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Clinical Supervision of Counsellors in Botswana: A Mixed Method Study of Perceptions, Knowledge, Attitudes and Practice

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Abstract

Perceptions and attitudes are two concepts often used interchangeably and it is common for people to refer to a person's attitude as perceptions to explain their behaviour. Attitudes may also 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. Pickens (2005, p.52) defines perceptions as "a mental or neural state of readiness, organised through experience, exerting a dynamic influence on the individual's response to objects and situations to which it may be related". Perceptions and attitudes play a significant role in human social behaviour. According to Pickens (2005), perceptions are related to attitudes and sometimes difficult to differentiate. To establish the perceptions of counsellors towards clinical supervision (CS) in Botswana, two hundred and ten (210) counsellors and thirty-eight (38) supervisors were recruited to determine the level of access, knowledge of CS, attitudes, and CS practices. The study used the explanatory sequential research design; quantitative data was collected first and analysed to inform the qualitative data collection. The two data sets were merged through a meta-analysis to establish convergence and divergence. The total population sample was 248 practising counsellors of any gender drawn from 5 districts. More counsellors identified as females (79.3%), and (20.7%) as males; none indicated any other gender. The study revealed poor CS access, limited knowledge, limited training, and a lack of guiding principles. Surprisingly, both counsellors and supervisors had positive attitudes and more convergence than divergence. The study recommends the development of a CS national framework, a review of the counsellor education curriculum, effective regulation and future research to consider the use of the focus group method.

Keywords: 1. Attitudes, 2. Botswana, 3. Clinical Supervision,4. Knowledge, 5. Perceptions, 6. Practice

Introduction

The word perception is believed to be 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; to perceive or to make sense of (Wyllie,2024). The concept development of perception is based on an individual's understanding of a phenomenon and the meaning attached to it; often, past experiences with similar situations influence people's interpretations. Perceptions are formed is shaped by whether or not in previous encounters the challenge was successfully or unsuccessfully addressed. Typically, if previously successful, the situation may be perceived positively, and if previously unsuccessful, the incident may be perceived negatively. Ajzen (2020), Ajzen and Fishbein (2005) argue that the performance of specific behaviours can be explained by considering the proximal attitude toward the behaviour rather than the distal attitude toward it, hence, to understand counsellors' perceptions towards clinical supervision (CS) it was necessary to engage practising counsellors(supervisees) and clinical supervisors (counsellor supervisors) to examine their knowledge, attitudes and practices of clinical supervision. There are various factors that may influence individuals' perceptions about a particular behaviour such as beliefs, past experiences, perceived benefits, losses, social pressures, one's personality, pre-existing attitudes, knowledge and intentions. Therefore, it is common for people to be selective and attracted to the stimuli they believe have positive benefits and ignore those they perceive as having the potential to trigger psychological distress (Wyllie,2024). Given this understanding, people's perceptions of certain activities and planned behaviours like CS may positively or negatively influence the practice; may be influenced by the perceived benefits, existing knowledge and competencies, or lack thereof based on self-evaluation and evaluation by others. Literature shows exisiting relationship between perceptions, attitudes and knowledge, hence, theories of knowledge, attitude and practice (KAP) were adopted to underpin this study.

Purpose Statement

The purpose of this study was to establish the perceptions of counsellors towards clinical supervision in Botswana and this was done by determining the level of access examining the knowledge, attitudes, practices of clinical supervision, establishing the ethical principles guiding the practice and examining strategies for improvement. The desire to investigate this phenomenon was motivated by the existing knowledge gap revealed by the dearth of local literature and lack of knowledge resources despite extensive international literature benchmarks revealing the extensive benefits of CS in counselling. According to Muchado (2018), Msimanga and Moeti (2018) and Wyllie (2024), contemporary counselling is relatively new in Botswana and not readily embraced as is often shrouded with stigma and hence equally signifies the infancy of CS in the country.

Literature Review

The Concept of Clinical Supervision in Counselling

Clinical supervision (CS) is an intervention in counselling and across mental health professions for clinical support and professional development for improved therapeutic performance and ethical counselling services. It provides a forum for counsellors to sharpen their knowledge, skills and techniques as they reflect on their clinical practice. Through CS, clinical supervisors evaluate the supervisees' (counsellors) knowledge and competencies and offer mentorship and coaching for their professional growth. Supervision also helps to prevent burnout and counsellor fatigue, hence, based on its benefits has become a mandatory requirement in counselling and other mental health professions mostly in developed countries though found lagging in developing countries like Botswana (Wyllie,2024).

