PSYCHCEs

Clinical Supervision Methods and Models

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Introduction

Clinical supervision is necessary in behavioral health practice, as professionals are tasked with helping complex clients in various work environments. Supervision is a process that allows ongoing observation and intervention while promoting the supervisee's learning development, the refinement of skills, and the enhancement of the therapeutic environment. Supervision can be delivered in various ways, such as in person or through telehealth, and it can be done in an individual, dyadic/triadic, or group setting. Several models of supervision may be considered when determining what is best suited for the supervisee, organization, and client. Each model follows a different framework and provides various approaches based on the therapy or treatment being given.

What is Clinical Supervision and Why is it Important

Clinical supervisor serves an essential role in ensuring that behavioral health professionals are operating within the standards of practice as well as being able to identify when one is not performing adequately. Supervisors are committed to upholding the ethical principles and standards of their professions, adhering to state and federal statutes regulating clinical practice, complying with relevant education and training standards, and practicing competent supervision.

Clinical supervision is an intervention provided by a more senior member of the profession to a more junior colleague who is usually a member of the same profession. The relationship is evaluative and hierarchical, extends over a period of time, and has the purposes of enhancing the professional functioning of the supervisee, monitoring the quality of professional services offered to the clients served, and acting as a gatekeeper for the particular profession the supervisee is attempting to enter (Meier, 2019).

Key concepts of supervision include:

Evaluative

- The supervisor evaluates the supervisee's readiness to practice
- Evaluates competencies in knowledge, intervention skills, and relational capacities
- Assesses the supervisee's ethical and professional conduct

Hierarchical

- Supervision is evaluative
- The supervisor has interpersonal influence over the supervisee

Extends over time

- Supervision is different than training or consultation, which tend to be brief and time-limited
- Extends over time which allows for growth and development
- This is evident when the supervisee moves through developmental stages (Meier, 2019).

Supervision involves several elements that are built through a supervisory relationship with the supervisor and supervisee. These elements are:

- Developing the supervisee's professional skills
- Supervisee's gaining self-awareness
- Protecting the client
- Mentoring and evaluating the supervisee's work with clients (Meier, 2019).

Supervision is important to ensure high standards and quality of professional practice. Effective supervision is crucial for monitoring, improving, and advancing the field of therapy. Supervision assists the supervisee by monitoring the quality of the work and the client's progress. By maintaining regular, quality supervision with a qualified supervisor, supervisees will:

- Experience growth in self-awareness, skill, and knowledge.
- Be aware of and trained in best practices for their area of practice.
- Be evaluated regularly and given feedback on professional competencies
- Be more aware of ethical and legal requirements
- Experience greater work satisfaction, health, and career longevity
- Provide more effective and high-quality services to clients (Meier, 2019).

The goals of supervision are:

Protect the welfare of the client

The fundamental goal of supervision is to protect the welfare of the client by ensuring the supervisee is providing sound and ethical therapy. The supervisor is responsible for the quality of treatment provided and must ensure that no harm is done to the client. The best protection for the welfare of the client is helping the supervisee develop principles of professional practice. The supervisor also monitors the supervisee's skills, abilities, and limitations and encourages supervisees to monitor their practice for potential risks, complications, and treatment failures.

Professional development of the supervisee

Supervision assists in the development and maintenance of the supervisee's clinical competencies. Supervisees should be encouraged to expand their

knowledge and seek out opportunities beyond their basic responsibilities. Supervision helps develop primary competencies in general knowledge, clinical skills, technical skills, clinical judgment, and emotional maturity.

Facilitate the supervisee's self-awareness, self-development, and understanding

Through supervision, the supervisees becomes more self-aware, which increases their well-being and, in turn, the quality of care to clients. Both professional and personal development is the responsibility of the supervisor. Supervisors should monitor their supervisees for signs of burnout and work frustrations and address issues early on; supervisees should be taught how to self-monitor for burnout, compassion fatigue, and professional impairment. Research has shown that regular, quality supervision is one of the best ways to guard against burnout and professional impairment (Meier, 2019).

Methods of Delivery

Methods of supervision can vary depending on the model of supervision, the supervisee's needs and skills level, the client demographic being served, the supervisee's work setting and role, and the supervisor's competence. The supervision method may change over time with the supervisee's and/or supervisor's professional growth. Verbal exchange and direct observation are the two most used forms of supervision. During verbal exchange, methods of supervision cases are discussed, along with ethical and legal issues and personal development. The verbal exchange method is more easily accomplished than direct observation and can be done in person, by phone, or with computer-based technology. The disadvantage of verbal exchange supervision is that it relies on supervisees' ability to report their therapeutic activities accurately. While direct observation requires more time and effort, it does provide a more accurate understanding of the supervisee's abilities and skills. Many agencies, educational

programs, licensing boards, and supervisors now recognize that relying on more than verbal exchange methods of supervision is required and possibly negligent if this does not occur. Direct observation supervision, particularly with students and beginner therapists, adds a level of protection for clients, supervisees, and supervisors. It is also a risk management strategy to protect a supervisor's vicarious liability based on their supervisee's actions (Corey et al., 2021).

