supervision.

The 24-item questionnaire developed by Mehrtens *et al.* was supplemented by additional background questions. The 24 items of relevance here cover four categories of psychotherapy supervision: formal written therapy policies and procedures, supervision structure, institutional policies and procedures, and knowledge of a lawsuit against a supervisor at the institution.

Directors of adult psychiatry programs ($n = 189$) were contacted via electronic mail and invited to participate in this study. Participants' responses in the study were confidential. Responses were received from 64 program directors (response rate = 35%).

The results of the study of actual risk management practices for psychotherapy supervision in residency training programs are instructive but hardly surprising. Formal supervision guidelines are present in 87.5 percent of the respondent training programs. Requirement of documentation that trainees have received training guidelines, understand appropriate conduct in therapy, and are providing written material to patients regarding boundary expectations are all under 15 percent. Similarly, in regard to the structure of supervision, establishment of regular supervision hours is usually required (78.1%), but the rates of requiring documentation of supervisory sessions, supervisors regularly reviewing charts, and supervisors regularly assessing resident competency before providing therapy all fall between 42 and 31 percent. This rate suggests that supervisors and trainees are opposed to or are just too busy to provide the degree of anticipatory and postsession documentation recommended by forensic psychiatry articles on the topic of psychotherapy supervision.

The Argument

What are we to make of this disconnect between expert recommendations and actual community

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practice regarding formalization and documentation of psychotherapy supervision? Is it the case that the forensic psychiatry journal articles are presenting the ideal and that, like much in life, the practitioners fall far short of this ideal? Or is it the case that the forensic psychiatry guidelines, being more lawyerly than clinical, recommend a level of documentation that is not only onerous, but unnecessary (given the nil rate of reported lawsuits in both this article and in an earlier survey of training programs) and possibly even antipathetic to a relevant and richly educational supervisory experience? Keeping in mind that none of the psychiatry programs canvassed reported even a single case of a lawsuit against a supervisor for therapy work done by a resident, what is the evidence that adhering to these additional rules for documentation and imposing greater formality on the relationship between supervisor and resident, and resident and patient, would have a positive effect in reducing liability risk?

In view of the large denominator in this survey (number of lawsuits/number of trainees in supervision), the finding that there were no lawsuits reported by any of the 64 programs that returned questionnaires does not mean that the topic of liability risk is unimportant, but it might mean that the procedures in place at the present time, casual as they might appear to be, are sufficient to minimize the risk of lawsuit. Furthermore, it might mean that any recommendations for change toward a more stringent liability-conscious educational policy for resident supervision should be weighed against the risk that more will be lost in the process of supervision than will be gained by instituting these risk management recommendations.

Specifically, we have not seen a discussion of whether there may be deleterious effects of requiring residents to sign documentation that they have received training guidelines or understand appropriate conduct in therapy or have received written material regarding boundary expectations. It appears that it is not sufficient to provide trainees with written material about boundaries in therapy, but they should attest that they have received such material. Should we not have them sign that they have read the material, not just received it? Requiring a trainee to sign for the receipt of training material betrays a cynical and self-protective approach that places the resident in a potential future adversarial role. It is just this sort of approach that delineates the legalistic attitude toward risk management at the cost of a cooperative working relationship between supervisor and trainee. A culture of distrust between resident and training program is generated. If one expects trainees as a matter of course to lie, whether under stress or all the time, or to claim that no one ever told them that they should not engage in sexual behaviors with their patients or their supervisors, then perhaps we should require them to sign ever more forms and disclaimers.