The American Psychological Association ([APA], 2014) perceives CS as a clinical intervention for providing counsellors' professional development to ensure effective counselling services. It is considered an effective tool for ensuring the effective implementation and application of theoretical knowledge and skills attained by counsellors during training to real-life clients' situations. It helps counsellors to align theory, knowledge, attitudes and practice. Goodyear (2014); and the Australian Counselling Association ([ACA],2019) view CS as important for enhancing clinical knowledge and counselling competencies. Similarly, Johnson (2020) postulates that CS was developed to improve the practical application of counselling theories and techniques and provide the monitoring and evaluation function to ensure quality and ethical practice. Clinical supervision has educational and developmental benefits to supervisees through qualified and experienced clinical supervisors who provide clinical support services.

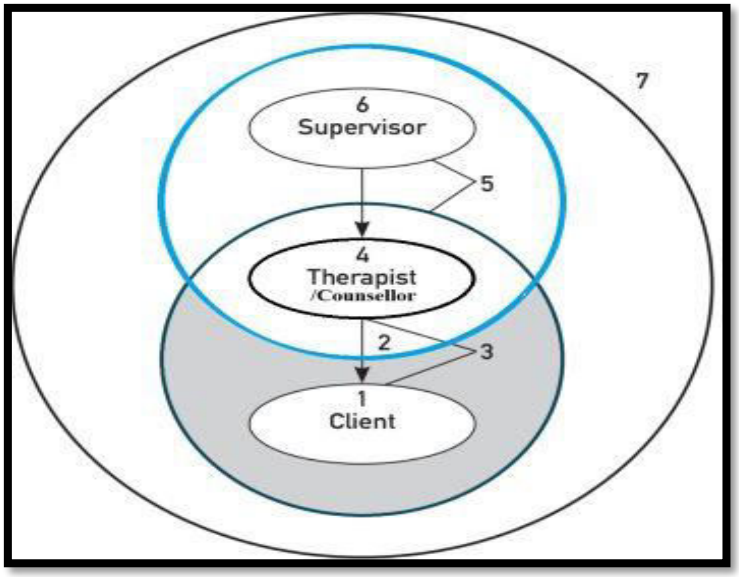
Clinical Supervision is an important clinical process for counsellors' educational and professional growth that targets knowledge, attitudes, competencies and skills to prevent harm to clients and ensure professional integrity. Some definitions show hierarchical differences between the supervisor(s) and the supervisee(s) for example; Goodyear (2014, p.9) Bernard and Goodyear (2004, p.8) opine; "Intervention provided by a more senior member of a profession to a more junior member(s) of that same profession" and goes on to say that it has the monitoring and evaluative aspect of ensuring the safety and protection of clients. Falender and Shafranske (2021, p.3) define clinical supervision as interpersonal collaborative training; a "distinct professional activity in which education and training aimed at developing science-informed practice is facilitated through a collaborative interpersonal process".

There is a significant distinction between CS and administrative supervision which is a managerial function that focuses on administrative duties such as time management, responsibilities within the agency and professional relationships but not the clinical and therapeutic counselling processes inside the therapy room. CS ensures the quality of the counselling process during the therapy session whilst administrative focuses on office roles.

In this study, supervision is used interchangeably with "clinical supervision" and "counsellor supervision". The concept of CS in other settings and countries may differ based on organizational policies, educational policies and general dynamics.

In this study, CS is defined as a professional relationship for providing clinical expertise, mentorship and coaching to a counsellor(s) by a qualified and experienced professional counsellor to ensure effective counselling services through an evaluative clinical process to safeguard the welfare of clients and the credibility of the counselling profession. This broad definition has inherently encompassed all aspects of supervision, accentuating the tripartite nature of supervision that does not only end between the supervisor and supervisee but indirectly cascades down to the beneficiaries (Wyllie,2024).

Figure 1
Showing the Tripartite Nature of Supervision



Adopted from Hawkins (2018, p.387,389). The Seven eyed model

The Influence of Perceptions on Behaviour

How behaviour is perceived and managed can influence the actions, practice and participation in such behaviour. Therefore, the perceptions held by counsellors towards CS can influence their desire to participate; counsellors' perceptions, attitudes and knowledge can influence whether or not they engage in the CS practice (Johansen et al.,2011).

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, hence, Ajzen and Fishbein (2005) argue that a person's attitude and behaviour are influenced by their beliefs and revision of the beliefs due to newly acquired information over time.

Concept of Knowledge

The concept of knowledge hasn't been explicitly defined despite its significance in human life. It is assumed that limited knowledge may influence attitudes, feelings, perceptions and practices negatively leading to a negative evaluation and perception of the CS practice. However, if adequate and accompanied by skills, it may be perceived positively resulting in a positive attitudes and behaviour towards the practice. Hunt (2003) opines that knowledge creates the ability to be orderly, effective and well-structured in achieving things, therefore, it is possible that with adequate knowledge of CS and proper skills, the practice could be orderly implemented in Botswana.

