Current Risk Management Practices in Psychotherapy Supervision

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Psychotherapy competence is a core skill for psychiatry residents, and psychotherapy supervision is a time-honored approach to teaching this skill. To explore the current supervision practices of psychiatry training programs, a 24-item questionnaire was sent to all program directors of Accreditation Council for Graduate Medical Education (ACGME)–approved adult psychiatry programs. The questionnaire included items regarding adherence to recently proposed therapy supervision practices aimed at reducing potential liability risk. The results suggested that current therapy supervision practices do not include sufficient management of the potential liability involved in therapy supervision. Better protections for patients, residents, supervisors and the institutions would be possible with improved credentialing practices and better documentation of informed consent and supervision policies and procedures.

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Supervision is an important practice that aids in the professional and educational development of future physicians and medical professionals across various fields. This practice involves the provision of guidance and education regarding appropriate patient care.[1] Psychotherapy supervision is a longstanding approach to ensuring psychotherapy competence, which is a core skill for psychiatry residents. Although supervision is a vital component in the development of psychotherapy competence, providing psychotherapy supervision to trainees may be risky for the supervisor. A supervisor may be held liable for harm caused by a supervisee, which may result in lawsuits, criminal charges, or professional penalties against the supervisor.[2,3] Patients harmed by a trainee's actions may have incentives to designate psychotherapy supervisors or their institutions as the defendants in a lawsuit, namely the prospect of increased damage awards.[4]

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Providing education regarding ethical behavior and appropriate care is the best way to prevent unethical behavior by supervisees that may harm the patient.[5] Many supervisors agree that providing consistent, reliable, and responsible supervision will improve the educational experience for the residents and improve patient care.[4] However, even with adequate and appropriate education, problems may still arise. In one study, more than 80 percent of trainees admitted to withholding information from their supervisors within a single supervision session secondary to interpersonal problems, anxiety, or impression management.[6] This tendency is potentially problematic if the resident withholds relevant information that is necessary for proper case conceptualization. Furthermore, previous studies have indicated that both residents and psychotherapy supervisors may not be adequately informed of the liability risk associated with therapy supervision. For example, in one study, 87 percent of psychiatric residency training programs surveyed indicated that their program did not provide therapy supervisors formal training regarding the legal risks associated with supervision. Consequently, supervisors may not truly understand the risks associated with therapy supervision and the need to mitigate these risks.[3]

Although a psychotherapy supervisor may never be in direct contact with a patient, he may still be held liable for a supervisee's misconduct or inappropriate care.[4] Vicarious liability refers to the legal responsibility of a supervisor or sponsoring agency for the negligence of the supervisee.[3,7] In this situation, the supervisor does not have to interact directly with the patient in any way to be considered liable. A supervisor may also be held liable for harm caused as a direct result of the supervisor's actions, which may include failure to provide adequate supervision or failure to follow program standards.[4] This relationship allows for injured parties to receive restitution from the attending physician, who presumably has greater assets and better resources to prepare for such an incident than does the resident.[3] Therefore, the attending physician may be at risk for litigation, even if the physician has not had direct contact with the patient. Furthermore, a sponsoring agency may be held liable for the failure to provide or enforce appropriate standards for supervision, resulting in the potential culpability of both the supervisor and the employing institution. Given these factors, in addition to their perceived lower professional status, many residents do not feel legally accountable for mistakes made. In fact, most residents feel that lawsuits are an inevitable byproduct of the practice of medicine, but one study demonstrated that none of the residents surveyed felt that they would be liable for mistakes made in training.[8]

In addition to resident error, harmful or negligent supervision may negatively affect patient care. Harmful supervision refers to behaviors that harm, exploit, or victimize the supervisee, such as unnecessarily harsh evaluations, whereas negligent supervision may refer to the supervisor's inaction when a problem arises. In both cases, the quality of care that the client receives is weakened.[9] In most fields, the relationship between the supervisor and supervisee is complicated and, at times, delicate,[3,5] especially in mental health supervision. Supervisors are expected to serve as facilitators of self-exploration, in addition to serving as educators and evaluators, which creates unavoidable dual relationships.[5] However, some supervisors engage in avoidable and inappropriate dual relationships with their supervisees, which may cause undue harm to the supervisee or patient. For example, one study found that 11.8 percent of therapy supervisors endorsed the belief that maintaining a sexual relationship with a supervisee, although not ethical, is "less than totally harmful." This suggests that these supervisors feel that a sexual relationship with a supervisee is unlikely to result in psychological, emotional, or physical harm or trauma. This same study found that approximately one-third of supervisors surveyed believe that using drugs or drinking alcohol with supervisees is not at all harmful or is merely inadequate supervision for the supervisee.[9] A nationwide survey of American Psychological Association members found that 10 percent of practitioners admitted to having a sexual relationship with an educator when the practitioners were trainees, and 13 percent endorsed maintaining a sexual relationship with a trainee as a practitioner.[10,11] Further, a nationwide survey of psychiatry residents yielded a similarly troubling trend, in that 4.9 percent of residents admitted to having sexual involvement with their clinical supervisors.[10,12]