There appears to be a lessened concern or understanding on the part of the forensic recommenders of what supervision is all about and about its role in the education and training of residents in psychiatry. This role includes imparting moral attitudes and identifying characterological virtues necessary for residents engaged in the process of psychotherapy with patients. There is a common assumption that providing statistical information which finds sex with patients both harmful and illegal would cause psychiatrists to refrain from such activities. This presupposes that decisions to engage or not engage in sex with patients are primarily cognitive ones, such that providing more factual information will convince the resident to behave properly.[5] It is our opinion that it is not more information that residents necessarily need; the problem is not a cognitive one, but a moral and conative one. It goes to character and moral integrity, not lack of information. Residents know what is right and wrong in terms of sexual behaviors with patients. One cannot complete four years of medical school and not know this. However, their knowledge does not sufficiently guide their ethics decision-making.

We believe that forensic psychiatrists who recommend the risk management safeguards of increased certification and documentation as outlined in the article under consideration are concerned about the process of therapy. However, their writings do not suggest recognition that such a legalistic structure might interfere with the work of supervision in which resident and supervisor must engage. We do not have evidence for this statement, but will try to lay out what we see the resident–supervisor process aims for, which is much more than just a cognitive process of avoiding exploitative and unethical behaviors.

Discussion

After paying attention to the necessity and wisdom of maintaining some awareness of risk management principles, we examine two questions: where does risk management fit into the psychiatric enterprise of taking care of patients (ignoring research ethics and risk for the moment); and what are the deleterious, unintended consequences of emphasiz-

ing litigation liability and risk management procedures in the supervisor–trainee relationship?

The work by Mehrtens and colleagues, and the literature it cites, focuses on rules to observe and procedures to follow to protect ourselves, our patients, and institutions from liability and lawsuits. We do not intend to be cavalier about risk management rules. We fully respect the degree to which a lawsuit against a physician may be disturbing and possibly catastrophic. The question then becomes what are the best methods within psychotherapy supervision of teaching principles of ethics and behaviors that would diminish liability risk without decreasing the larger focus on psychotherapy competence. The risk management rules are presented as obvious, and the goals of self-protection as unimpeachable, but we suggest that the scope of the thesis could be broadened to include a philosophical examination or justification of where risk management fits into an ethics perspective on how we want to conduct medical practice in general, and psychotherapy supervision and practice in particular.

The authors do not discuss possible or likely negative consequences of introducing greater formalization into the trainee–supervisor process. Neither do they consider what is gained or lost with a risk management approach that gathers its own momentum and prominence. In joining the fields of law and medicine specifically to a consideration of risk mitigation, we are dealing with two different models. The legal perspective is inherently conservative. The medical enterprise, in dealing with life's contingencies and casualties, is inherently risky. Different ethics frameworks apply to each discipline. Further, relative to other medical fields the psychiatric domain, because of the particular vulnerability and, often, compromised competence and autonomy of persons with mental disorders and of negative social attitudes toward mental illness, requires additional ethics-related considerations (values, ideals, and distinctive prescriptions) that ought to be conveyed to its trainees.[6,7]

We recognize that there is risk-taking in law, and there is proper conservatism in medicine, but every physician knows that all our assessments and treatment decisions involve risk to the patient (and family) and therefore, indirectly to ourselves. Risk is built into the very fabric of decision-making about human life under conditions of uncertainty. The risk management advocate will say that this is all the more reason for taking risk management more seriously and less casually than we ordinarily do. This is true and therefore these articles are to be respected for what they offer us, but the sum of what these articles recommend to mitigate liability in the psychotherapy supervisory process is improved credentialing practices and better documentation of informed consent and supervision policies and practices.

We are concerned with what is gained and what is lost when one invites into the tent risk management, with its focus on credentialing and documentation. What about the substantial risks of inattention to moral assessments, ethics choices, and interpersonal clumsiness on the part of trainees when liability concerns become prominent? Medicine has to take risks while not being cavalier about the possible serious consequences to patients and physicians when lawsuits are entered. We think this is true in all of medicine but wish to focus on psychotherapy. To practice defensively is to keep us so safe that we refuse to extend ourselves in ways that might carry a risk but also the chance of a breakthrough or even a small gain. We should not ignore risk, especially when it is primarily the patient who is at greatest risk. If we are to engage in psychotherapy without some risk during the process of engagement, nothing much happens.