According to Hunt (2003), behaviour change comes from acquired knowledge and the application of acquired information, and learning has the concept of knowledge resulting in behaviour modification accompanying practice. However, knowledge is an abstract concept that cannot be observed but can be inferred based on observable behaviour and practices. Given this perspective, acquired knowledge in CS should be evident in the application of skills and attitudes, both self-evaluated and evaluated by the supervisor on whether indicators of acquired theoretical and applied scientific knowledge exist in practice. According to Bolisani and Bratianu (2018) for one to be considered knowledgeable, acquired information must influence beliefs, attitudes, perceptions, practices and behaviour. Therefore, unless counsellors possess CS knowledge, the application remains a challenge.

Concept of Attitude

Issues about knowledge, attitudes and practice constructs are complex as there are various factors involved. Bohner and Dickel (2010, p.392) purport that, "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". This involves cognitive assessment and the impact of held perceptions toward objects and situations, it includes the organisation of motivational, emotional, perceptual, and cognitive processes in some aspects of one's world. Many people regard attitude as likes and dislikes towards things, objects or people, whilst others consider it to be a psychological tendency to express one's preferences towards objects and behaviours based on either positive or negative evaluation and attitudes are outwardly demonstrated following such evaluation (Wyllie,2024).

According to Ajzen &Fishbein (2005), it is a learned predisposition to respond favourably or unfavourably towards people, ideas, objects or situations based on an evaluation made, either positively or negatively, and one's perceptions may influence the evaluation of a particular behaviour positively or negatively.

The concept of attitude has cognitive, affect and behavioural aspects and information individuals hold about the behaviour has the potential to influence the emotional aspect and the behaviour towards positively or negatively.

Ajzen and Fishbein (2005) further argue that the level of intention one has towards the behaviour plays a role, but the level of intention alone may not adequately help predict behaviour because degree to which an individual has control (knowledge and skills) over performing the behaviour also plays a critical role. Therefore, if the level of perceived behavioural control is low, chances are that it may manifest in the form of unfavourable evaluation leading to dislike and unwillingness to perform the planned behaviour (Wyllie,2024).

Concept of Practice

Practice 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). 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 practical demonstration of skills and knowledge acquired.

Myriads of literature (Ajzen & Fishbein, 2005; Bernard & Goodyear,2004; Pickens,2005) show that attitudes are learnt behaviours formed through the modelling process, and from personal experiences through interactions with people and situations that can influence decision-making, actions and people's choices to like or dislike something, someone or a practice. It is about behaviours portrayed as the application of knowledge; putting theory into practice as influenced by knowledge and attitudes. Therefore, CS could be abstract until practised and its application is determined by the knowledge and skills of counsellors.

Theoretical Framework

The theory of Reasoned Action (TRA) and Theory of Planned Behaviour (TPB) assume that the best predictor of a behaviour is the behavioural intention, which in turn is determined by attitude toward the behaviour and social normative perceptions regarding it (Kutscha, et al.,2020; Ajzen & Fishbein,2005). TRA and TPB focus on the constructs of attitude, subjective norms, and perceived control in explaining the variance in behavioural intention as a predictor of several different behaviours.

Ajzen and Fishbein (2005) assert that attitudes toward certain planned behaviours such as clinical supervision are a better predictor of the probability of performing the behaviour and define the underlying beliefs such as behavioural and normative beliefs, intentions and their influence on one performing the behaviour.

Therefore, individuals with strong beliefs of positive gains from acting out the behaviour are likely to have a positive attitude towards performing it. Whereas, those with strong negative beliefs about negative results from performing the behaviour are likely to have negative attitudes towards performing the behaviour resulting in inaction. Similarly, Kutscha et al. (2020) opine that an individual's subjective norm is influenced by normative beliefs; whether certain significant people approve or disapprove of the behaviour, and the level of motivation.

TPB further assumes that perceived behavioural (PBC) control is an independent predictor of behavioural intention; the perception one has of their ability to confidently and successfully perform the behaviour is critical. Therefore, TRA and TPB provided a framework to understand the CS phenomenon by examining the knowledge, attitudes and practices in CS. These theories of Knowledge, Attitudes and Practice (KAP) were considered suited to undergird the study and theoretical triangulation was deemed appropriate (Ajzen & Fishbein,2005; Glanz, 2022).

Method

Participants

We surveyed 210 practising counsellors and 38 clinical supervisors from governmental and non-governmental institutions who were randomly selected from various environmental settings; public and private schools, government and privately owned tertiary institutions, NGOs and those in the private practice. Respondents were recruited from the 5 purposefully selected districts (Central, Kgatleng, South-East, Kweneng and Southern) out of the 10 districts. Participants were aged between 25 and 65 years with a minimum experience of 3 years in counselling. The study used probability and non-probability sampling (Tansey,2009). The total study population sample was 248; quantitative data had 162 respondents who identified as females and only 48 who identified as males and in the qualitative phase there were 7 males and 31 females who participated in the interviews; none (0) indicated any other gender.