Many factors go into choosing what supervisory methods to use. Six possible reasons for choosing a specific supervision method include:

1. Supervisor preferences - this is usually influenced by one's worldview, theoretical orientation, and past experience.
2. Supervisee developmental level
3. Supervisee learning goals
4. Supervisor goals for the supervisee
5. Supervisor's own learning goals as a supervisor - this may include becoming more comfortable with a specific supervisory intervention.
6. Contextual factors - organizational policies, agency capabilities, and client difficulties (Bernard & Goodyear, 2019).

Time Factors of Supervision

Pre-Therapy Briefing

Before a therapy session with a client, the supervisor and supervisee meet to discuss treatment approaches and concerns. If this is a new client, the intake information will be reviewed, and assessment needs to be explored based on the identified problem in the intake. If this is an established client, themes from the

previous session may be discussed, as well as reviewing previous interventions and the client's response to them. If there is a specific technique or intervention the supervisee is going to use in session, these steps may be reviewed in supervision prior. Pre-therapy briefing can help build self-confidence in new therapists or those in training (Meier, 2019).

Concurrent Supervision is a method of supervision that takes place while the session is ongoing. This type of supervision can take place through:

Live Observation

This is a one-directional observation by the supervisor while the supervisee is in session with a client. This may be through a one-way mirror or via camera and live stream. There is no interaction between the supervisor and the supervisee during this time, but the supervisor can observe and take notes in real time. The benefits of this type of supervision are that the supervisor can intervene in case of crisis and can give feedback immediately following the session. This can also be used in educational formats where other supervisees are also observing the session. This must be done with tact so that feedback is constructive and not critical, which will deteriorate trust (Meier, 2019).

Live Supervision

During live supervision, the supervisor gives feedback and direction while the session is taking place. This can be done as co-therapy, with the supervisor and supervisee conducting the therapy session together, or it may be with the supervisor entering the session or the supervisee stepping out of the session. Other ways may be the supervisor phoning into the session, supervisees having a bug in their ear to receive directions, or through a monitor behind the client that the supervisee is facing and can receive feedback on (Meier, 2019).

Reflection Team

A reflecting team is made up of a small group of therapists who observe the session through a one-way mirror and then discuss their observations. Typically, when a reflecting team is used as a manner of supervision, the client is introduced to all members of the team before the start of the session. The client and supervisee have a session of approximately 30-40 minutes and then switch sides with the reflecting team, and they get to observe the team discussing the first part of the session for approximately 15 minutes. The client and supervisee then switch sides again and return to the therapy room for 10-15 minutes to discuss and respond to the reflection team's observations (Meier, 2019).

Ex-post facto supervision is a method of supervision that takes place after the therapy session has terminated. This can be through self-reporting, reviewing case notes, or reviewing audio or video recordings of the therapy session.

Self-Reports

This is the most common method of supervision, where the supervisee shares with the supervisor what happened during the therapy session. While it is an easy and simple form of supervision, it is also one of the least effective. At its best, it can be a powerful self-reflection tool, but at its worst, it is fraught with bias, distortion, and inaccuracies. Self-report supervision should be used in conjunction with other types of supervision, especially with new and in-training therapists (Meier, 2019). Supervisees may also avoid discussing problematic cases, therefore avoiding necessary supervision to help overcome a challenging client (Corey et al., 2021).

Process Notes

This type of supervision is less used as it is time-consuming. It includes the supervisee's notes from the therapy session, its content, interactions between the client and supervisee, the interventions used and rationale, as well as the supervisee's feelings about the client and the session (Meier, 2019).

Case Notes

Case Notes are written by the supervisee following their completed session with a client and typically follow a format such as PAIP (Problem, Assessment, Intervention, and Plan) or SOAP (Problem, Assessment, Intervention, and Plan). Case notes can be reviewed in supervision to reflect on the session, the use of interventions, and the therapeutic relationship between the supervisee and the client (Meier, 2019).