Engaging in dual relationships is problematic for several reasons. First, the supervisor may face consequences for sexual harassment under Title IX within a university setting.[13] If the training occurs outside of a university setting, such as within a private hospital, the supervisor may face consequences for sexual harassment under Title VII, given that the supervisee is an employee of the institution.[14] Further, the institution may be held vicariously liable for the actions of the supervisor.[15] In fact, there have been documented cases in which the court has found academic institutions liable for sexual relationships between faculty and students.[10,16] From an ethics viewpoint, sexual relationships between supervisor and supervisee may result in exploitative dual relationships. Such relationships have been condemned by many ethics committees, such as the American Psychological Association, because of the potential harm to resident training and to patient care.[5] For example, a resident involved in a dual relationship with a supervisor may feel uncomfortable exploring erotic countertransference with a patient, lessening the likelihood that the resident will receive proper supervision to work through the problems and that the patient will receive appropriate care. Given the potential harm to resident education and patient care as well as potential liability for the supervisor and institution, all parties would be likely to benefit from the provision of institutional guidelines that delineate appropriate and inappropriate supervisor–supervisee relationships.

The potential professional and legal consequences of negligent supervision are significant enough to merit some consideration. Despite the increasing demand for accountability among medical professionals, there are few studies that have specifically evaluated the legal implications associated with the supervisor–supervisee relationship. However, several studies have evaluated risk management among institutions. For example, Schulte *et al.*[3] conducted a nationwide survey of psychiatric training directors to evaluate their awareness of how supervision could create liability. As a result of the study, they proposed that supervisors receive annual formal education about the liability associated with psychotherapy supervision, as well as adequate documentation of supervision notes, informed consent practices, and disclosure to the patient regarding the nature of the supervisory relationship.[3] More recently, Recupero and Rainey[4] provided suggestions designed to manage risk and liability for psychotherapy supervisors. In addition to providing appropriate education to trainees, these included the documentation of informed consent practices for both patients and residents. Specifically, patients should be informed that a resident, under supervision, is responsible for their care. This requirement has important implications for training, as residents may be unwilling to disclose their training status to patients.[3] Supervisors can further mitigate their risk by documenting that their residents understand the boundaries of the therapy and supervision relationship. The documentation that patients and residents understand their respective roles in the patient's care may benefit the supervisor should any legal questions arise. In addition, requiring such disclosure and documentation may encourage supervisors to avoid inappropriate dual relationships that may be harmful to the supervisory relationship and patient care. Supervisors may also reduce liability risk by conducting chart reviews, scheduling and documenting regular supervision times, and establishing protocols for the management of suicidal or violent patients.

The present study seeks to explore the current psychotherapy supervision practices of psychiatric training programs, in relation to the risk-management suggestions of Recupero and Rainey.[4]

Methods

Program directors of adult psychiatry programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) were contacted via e-mail ($n = 189$) and informed that their participation in the study was voluntary and responses would be confidential. A 42-item web-based questionnaire was then administered electronically to all participating program directors. This questionnaire contained 3 items related to the demographics of the program, 8 questions defining the supervisors at the institutions, 29 questions regarding the risk mitigation proposals of Recupero and Rainey,[4] 2 questions regarding knowledge of any potential lawsuits related to therapy supervision, and a request for comments. After the initial invitation to participate in the survey, two reminder e-mails were sent to those who did not respond. This study was approved by the Louisiana State University Health Sciences Center (LSUHSC) New Orleans Institutional Review Board.

Table 1 Demographics of the Sample

Demographic Characteristic	Frequency	%
Type of program		
Medical school–affiliated program	50	78.1
Other	13	20.3
No answer	1	1.6
Institution's city size		
Large city (population >250,000)	45	70.3
Mid-sized or small city (population <250,000)	19	29.6
Types of therapy supervisors		
Full-time MDs	60	93.8
Community MDs	50	78.1
Full-time PhDs	55	85.9
Community PhDs	41	64.1

Results

Responses were received from 64 program directors (a 35% response rate). A summary of the demographics of the sample is found in Table 1. A majority of the programs were medical school affiliated ($n = 50$; 78%); however, several of the programs identified themselves as hospital residencies ($n = 6$; 9%) or community residencies ($n = 5$; 8%). Most of the programs that responded were located in large cities with populations greater than 250,000 people ($n = 45$; 70%).