Procedure

The study used an Explanatory Sequential research design. The instrument for quantitative data collection was self-developed and pilot-tested on 36 randomly selected practising counsellors before utilization. The instrument development was guided by Andrade et al. (2020); Ajzen (2006) and USAID (2011) on how to develop KAP questionnaires and surveys because a suitable instrument for adaptation could not be found.

Professional counsellors and experts in CS practice were engaged in the verification and validation of the instrument involving language scrutiny and content validity. The instrument and variables were tested for validity and internal consistency using Cronbach's Alpha and met the expected Cronbach's Alpha value of .924 and the lowest was .728. Participation was anonymous and posed no risks to participants. Data was collected through the quantitative and qualitative methods for corroboration and validation; triangulation of research methods, theories, data collection strategies and data analysis techniques to reduce biases.

Results

The study findings are arranged according to the research questions and presented in frequencies and percentages in Tables 1- 8 and Figures 2-4.

Quantitative

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

Table 1

Showing Participants' Level of Access to Clinical Supervision in Frequencies and Percentages (N=210)

Item	Strongly Disagree N (%)	Disagree (N / %)	Neutral N (%)	Agree N (%)	Strongly Agree N (%)
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.)	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)

Table 1 above shows that only (23.3%) of the respondents accessed clinical supervision, (4.8%) accessed it once a year, (56.6%) disagreed and 20.1% were neutral. The duration of CS was between 60 and 90 minutes, only (17.1%) agreed, (44.3%) were neutral and (38.6%) disagreed. On the format of CS accessed; (13.3%) agreed with the Individual, (70%) disagreed and (16.7%) were neutral. (8.6%) accessed Group format, (76.1%) disagreed and (15.2%) were neutral. On Peer-to-peer format, (11.4%) agreed, 52.9% disagreed and 37.7% were neutral.

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

Table 2

Showing Data Summary of Participants' Knowledge of Clinical Supervision (N=210)

Item	Strongly Disagree N (%)	Disagree N (%)	Neutral N (%)	Agree N (%)	Strongly Agree N (%)
1. I know clinical supervision is 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(2.4)	79(37.6)	44(21)	76(36.2)
5. I know how to address ethical dilemmas in supervision competently.	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)

Question 2 examined the counsellors' knowledge of CS; 115 (54.7%) agreed to know CS,

79 (37.6%) disagreed, (7.6%) were neutral. 60 (28.5%) agreed to be trained, 128 (60.9%) disagreed and (10.5%) were neutral. On application of theoretical knowledge in clients' real-life situations; 62(29.5%) agreed, 107(50.9%) disagreed and 41(19.5%) were neutral. On confidentiality; 120(57.2%) agreed,79(37.6%) was neutral and 11(5.2%) disagreed. Knowledge and competency are intertwined; 74(35.2%) agreed with competency to address ethical dilemmas, 31(14.6%) were neutral and 105(50%) disagreed. Rapport-building is important in therapeutic alliance; (50%) agreed to know its importance, 46(21.9%) were neutral and 59 (28.1%) disagreed. Based on this data, it can be concluded that there are limited CS competencies among counsellors in Botswana.

Research Question 3: What is the Attitude of Counsellors Towards Clinical Supervision in Botswana?

Table 3
Showing Data of Participants' Attitudes Towards Clinical Supervision (N=210)

Item	Strongly Disagree N (%)	Disagree N (%)	Neutral N (%)	Agree N (%)	Strongly Agree N (%)
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(4.3)	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)

Research question 3 examined the attitudes of counsellors towards CS, their interest in learning about CS, their beliefs, whether they enjoyed attending sessions, their

comfortability working with their clinical supervisors and their likes and dislikes of CS. (144,68.5%) had a positive attitude; believed that it enhances counselling skills, (64,30.5%) were neutral and (2,1.0%) "strongly disagreed". (205,97.7%) indicated interest to learn more about it, (2,1.0%) were "neutral". It can be concluded that the majority of respondents have an interest in learning about CS. Many (150,71.5%) believe CS is a good intervention, (28.1%) were neutral and .5% disagreed. (94,44.8%) agreed with "enjoy attending CS sessions", (72,34.3%) disagreed and (44,21.0%) were neutral. (66,31.6%) agreed with being comfortable working with their clinical supervisor, (111,53.1%) were not comfortable and (32,15.2%) were neutral on the issue. Data showed that (196,93.3%) did not agree with the statement; "I don't like Clinical Supervision", (5,2.4%) were neutral and (9,4.3%) agreed". Therefore, it can be concluded that less than half of the counsellors do not enjoy CS, however, many do not dislike.