Audio or Visual Recordings

Recordings enable a supervisor to watch or listen to a full session conducted by a supervisees to clearly visualize how they conduct a therapy session. It also allows the supervisor to establish who the clients are and how they interact in therapy. By using the recording in supervision, the supervisees can observe themself and notice patterns they may have in their interactions with clients that are positive or negative. Finally, a recording can be used to assess the supervisee's skills in screening, assessment, diagnosis, and interventions and treatment (Meier, 2019).

Individual

Individual supervision is the most common format of providing supervision. The supervisor and supervisee will meet face-to-face to discuss cases and explore

topics based on the supervisee's professional development needs. An advantage of individual supervision is that it gives supervisees individualized and detailed attention to their clinical work and skills development. Individual supervision is often a licensing requirement. The frequency and duration of the supervision meetings can vary depending on the supervisee's needs and the licensure requirements (Corey et al., 2021).

Some supervisees may respond best to the one-on-one attention of individual supervision and may be more comfortable disclosing challenging case information that they would otherwise feel uncomfortable sharing in a group setting.

Case Consultation

Case consultation is the most common supervision method and it involves discussing the supervisee's cases and providing support. Case consultation can be used in individual and group supervision. During this verbal exchange method, supervisees share the major issues of each of their cases with the supervisor. The supervisee and supervisor may discuss the reasons the client is seeking therapy, probable diagnoses, therapeutic interventions used, relationship challenges, ethical, legal, and multicultural issues, and they will likely review case notes. A drawback of case consultation is that it relies on the supervisee's self-report and, therefore, has its limitations. Many times, a supervisee can say all the right things during case consultation, but when the supervisor has a direct observation of a session, there is a clear gap in what is reported versus what is observed. Furthermore, the supervisor may realize that although the supervisee clearly understands concepts, observed clinical skills don’t match this knowledge. Supervisees may also struggle with their perception of what is happening in the therapy session, which may not be accurate in reality. None of this means the supervisee is deliberately misleading the supervisor; it can be an issue regarding perception, and it should not be minimized that supervisees wish for positive

feedback (and possibly a grade) from their supervisor. Despite these drawbacks, case consultation is the most common supervision method used, and it can be effective when paired with other methods of supervision (Corey et al., 2021).

Cotherapy

In this method of supervision, the supervisor and the supervisee work as co-therapists, providing therapy to an individual client or group. Together, they will review the specifics of the case or group and what role each of them will take as they provide therapy together. Some disadvantages to this approach are that, on occasion, supervisors take over providing the therapy and do not allow the supervisee to learn the therapy process. This is especially true if the supervisee is struggling and the supervisor jumps in too soon to "save" the situation. Another disadvantage is the client may default to the supervisor as the main therapist and discount the supervisee. Either of these situations will have a negative impact on the supervisee's learning experience.

After a co-therapy session, the supervisor and supervisee will discuss their work together in a supervision session. Co-therapy supervision allows the supervisor to have first-hand experience of the supervisee's skills. The supervisor can demonstrate or model a specific skill in the therapy session. This method of supervision offers accurate information on the supervisee's abilities as a therapist. Co-therapy can be an effective and beneficial method for both, providing in-vivo training and eliminating some of the limitations of verbal exchange supervision (Corey et al., 2021).

Live Observation

During live observation, the supervisor or observing team directly observes a supervisee in a therapy session either by sitting in on the counseling session,

through a one-way mirror, or on a video monitor. The purpose of live observation is to assess the supervisee's therapy skills when working with a client. The client must give written permission for the supervisor to sit in on the session or observe from another room. Live observation may happen occasionally or during every session. The supervisor and supervisee will meet to discuss the case that was observed, and feedback will be given to the supervisee at that follow-up supervision session.

There are a number of variations to live observation. Supervisors may remain silent throughout the sessions and only observe, or they may interrupt sessions to discuss the supervisee's approach during the session (this may be done directly in front of the client or by stepping out of the room to receive brief feedback and then returning). Should interruptions be used, they must be done within limitations, as too many interruptions can be distracting for the supervisee and the client. Another variation involved using scheduled breaks during the session for the supervisor and supervisee to have a discussion of the supervisee's techniques being used. In another approach, the supervisor may take over the session to demonstrate a specific technique with the client. This is another strategy that should be used within limitations, as taking over the session impacts the supervisee, the client, and their relationship. Maintaining the welfare of the client and the dignity of the supervisee are the most important.