Programs reported the use of a variety of professionals as psychotherapy supervisors (Table 2). Most of the programs used full-time psychiatry faculty members (93.8%), full-time PhD faculty (85.9%), community psychiatrists (78.1%), and community PhDs (64.1%). Although most of the programs used

Table 2 Supervision Survey Results

Survey Item	Frequency	%
Formal written therapy policies and procedures		
Residents required to inform patients that they are under supervision	56	87.5
Clear supervision guidelines available	50	78.1
Established protocol for emergency supervision when supervisor is unavailable	47	73.4
Policy in place that lays out appropriate resident conduct in therapy	21	33
Established protocol in place for supervisor–resident boundaries	17	26.6
Residents required to inform patients in writing that they are under supervision	15	23.4
Require documentation of receipt of training guidelines	11	17.2
Require documentation that supervisors understand expectations in terms of conduct	5	7.8
Require documentation that residents understand expectations in terms of conduct	3	4.7
Provide written material to patients regarding boundary expectations	5	7.8
Supervision structure		
Supervision schedules are generally adhered to	53	82.8
Regular supervision hours established	50	78.1
Supervision sessions documented	27	42.2
Supervisors routinely review chart documentation	23	35.9
Supervisors assess resident competency before providing therapy with increased risk	20	31.3
Institutional policies and procedures		
Institution's malpractice insurance covers liability for employed supervisors	48	75.0
Protocol in place should a patient need treatment from a more experienced clinician in case of emergency	47	73.4
Program uses therapy supervisors as the supervisor of record	47	71.9
Credentialing process for nonemployed supervisors	33	51.6
Billing issued in the supervisors' name	27	42.2
Program directors are required to make supervisors aware of concerns about a particular resident	26	40.6
Outside therapy supervisors must provide evidence of malpractice that covers therapy supervision	14	21.9
Program provides an assessment of resident competency before providing high-risk therapy (hypnosis, Amytal interview)	13	20.3
Institution's malpractice insurance covers liability for nonemployed supervisors	12	18.8
Knowledge of a law suit against a supervisor at the institution	0	0

community professionals as supervisors, very few paid them for their services (20%). Few institutions endorsed the use of graduate students as therapy supervisors (3%).

Although many of the program directors indicated that their programs provided patients with appropriate informed consent for treatment by a trainee receiving supervision, few required documentation of this practice. Most of the programs required residents to tell their patients that they were currently under supervision (87.5%), however few required documentation of this practice (30%), and even fewer provided written material to patients explaining that a resident was responsible for their care (23.4%). Almost all of the programs reported having clear supervision guidelines for residents (78.1%). However, very few programs required that residents document the receipt of the guidelines (17.2%). Even fewer programs required that the supervisors sign a similar contract (7.8%). One-third of the programs had policies in place that addressed resident conduct during therapy, yet few required documentation that residents understood these expectations (17.2%). A majority of the programs (73.4%) did not have a protocol in place to ensure that residents understand what is appropriate and inappropriate behavior regarding the supervisor–supervisee relationship. Almost none of the programs distributed to the patients of residents information sheets regarding the boundary expectations for the therapeutic process (7.8%).

Only 35.9 percent of programs indicated that psychotherapy supervisors routinely reviewed chart documentation. Less than half (42.2%) of all programs indicated that supervision sessions were documented. Almost all of the programs indicated that regular hours for clinic supervision were established (78.1%) and generally adhered to (83%). A majority of the programs (73.4%) indicated that there was an established protocol in place if a supervisor was unavailable. Most institutions also had protocols in place should a patient need treatment from a more experienced clinician in case of emergency. Less than half of the program directors (40.6%) were required to notify the therapy supervisor of any special concern about a supervisee. Few programs (20.3%) endorsed providing an assessment of resident competency before providing high-risk therapy.

A majority of the programs (74%) did not use therapy supervisors as the supervisor of record. In more than half of the programs, the billing was also not issued in the therapy supervisors' name (57.8%). Some of the program directors noted that billing was issued in the name of another supervisor, who was referred to as the "billing supervisor." This practice was especially common when the psychotherapy supervisor was a nonemployed, community supervisor. A majority of the programs (75.0%) indicated that the current malpractice insurance at their institution covered liability for employed psychotherapy supervisors, but very few of the programs provided malpractice insurance for nonemployed supervisors (18.8%). Only half of the programs (51.6%) surveyed had a credentialing process for nonemployed supervisors.