Research Question 4: What is the Practice of Counsellors Towards Clinical Supervision in Botswana?

Table 4

Descriptive Data Summary on Participants' Clinical Supervision Practice (N=210)

Item	Strongly Disagree N (%)	Disagree N (%)	Neutral N (%)	Agree N (%)	Strongly Agree N (%)
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)

Research Question 4 was to determine counsellors' CS practice by establishing confidence in providing CS, listening ability, empathy, therapeutic working alliance, application of CS within the legal and ethical boundaries, and the ability to maintain eye contact. (52.7%) of the respondents admitted toa lack the confidence in conducting CS, (31,15.3%) chose to be neutral, (65,32.0%) agreed with having the confidence to provide CS; they chose.51.4% agreed with the importance of empathy and working alliance, and (22.6%) agreed with the ability to use CS skills within legal and ethical boundaries. It can be concluded from the data that there are ineffective CS practices among many counsellors.

Research Question 5: What are the Ethical Principles that Guide the Clinical Supervision of Counsellors in Botswana?

Table 5

Descriptive Data Summary on Ethical Principles Guiding Counsellors' Clinical Supervision (N=210)

Item	Strongly Disagree N (%)	Disagree N (%)	Neutral N (%)	Agree N (%)	Strongly Agree N (%)
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)

Question 5 sought to establish ethical principles guiding counsellors' CS practice by examining the protection of clients' issues and records, the application of unconditional Positive Regard (UPR), determining their affiliation to a regulatory body, the use of Botswana Counselling Association (BCA) ethical codes, affiliation and the use of any existing ethical codes and the awareness of ethical principles. (204,97.2%) counsellors agreed to value confidentiality and privacy of clients' records in their clinical practice, (2,1.0%) chose neutrality, (4,1.9%) disagreed. (144,68.5%) agreed to practise (UPR), (60,28.6%) were neutral and (6,2.9%) disagreed. (116,55.2%) indicated not being affiliated with a local counselling regulating body, (32,15.2%) were neutral and (62,29.5%) admitted affiliation to a counselling regulating body.

More than half (128, 60.9%) indicated not using BCA ethical principles, (30,14.3%) chose neutrality, and (52,24.8%) agreed to use BCA ethical principles. Similarly, (102,48.5%) agreed to use principles for different regulating bodies, and (25,11.9%) were neutral. Concerning lack of awareness of any ethical guiding principles, (136,64.7%) disagreed with the statement, (58,27.6%) were neutral and (16,7.7%) agreed. It can be concluded from Table 5 that there is a lack of ethical guiding principles for the CS practice in Botswana.

Research Question 6: What are the Strategies Towards Improving the Clinical Supervision of Counsellors in Botswana?

Table 6
Descriptive Data Summary of Participants on Possible Strategies Towards the Improvement of Clinical Supervision (N=210)

Item	Strongly Disagree N (%)	Disagree N (%)	Neutral N (%)	Agree N (%)	Strongly Agree N (%)
1. Training counsellors in clinical supervision could help improve clinical supervision	6(2.9)	1(0.4)	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	1(0.5)	2(1)	74(35.2)	23(11)	110(52.4)

licensing body could greatly improve clinical supervision.					
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(58.1)
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 6 above shows the data on strategies suggested by the respondents towards the improvement of clinical supervision in the country. (119,56.7%) agree with training counsellors, (84,40.0%) remained neutral, (7,3.3%) disagreed. A significant number (201,95.7%) agreed with making clinical supervision mandatory, a few disagreed (1,0.5%) and (7,3.3%) were neutral. (133,63.3%) agreed with establishing an accreditation and licensing body, (74,35.2%) were neutral and (3,1.4%) disagreed. (152,72.3%) agreed that regular planned clinical supervision sessions were a good strategy (56,26.7%) were neutral and (2,1%) disagreed.