Using a one-way mirror is another method for live observation. The supervisee and client are in one room, with the supervisor in the adjoining room, observing the counseling session through the one-way mirror. There is also audio transmission from the therapy room into the observation room. While both the supervisee and client are aware they are being observed, they can not see the supervisor. This method has numerous variations for providing supervision. The supervisor may observe the session and provide feedback to the supervisee at their next supervision meeting or may provide feedback during the session. This

may be accomplished through a bug-in-the-ear; the supervisee wears an audio receiver in their ear, and the supervisor provides feedback and suggestions to the supervisee via a microphone to the earpiece. This method allows the supervisee to make adjustments immediately in the session with the client rather than waiting for feedback during the post-session supervision meeting. The challenge with the bug-in-ear method is that it can be distracting, especially if the supervisor gives too much feedback. Alternatively, a signal can be given to the supervisee that the supervisor wishes to pause the session and give feedback to the supervisee (buzzer, alert light, knock on the door). The supervisee may step out of the session and into the observation room for feedback, or have

a phone to call into the observation room. There can also be a few scheduled breaks where the supervisee will pause the session with the client and go to the observation room with the supervisor to receive feedback and then return to the therapy room to implement the suggestions that were received. A one-way mirror is an effective way to observe supervisees directly and provide feedback during their work with their clients. A drawback is that it does require two rooms, a one-way mirror, and audio equipment. As with any direct observation, it also requires the permission of the client (Corey et al., 2021).

Video Recording

In this method of supervision, the supervisee will video record their session(s) with the client or group and then watch them in supervision. An advantage of video recording over live supervision is that key moments of the session can be replayed multiple times if needed, and the video can be paused to have a discussion over what is happening in the session. Recording sessions at different stages of therapy provides supervisees with a comparison of the progress they have made. Disadvantages of video recordings are possible technical difficulties,

including failure to record, poor audio, and poor video, all of which make rewatching difficult to impossible (Corey et al., 2021).

Corey et al. (2021) offer the following suggestions when using video recordings for supervision:

1. Set up the equipment such that the camera has a clear view of the faces and full bodies of both the supervisee and client in order to observe body language.

2. The audio portion of the recording often suffers due to poor reception by the camera microphone. It is very frustrating to video record only to find the audio portion nearly impossible to hear. The use of an external microphone placed close to the supervisee and the client is ideal, but if not feasible, move the camcorder as close as possible to the supervisee and client for better audio recording.

3. Provide full disclosure of the recording process and usage to clients and obtain clients' written consent for the recording. Assure clients that they have the option to rescind their consent at any time and that the recording will be used only for the training purposes and then erased. Also, assure the client, who may be anxious about being recorded, that the discomfort often subsides shortly after beginning the recording session.

4. Have a definite plan for how to use the video recording as means to accomplish the goals of supervision. Supervisees need to prepare themselves for presenting specific aspects of the recording and come to supervision sessions with questions.

5. One recorded session may be an hour long, making it impractical to view the session in its entirety during the supervision session. The supervisor can

select segments to review and discuss with the supervisee. Supervisees can also decide which portions of a recording they would like to review.

6. At the end of the viewing, ask supervisees what they have learned and what they would do in future therapy sessions based on this learning.

Interpersonal Process Recall

Interpersonal Process Recall is a method of using video recording in supervision to assist supervisees in processing relationship dynamics with clients and to increase self-awareness. Supervisees are video recorded while counseling a client and then shown the recording immediately following the session. By reviewing the recording right away, supervisees are able to recall thoughts and feelings they experienced during the therapy session in detail but, for various reasons, did not express. The video may be stopped at any point during supervision to explore and discuss various aspects of the session. The main goal of this type of supervision is to help supervisees explore their internal processes, including motives, thoughts, and feelings that were at play during the therapy session. As this is a detailed supervision method, it may take numerous supervision sessions to completely process a one session video recording (Corey et al., 2021).

Audio Recording

If live observation or video recording is not available, audio recording is an alternative method that may be used. It is not as useful as it does not provide body language or facial expressions that one can have with video recording or live observation. One way to utilize audio recordings for supervision is to have supervisees provide written transcripts and self-critiques of their audiotaped sessions with clients as a way to facilitate feedback during supervision sessions.

The same procedures for consent, review, and confidentiality required for video recording apply to the use of audio recording (Corey et al., 2021).

Role Play and Role Reversal

Acting out different scenarios with the supervisor and supervisee acting as therapist and client can be an effective add-on to supervision. Role-playing can also be used in group supervision. The benefit of using role-playing as part of supervision is that it allows the supervisor to see the supervisee in action versus talking about situations and issues.

Role reversal is a variation of role play where the supervisee will play the role of the client and the supervisor that of the therapist. This can be helpful for the supervisee to develop empathy for clients and their possible experiences in therapy. Another variation of role reversal is the supervisee plays the role of supervisor and the supervisor that of the supervisee. This encourages supervisees to view issues that have been discussed in supervision from a different perspective and can help support their learning (Corey et al., 2021).