No program directors endorsed any knowledge of a lawsuit against a supervisor at their institution.

Discussion

Current psychotherapy supervision practices in American psychiatry training programs do not generally include management of risks and liability associated with supervision in a manner consistent with the suggestions previously proposed by Recupero and Rainey.[4] In their commentary on the Recupero and Rainey article, Hall and colleagues[10] asserted that better protections are possible for all invested parties when supervisors are aware of the risks and potential risk management solutions. As a result, supervisors are encouraged to seek out risk mitigation solutions and incorporate such practices into their training approaches. Although the risks associated with psychotherapy supervision are often assumed to be the responsibility of the supervisor, institutions may find that additional attention to risk mitigation may better serve to protect their faculty, trainees, and patients. Institutions may also find that greater emphasis on risk management may serve to protect the institution, given society's increasing desire for accountability. Supervisors are encouraged to become familiar with risk mitigation practices, but institutions may benefit from the establishment of formal training in such practices. In a related review, Schulte and colleagues[3] noted that informal education on risk management may not be sufficient alone to improve practice.

Overall, the results of the present study suggest that current risk management practices have much room for improvement. Although nearly all programs reported appropriate education of residents, supervisors, and patients about the roles and expectations of the resident and the supervisor, most programs did not endorse the documentation of these practices. By requiring documentation, supervisors may lessen their personal liability and provide additional protections to the resident and patient. By obtaining documentation that the resident understands the boundaries and expectations of a therapeutic relationship, a supervisor may also provide additional protections for patients. Delineating and documenting the expectations regarding the supervisor–supervisee relationship may discourage the development of inappropriate dual relationships among trainees and their supervisors. Given that these relationships may indirectly inflict harm on the patient, establishing these boundaries may further protect patient care and thus mitigate litigation risk. Therefore, institutions are encouraged to establish protocols requiring the documentation of informed consent practices for residents, supervisors, and patients and any other involved party.

Only half of the institutions required a credentialing process for nonemployed therapy supervisors. This process has become routine and expected in most hospitals and increasing numbers of outpatient facilities. Incorporating the credentialing of psychotherapy supervision into routine hiring practices may serve to mitigate the potential risk of the institution. As a result, institutions should consider requiring all supervisors to complete a standard credentialing process to ensure that all supervisors are adequately qualified and competent to supervise trainees.

Only about a third of therapy supervisors routinely reviewed chart documentation. Therapy documentation is a skill for which residents need supervision and coaching, particularly regarding the medicolegal aspects of charting sensitive information. There are several benefits associated with routine review of chart documentation, aside from coaching residents in appropriate documentation. For example, patients may benefit from the increased likelihood that their chart documentation is accurate and complete. Patients may also benefit from this additional supervisory exercise that helps assure that the therapeutic techniques and approaches used by the resident are evidence-based, appropriate, and consistent with the treatment plan agreed on in the supervision session.

Limitations of our study include concerns voiced by some participants in the study that the questions were hard to answer because the responses were more complex than the yes or no responses allowed. Although all ACGME-accredited programs in the country were invited to participate, only 35 percent participated. Therefore, it is possible that these findings do not generalize to all programs and more participation could have revealed different trends. Finally, by limiting the sample to only program directors and not supervisors or residents, the results represent an indirect glimpse into therapy supervision. However, the present study provides a foundation upon which further research may be built. Future research may incorporate all involved parties, including, but not limited to directors, supervisors, residents, institutions, and even patients themselves.

Although the practices proposed by Recupero and Rainey[4] and encouraged by the present study, may appear to be common sense on the surface, the authors of the present study acknowledge that these are not without practical implications. Supervisors (largely uncompensated) may oversee many trainees who are also expected to see many patients, limiting the amount of time that a supervisor can spend on any individual case. Further, supervisors must also attend to their own professional responsibilities, such as teaching, writing, and administrative duties that may also impede the attention given to supervisory responsibilities.[10] Administrative support will certainly be needed to institute or improve related policies and procedures. Nonetheless, risk mitigation appears destined to become an essential component of supervisory obligation.

Conclusion

The occurrence of faculty members being sued in their role as psychotherapy supervisors is rare. However, in an increasingly litigious society, traditional resident psychotherapy supervision practices may hold some unrecognized risk exposure. Better protections for patients, residents, supervisors, and the institutions may be possible with routine credentialing practices, better documentation of informed consent and supervision practices, and routine chart review. Risk management in psychotherapy supervision continues to require interest and investment, and may provide exposure protection and other benefits for supervisors, residents, institutions, and patients.

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