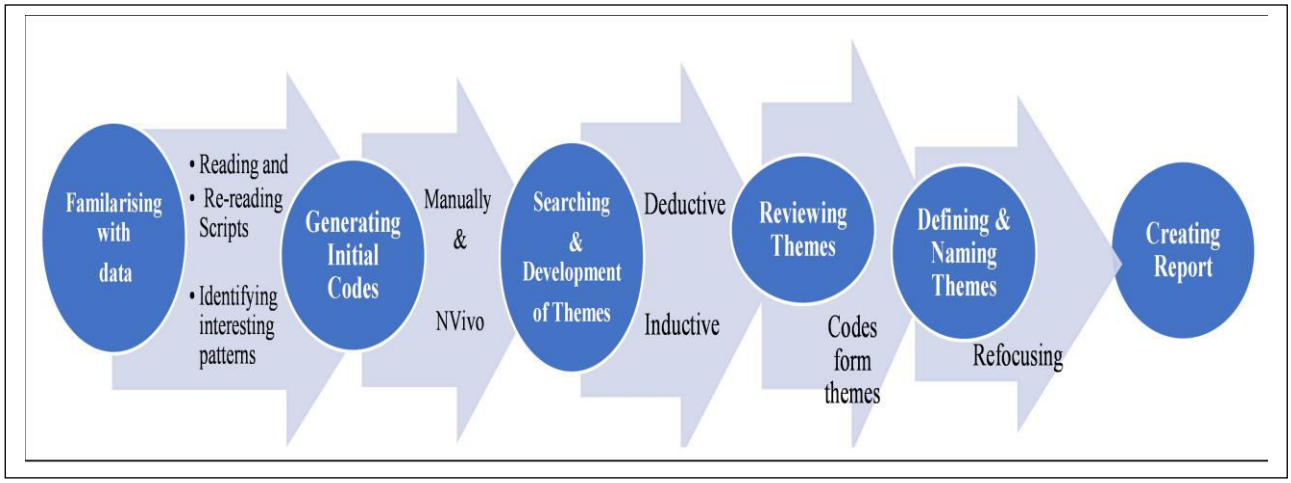
Data also showed that (204,97.1%) perceived creating awareness of CS services as a good strategy towards improvement, (4,1.9%) were neutral and (2,1.0%) disagreed. (157,74.7%) believed that instilling a good practice of documenting, ethical and legal compliance can go a long way towards improving CS, (52,24.8%) were neutral and (1,0.5%) strongly disagreed.

The results of study 1 (quantitative data) on their own do not give a clear picture of clinical supervision status regarding all the variables, therefore, there was a follow-up through interviews with clinical supervisors to seek corroboration, validate and explain what the quantitative numbers indicated.

Qualitative Findings

In this phase of the sequential research design of the mixed method study, 38 interview respondents were clinical supervisors from various counselling environmental settings from the 5 districts. This part of the mixed method intentionally adopted the interpretive stance to give the inductive aspect the explanatory role to the quantitative data results (Wyllie (2024). Thematic analysis and NVivo were deployed. Braun and Clarke (2006, p.79) define Thematic analysis as; "a method for identifying, analysing and reporting patterns (themes) within data", whilst Kiger and Varpio (2020), assert that thematic analysis is an appropriate method for analyzing qualitative data as it entails searching across a data set to identify, analyze and report repeated patterns. The thematic data analysis approach followed the deductive and inductive processes in Figure 2 below;

Figure 2
Showing the Thematic Process Sequence



Wyllie (2024, p.237)

Table 7
Showing Qualitative Content Analysis Results of the Interview Responses by the Variables (N=38)

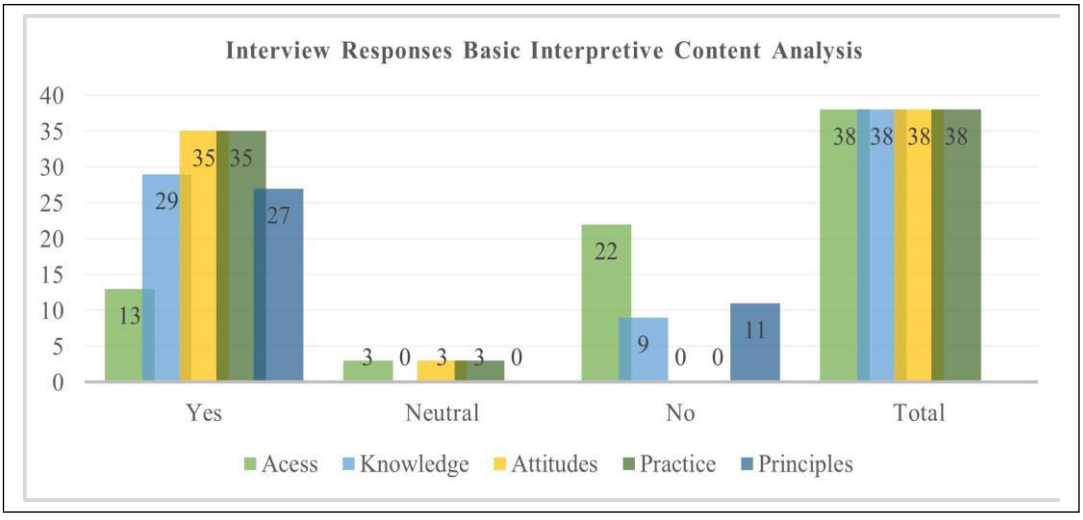
Responses	Access N (%)	Knowledge N (%)	Attitudes N (%)	Practice N (%)	Ethical Principles N (%)
Yes	13 (34.2)	29 (76.3)	35(92.1)	35(92.1)	27(71.1)
Neutral	3(7.9)	0(0)	3 (7.9)	3(7.9)	0(0)
NO	22 (57.9)	9(23.7)	0 (0)	0(0)	11(28.9)
N=100 (100)	38 (100)	38(100)	38 (100)	38(100)	38(100)