Modeling and Demonstration

Modeling is a way of teaching supervisees as they observe supervisor actions as they complete various professional tasks. This may include ethical decision-making, applying clinical methods, and writing case notes. Modeling often happens naturally throughout the course of supervision and shows supervisees' professional attitudes, beliefs, and behaviors, which they will hopefully emulate in the future.

Demonstration is showing the supervisee how to perform a specific task or skill. This may be how to conduct an intake session or various interventions that may

be used to engage a reluctant or mandated client. Skills may be demonstrated through role play or cotherapy. It is important that supervisors point out that they are demonstrating one way of intervening in the situation at hand but that there are often numerous ways to approach a problem. Modeling and demonstrating may be more powerful than discussions in supervision, as actions often speak louder than words (Corey et al., 2021).

Coaching

Coaching can be an effective form of supervision as it encourages supervisees to explore various topics for themselves. The supervisor, as a coach, has less authority and is more of a personal adviser, focusing on the supervisee's agenda. Asking the right question is often more important than having the right answer when coaching. Coaching is very similar to person-centered supervision. The goal is to listen to the supervisees and help them discover for themselves what they need to learn. It also has similarities with the solution-focused model, as supervisees are encouraged to examine issues and find their own solutions.

While the coaching method of supervision can be applied to all levels of supervisee experience, it works very well with experienced therapists and in peer supervision. Coaching is a less structured model of supervision and it requires supervisees to determine and verbalize what they need from supervision. Coaching will not work well with supervisees who need structure and direction from their supervisors or who may have difficulties speaking up for themselves and advocating for their needs. Coaching is a collaborative method of supervision that sees the supervisor and supervisee form a partnership to meet the goals of supervision (Corey et al., 2021).

Homework

To supplement supervision, homework might be assigned. This can include journaling, readings, or videos on clinical, ethical, legal, or any other topic of interest. To use it most effectively, homework should be relevant to cases or supervisees' desires to learn more on a topic and, upon completion, should be discussed in supervision on how new knowledge gained from homework can be applied to current client(s). Using homework can accelerate a supervisee's learning as it reduces the need to spend time during supervision covering basic concepts that could easily be learned outside of supervision. It may increase the time available in supervision to discuss cases in greater depth (Corey et al., 2021).

Written Information Methods

Process notes are written notes outlining the supervisee's conceptualization of the counseling process, including diagnosis, goals, objectives, and treatment strategies. Process notes summarize reactions such as transference and the therapist's subjective impressions of a client. Personal details about the client and the therapist's thoughts, feelings, and reactions to the client are typically included. Process notes are NOT part of a client's medical record; they are the personal property of the therapist and are not kept in the client's medical file but rather in the therapist's professional file. As these do contain confidential information, they must be locked up and/ or destroyed upon use (Corey et al., 2021).

Progress notes are factual notes on what transpired during the counseling session and include client statements, behavior, and demeanor. Progress notes are part of the client's official medical record. Progress notes are behavioral in nature and address what people say and do. They contain information on diagnosis,

functional status, symptoms, treatment plan, consequences, alternative treatments, and client progress.

Both of these written methods provide a more detailed review of a session than the supervisee's self-report. Other types of written methods include logs, notes, journaling, verbatim transcriptions of sessions, process recording, case review forms, and worksheets. Written methods can be useful in encouraging the supervisee to conceptualize from the notes what is going on in the session and with the client. These can be used in conjunction with any of the other methods of supervision (Corey et al., 2021).

Nonlinear Supervision Methods

Nonlinear supervision strategies tend to encourage more reflection on the part of the supervisee. One nonlinear technique is that of the use of a sand tray. The supervisee uses small figures in the sand to represent the counseling dynamics. Through depicting the relationship dynamics in the sand tray, supervisees may acquire insights into the therapeutic relationship they had previously been unaware of. As supervisees present their cases through the figures in the sand tray, supervisors may have additional insights they can then share with the supervisees.

Another method of nonlinear supervision is drawing. Drawing a picture of the dynamics in session using symbols or pictures can be a powerful method of seeing patterns or needs that may not have arisen previously.

A third example of nonlinear supervision is that of the use of fairy tales and mythology. These stories typically have rich themes that can help supervisees establish the meaning of their development. The supervisor may choose a story that addresses a developmental task and illustrates the universality of the struggles supervisees were experiencing and may have believed unique to them.

Movies, literature, and art may be used in similar ways to illustrate a point or theme the supervisor is looking to normalize for the supervisee (Bernard & Goodyear, 2019).