Psychotherapy is essentially an exploration between patient and therapist; psychotherapy supervision is an exploration between psychotherapy trainee (resident) and supervisor. The task of psychotherapy supervision is to present the trainee with a thoughtful but necessarily unfinished overview of the approach and goals of therapy, of what therapy is supposed to do in assisting patients to move toward greater health and away from disruptive and harmful patterns of thinking and behaving.

The foundation for teaching psychotherapy is an ethics-based one, requiring consideration of character virtues that go beyond the important but basic Hippocratic virtues of benevolence, nonmalfeasance, and equity. Radden[6] has written extensively about additional virtues that must be present or developed in psychiatrists because of the special nature of mental illnesses and the power inequity, especially in gender and cross-cultural disparities, between therapist and patient. Often patients have limited autonomy, greater vulnerability, and compromised judgment concerning the nature of their illnesses. The distinctive characteristics of the psychiatric setting include greater privacy than is usual in the rest of medicine

and the more personal nature of questions that may be asked. Patients are also aware that the psychiatrist has certain legal powers to detain and hospitalize them involuntarily. These differences call for the development of an extensive set of virtues that are relevant for working with vulnerable populations.

Radden includes among these virtues those of empathy and its prerequisites, such as personal warmth and compassion; integrity, self-knowledge, and self-unity; humility, tolerance, self-control, and scrupulosity; *phronesis*, a Greek term for the ability to size up and respond to a practical situation; and unselfing, a neologism referring to proper listening and responding while maintaining boundaries of a therapeutic relationship, or "to the personally effaced yet acutely attentive and affectively attuned attitude toward the patient, the relationship, and its boundaries, adopted by the ethical and effective practitioner" (Ref. 7, p 132). Unselfing is different from detachment; it involves experiencing and even communicating aspects of inner states (warmth, empathy, and compassion) while maintaining strict limits on self-disclosure, especially about aspects of the therapist's personal life (Ref. 7, p 134).

Radden emphasizes that language regarding virtues is often vague and that virtues themselves are inexactly and elastically understood (Ref. 7, p 107). The question is whether the virtues important for the therapist to possess can be taught and developed. Virtues are character traits that reflect stable dispositions toward certain habits of thinking and behaving. Although basic character virtues are presumed to be present by the age of entering professional school, a further honing and development of those traits specifically needed by psychiatrists for working with persons with mental illnesses has to occur. This is not a mysterious process, but requires discussions, role modeling, learning through studying and analyzing clinical examples that prominently involve ethics dilemmas, and practicing these behaviors, such as trustworthiness, until they become habitual (Ref. 8, pp 431–2). Much of this learning takes place through effective supervision.

Summary

The psychotherapy supervisor can have a critical role in the professional development of the future psychiatrist. A good psychiatry supervisor transmits, in addition to technical knowledge and skills and an appreciation of liability risks, a sense of the medical tradition of professional ethics and responsibilities. A supervisor has to discuss and teach the importance of boundaries in the therapeutic relationship, an area that is always value laden and fraught, imbued with the possibility of clumsy interactions and lost opportunities. To teach boundaries by focusing on the rules of risk management is stultifying; all the threats and predictions of what can go wrong are intimidating and inhibit therapeutic engagement with a patient. Primarily, the supervisor has to teach therapeutic behavior according to what is technically and ethically right (correct) and wrong (incorrect), not what minimizes risks. The forensic psychiatrist is in a position to enrich an ethics–legal perspective in the training of psychiatry residents rather than focus exclusively on self-protective maneuvers. Risk management is an important topic, but it should not overshadow deeper philosophical and ethics-related concerns. Finally, one of the tasks of a psychotherapy supervisor is to generate lifelong enthusiasm in the trainee for the difficult task of engaging in therapy.

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