Wyllie (2024, p.261)

In Table 7 above qualitative data indicates positive attitudes towards clinical supervision by supervisors, despite evidence of poor access, limited knowledge, questionable practice, limited awareness and lack of ethical guiding principles.22 out of 38 (57.9%) supervisors reported "No Access" to CS, 13 out of 38 (34.2%) reported CS access and 3 out of 38 (7.9%) chose to remain neutral. The majority of counsellor supervisors expressed a positive attitude towards CS; 35 out of 38 (92.1%). (35,92.1%) indicated that CS was part of their practice, (3,7.9%) disagreed.

(27,71.1%) reported being aware of the importance of ethical principles in their practice, and (11,28.9%) reported not using any guiding ethical principles in their CS practice.

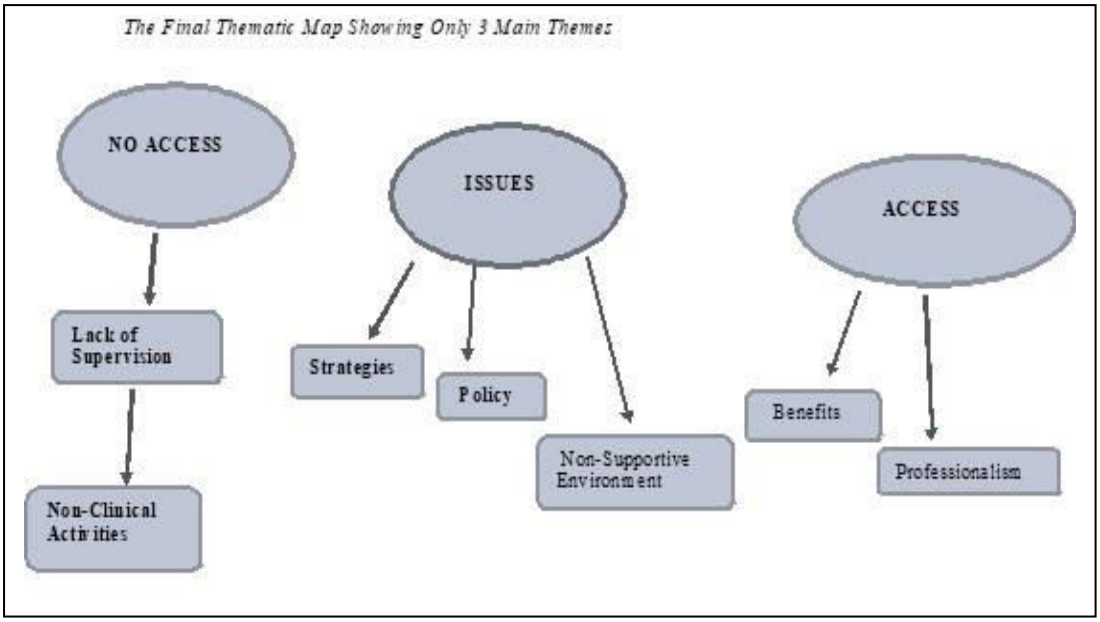
Figure 3
Qualitative Interpretive Content Analysis Results of the Interview Responses by Variables (N=38)



Wyllie (2024 p.261)

Figure 3 above mirrors Table 7 in descriptively showing basic qualitative interpretive content analysis results from the clinical supervisors' responses on the variables of access, knowledge, attitudes, practice, and principles. It can be concluded that data shows positive attitudes towards CS among clinical supervisors, limited access, and inadequate knowledge and practice, which is consistent with the findings from the counsellors. Apart from using NVivo to generate and develop themes, thematic mapping revealed three major themes (Braun& Clarke,2006) indicated in Figure 4 below.

Figure 4
Major Themes from Supervisors' Interview Responses



Wyllie (2024, p.245)

Access and No Access

Lack of Clinical Supervision

The majority of Counsellor supervisors reported a lack of CS, whilst others expressed being more involved in non-clinical activities. Supervisors reported receiving few counsellors for CS. The responses indicated that the majority of counsellors do not access CS and supervisors do not provide it due to various reasons such as working in unsupportive environments, lack of qualifications, and limited knowledge and competencies due to lack of training. Statements such as "I do not have access to CS, only administrative supervision during performance review" or "not many counsellors come to my clinic for CS" formed major themes.

Access

Positive and Negatives, Benefits and Professionalism

There are positive attitudes to CS for example, one said; "I do enjoy accessing clinical supervision, it helps as a sounding board and contributes towards my professional development…." another said; "Well, CS as a practice is not done in our country……".