Dyadic/Triadic Supervision

Dyadic and triadic supervision are used interchangeably in the literature, and both are defined as one supervisor meeting with two supervisees.

Triadic supervision is a tutorial and mentoring relationship between a supervisor and two supervisees. Drawbacks of triadic supervision include more demand on supervisors as they must interact with two supervisees simultaneously, who may also have varying levels of skills and needs and therapeutic approaches. There is also the struggle to balance the dynamics in the triadic supervisory relationship, which can cause an increased cognitive load on the supervisor. With proper training and a good peer fit with the supervisees, triadic supervision can lighten the workload for the supervisor. Issues to consider when matching peer supervisees include personality, motivation, comfortableness in challenging each other, and being open to feedback from their supervisor and their peer supervisee (Corey et al., 2021).

One model of triadic supervision is that of the Reflective Model of Triadic Supervision (RMTS). RMTS sessions last for 90 minutes. Supervisees are required to record their work, come to supervision with a minimum of one clinical case for review, and identify one to three specific segments of their recorded session to review. Prior to supervision, supervisees have already reviewed their recorded session, processed it using self-supervisory skills, and decided what material to address in supervision.

Phase 1

Supervisee #1 presents certain recorded segments along with specific feedback requests. Supervisee #1 is in conversation with the supervisor, and supervisee #2's job is to listen and observe. This happens on two levels: the conversation between supervisee #1 and the supervisor AND the internal conversation supervisee #2 may be having as part of the observer-reflector role. This phase of supervision lasts for 20 minutes.

Phase 2

The supervisor and supervisee #2 now discuss what thoughts and observations they wish to share with supervisee #1 based on what transpired in phase 1. Supervisee #1 is listening and reflecting during this phase. This phase is brief so as not to overwhelm supervisee #1 with too much feedback. This phase lasts for 10 minutes.

Phase 3

The supervisor resumes discussions with supervisee #1, processing what stood out to them while they were in the listening-reflecting role. The supervisor offers support and additional feedback to supervisee #1. Goals for the upcoming week are set during this phase. This phase lasts 10 minutes.

These three phases are then repeated with supervisee #2 by presenting recorded segments, listening, and receiving feedback.

RMTS supports peer supervision skills, including feedback delivery and reception of feedback. It establishes a working alliance between the supervisor and supervisee. It also provides a level of trust between supervisees, giving them support and a sense of universality (Kleist, 2021).

Group

Many supervisors and agencies prefer group supervision as it allows one supervisor to oversee multiple people at once, and supervisees can benefit from learning from each other. However, it does have the drawback of less individualized attention, and many licensure boards limit how many hours of supervision can be completed via group supervision if allowed at all. Group supervision allows the supervisor to see a parallel process of how supervisees interact with group members and how this may be similar to their interactions with clients.

Another advantage of group supervision is the opportunity to role-play. Role-playing allows supervisees to build awareness around countertransference issues and learn alternative views of working with clients who may be labeled as difficult. Role-playing can provide much material for post-enactment discussions (Corey et al., 2021).

A disadvantage of group supervision is the supervisor's challenge of balancing the group needs with the individual needs while always maintaining the importance of each client's well-being. It may be most effective to provide a mix of individual and group supervision.

Group supervision does have the added challenge that beyond case consultation and supervising case issues; supervisors must also establish a safe and accepting environment that is encouraging and meaningful to the supervisees and the supervision process. Regardless of the supervisory method used, group dynamics will develop, and the group will move through the group stages of the group process. These stages are:

Initial Stage

The focus of this stage is on orientation and exploration of the group structure, group rules, expectations, personal goals, fears, and developing the group as a safe place. A supervision contract is developed to ensure all supervisees know what is expected of them and so they can give informed consent. Explanations will be given on how group supervision works, goals will be set, and supervisees are encouraged to actively engage in creating the agenda for each supervision session. Supervisees are encouraged to actively engage in the group by sharing their thoughts and feelings surrounding the group to help create a trusting environment.

Transition Stage

In this stage, the group begins to shift into anxiety, resistance, conflicts, problematic behaviors, and struggle for control. Group supervisors must remain consistent and calm to help the group move into the working stage. During this stage, supervisees may question their acceptance in the group, experience performance anxiety, and struggle with their competence level. Encouraging supervisees to take risks in speaking up for what they need from group supervision, being open in their training needs, and disclosing issues they would like to explore all help strengthen the group dynamics and help move from the transition stage into the working stage.

Working Stage

When group members trust their level of safety, they can begin to be more open to learning from the supervisor and their group peers. As group cohesion increases, a sense of community will develop, allowing for open and direct interactions with one another and the supervisor. Should a conflict arise, it is able

to be dealt with effectively. Group members are comfortable presenting client concerns or challenges to the group, asking for feedback, and providing feedback to others.

Ending Stage

In this stage, supervisees are implementing what they have learned from the group into practice. Issues around termination and separation will arise and may be addressed through discussions on what the group meant to each member. Supervisees may acknowledge what they have learned through their participation in the group and treating clients. The supervisor's role in this stage is to help supervisees establish their therapeutic framework to help them integrate and implement what they have learned in the group into their daily practice with clients (Corey et al., 2021).

Advantages of Group Supervision

- Saves time and money
- Encourages peer feedback and a team approach
- Promotes peer interaction
- Supports fairness
- Less dependence on the supervisor
- Reduces fear and anxiety
- More opportunities for team building, role-playing, and simulations (Horn, 2022).

Disadvantages of Group Supervision

- Individual supervisees may not get their needs met in the group

- Self-disclosure may result in shame and embarrassment
- Supervisors may not have training in group supervision (Horn, 2022).

Technology-Assisted Methods

The use of supervision interventions through technology is rapidly growing. Technology-assisted supervision advantages can be seen when considering serving rural areas, serving the needs of international students, supplementing supervision in agency settings, and serving supervisees with disabilities. The use of technology allows supervisors to be much more accessible to supervisees to assist with clinical situations and crises that require more immediate supervisory attention.

Technology or computer-assisted techniques and online supervision include live supervision using the "bug-in-the-eye," email, chat rooms, instant messaging, live supervision through videoconferencing, desktop videoconferencing, listservs, discussion boards, blogs, as well as the use of cell phones and tablets. Keeping up with the constantly growing and evolving technology and how it can assist with supervision, along with ethical and legal issues, can be challenging. The quality of the supervision is also only as good as the equipment and the user's knowledge and ability to use the technology.

Telesupervision can be used the same as telehealth sessions, and most methods and models of supervision can be effective through telesupervision as they are in person. Drawbacks or challenges of technology-assisted supervision include the costs involved, unequal availability of the technology, the loss of nonverbal cues in the use of email and messaging, issues regarding informed consent and breaches of confidentiality, lack of training in the use of technology, and problems that occur with technological failures.

Supervisors providing telesupervision may consider the following:

- Consider the ethical ramifications of online supervision.
- Have a clear understanding of their professional code of ethics expectations for telesupervision.
- Establish expectations regarding the online supervisory relationship.
- Inform clients of online supervision's benefits and possible hazards and obtain their written consent.
- All telesupervision, video case conferencing, and case note sharing must be done through HIPAA-compliant systems.
- Routinely evaluate that telesupervision is meeting the supervisor and supervisee's needs (Corey et al., 2021).

When using technology for supervision, it is the supervisor's responsibility to comply with all state licensing boards, jurisdictions, and codes of ethics. For example, the National Association of Social Workers has "Standards for Technology in Social Work Practice," with the following being specific to the use of technology in supervision.

Standard 4.12: Social Work Supervision

Social workers who use technology to provide supervision shall ensure that they are able to assess students' and supervisees' learning and professional competence.

Interpretation

Some social workers use technology to provide supervision in a timely and convenient manner. When using technology to provide supervision, social workers

should ensure that they are able to sufficiently assess students' and supervisees' learning and professional competence and provide appropriate feedback. Social workers should comply with guidelines concerning the provision of remote supervision adopted by the jurisdictions in which the supervisors and supervisees are regulated. Social workers who provide remote supervision should comply with relevant standards in the NASW Code of Ethics, relevant technology standards, applicable licensing laws and regulations, and organization policies and procedures (NASW, 2023).

Telesupervision

Telesupervision is remote clinical supervision using technology. One study found that supervisee participants reported similar levels of supervision satisfaction and supervisory working alliance during in-person supervision and telesupervision. However, in-person supervisory relationships were established prior to transitioning to telesupervision. The study also established that telesupervision was not associated with lowered supervisee satisfaction or rapport, nor did it compromise the supervision experience. The most important aspects indicated by the supervisees were the supervisors' competence with the technology and the supervisors' characteristics of openness, supportiveness, and empathy (Tarlow et al., 2020).

Ethical Considerations

Telesupervision adds another layer of consideration that needs to be given to confidentiality, informed consent, competency, regulatory issues, documentation and record-keeping, and self-care.