However, a few indicated its benefits 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".

Issues

Non-Clinical Activities and Non-Supportive Environment

Many stated doing non-clinical activities as supervisors and working in non-supportive environments; "As a trained counsellor supervisor, I am knowledgeable on clinical supervision, the challenge is not being able to practice." "I only follow government protocols… I am not trained in CS".

Policy

The majority reported using ethical guidelines from foreign countries; for example; "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." Despite being aware of the existence of BCA, many reported not being aware of BCA ethical codes, not being members of the organization and not using the BCA code of ethics.

Portrayed in Table 8 below are supervisors' responses to research question 6 which solicited suggestions for improving the CS practice in the country. The Table shows that Supervisors' responses are convergent to the counsellors' quantitative data findings on the suggestions for improvement of Clinical Supervision in the country; focusing on making the practice mandatory, creating awareness, training of counsellors in CS, strengthening coordination, establishing an effective regulating body to ensure compliance and licensure, benchmarking from other countries and establishing protocols and/or national CS framework.

Table 8
Showing Interview Respondents' Suggested Strategies for Improvement of CS (N=38)

Suggested Strategy	Number of Participants N (%)
1. Clinical supervision should be included in the counsellor Education curriculum across mental health at the tertiary level.	16 (42.1)
2. All qualified counsellors and mental health services should be trained in clinical supervision.	19(50)
3. Establishing an active and effective regulating body for accreditation and licensure	23(60.5)
4. Clinical supervision should be made mandatory/ compulsory for all counsellors and all mental health services providers.	23(60.5)
5. Create awareness of clinical supervision and its importance to counsellors	18(47.4)
6. Benchmarking in other countries where clinical supervision is thriving then pilot what is culturally focused to the needs of our country.	2(5.3)
7. More research on clinical supervision to bridge the knowledge gap.	3(7.9)
8. Set standards and protocols that govern counselling and mental health services provision.	3(7.9)

Discussion

It can be concluded from the two data sets that more respondents believe that training counsellors in CS, followed by accreditation and licensure could help improve clinical supervision in the country.

Inference made from this study's results is that; the majority of participants reported having received very little or no clinical supervision; little or no access to clinical supervision, lack of training, and lacking competencies and confidence to offer CS. Despite this study revealed positive attitudes to CS. The implication is that there is a poor or low level of access to CS and this has practical implications for the provision of counselling services in the country.

There was a convergence between counsellors' and supervisors' findings on a lack of access to CS, inadequate knowledge of CS, lack of competencies, lack of training, poor regulation and lacking a guiding ethical framework.

Data shows that both counsellors and supervisors expressed concern and suggested mandatory implementation of CS and an effective regulating body to ensure compliance and effective CS practice in the country. The findings also established that many counsellors receive administrative supervision that focuses on non-clinical issues.

These findings have diverse implications for counsellors across the different mental health professions and for policymakers, regulating bodies, counsellor educators, practising counsellors and counsellor supervisors in Botswana.

Recommendations for Application

1. The findings have implications for policy, development and practice. Findings showed that very few counsellors access supervision, this is a concerning situation. There is a need for further research and replication using the focus group method.
2. Despite a significant number of counsellors desiring CS, there are various impediments such as a lack of clear policy, poor coordination, lack of training, and unsupportive environmental settings. There is a need for the development of the CS National Framework and regulation.
3. The need for accreditation and licensing bodies, compliance instruments, counsellor education curriculum review, and sensitisation of all mental health cadres on the significance of CS in their practice and skills re-tooling of qualified counsellors is crucial.

Limitations and Future Research

The study excluded inaccessible remote districts, it would be interesting to have more rural representation and examine if similar findings will be reached.

This study had a relatively low male representation, further research could be intentional in creating a gender-balanced sampling.

Replication with a larger population sample could provide interesting findings and could allow comparison between rural, semi-rural, and urban, as well as gender comparisons using the focus group method.

Conclusion

The results indicated that there are positive attitudes towards clinical supervision in the country among counsellors. The study further revealed issues contributing to the lack of implementation of clinical supervision such as limited knowledge and lack of skills due to lack of training. The findings confirm what was established through literature that there is limited knowledge, ineffective practices of clinical supervision, lack of ethical standards and the need to strengthen coordination, accreditation, and licensure. The findings adequately addressed the problem of the study and spoke to the problem statement indicating that there was indeed a need to explore the phenomenon to inform practice. The findings spoke directly to knowledge, attitudes, and practices of clinical supervision of counsellors in Botswana, and revealed the existing knowledge gap; the disconnect between theory and practice, and the need to transform and develop the CS practice in the country as currently the situation compromises the quality and standard of counselling services offered and puts the beneficiaries of the service at harm's way.

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