Supervisors are responsible for maintaining the confidentiality of their supervisees and their supervisees' clients. Telesupervision takes place in cyberspace where there are no absolute guarantees of privacy, and therefore, the threat of

unauthorized access to confidential material is increased. Furthermore, as with teletherapy, video conferencing platforms are even more vulnerable to such access unless they are equipped with appropriate security protocols. Additionally, unlike providing live teletherapy services, supervisors often supervise by viewing recorded therapy sessions. Although a very useful mode of supervision, it could constitute a potential threat to confidentiality unless the videos are stored, maintained, and viewed in secure physical and electronic settings. In addition, when telesupervision entails the transmission of documentation or other materials for review, there exists a potential risk of breaching client confidentiality. Even with the use of encryption software, there is still the risk that a person other than the supervisor might retrieve the communication and documents. The use of HIPAA-compliant websites or cloud storage sites that allow documents to be securely accessed by authorized individuals could be a better choice for the sharing of supervision materials. Other recommendations for addressing email confidentiality include disclaimers on emails stating that it is of a confidential nature, clear and documented agreements between supervisor and supervisee about how these issues will be handled, and the development of a standard operating procedure. Additional suggested protocols for maintaining confidentiality while engaging in telesupervision include ensuring that the supervisor and supervisee,s physical space is private, with reduced potential for interruptions or being overheard, and refraining from the use of identifying client information when discussing cases online or engaging in electronic communication (Grames et al., 2022).

Informed consent considerations apply to both the supervision contract and supervisees' telehealth informed consent with their clients. Informed consent for supervisory contracts should include an agreement on how online privacy will be maintained, confidentiality policies, security, and encryption for sessions that are audio or video recorded, including how they will be stored, kept, and used.

Supervisees must inform their clients that they are receiving telesupervision and the potential confidentiality risks that it involves (Grames et al., 2022). See Appendix A for an example of informed consent and Appendix D for an example of a supervisor-supervisee contract.

Just as supervisees are expected to practice with competence and professionalism, so too must supervisors. Supervisors must be competent in the use of technology and the ethical considerations involved in providing online services. Recommendations for supervisors providing telesupervision include reviewing their professional codes of ethics, acquiring training in technology, developing protocols and backup plans should there be technology failure, reviewing guidelines and updates from software providers, and regularly updating virus scan programs (Grames et al., 2022).

Jurisdiction is another possible ethical challenge in telesupervision. Supervisors may need to have a license to practice in their supervisee's state, or the supervisee's supervision hours through telesupervision may not count toward licensure. Supervisees must also be licensed in the state where they are providing telehealth services to clients (Grames et al., 2022).

Advantage

- The increased availability and access to supervisors with specific therapeutic expertise leads to enhanced supervisee training and competence.
- Increased scheduling flexibility.
- While there continue to be jurisdiction issues, the possibility of providing supervision to therapists in underserved or unreached communities globally is an exciting possibility.
- Increased access to supervision, especially in rural and developing areas.

- Reduced financial constraints and travel times.
- May decrease the supervisee's inhibitions (Grames et al., 2022; Horn, 2022).

Disadvantages

- Telesupervision relies on the technological competence of the supervisee, supervisor, and client. A lack of competency can create anxiety.
- Lack of or low internet connectivity due to bandwidth or bad weather, lack of internet access, or lack of technology knowledge all create challenges to the provision of telesupervision.
- Potential to have a less strong supervisory alliance.
- Possible environmental distractions (kids, pets, partners, scrolling)
- Interactions with others are different online. The challenge of extended, focused screen time that requires intense attention may lead to a high level of fatigue.
- Non-verbal cues and body language are harder to perceive.
- Email and texts can be easily misinterpreted
- Time lag: supervisees can not just walk down to the supervisor's office
- Technology is constantly changing, with new aspects to learn (Grames et al., 2022; Horn, 2022).

Other Methods of Supervision

Peer Supervision

Peer supervision is used most often in agencies or group practices. It consists of a group of therapists at similar training levels who meet regularly to provide each other with supervision. These groups often discuss challenging cases and topics, address ethical issues, and provide general support and feedback to each other. Peer supervision groups can be helpful for therapists in training, providing them with support and acceptance that they are not alone in their concerns as new therapists. Peer supervision groups can be helpful for therapists with years of experience, particularly around ethical dilemmas or to seek alternative perspectives. Peer groups do not have the evaluation piece to them that other traditional forms of supervision usually have. Peer group supervision is valuable for consultation on difficult situations, networking, and alleviating professional isolation and possible burnout. Peer supervision among established therapists can provide support for the emotional intensity and stress associated with providing therapy (Corey et al., 2021).

Team Supervision

Team supervision is often found in agencies or institutions where a group of professionals from different disciplines meet to discuss shared cases and clinical issues. Depending on the setting, it may also be called case conferencing or grand rounds (Corey et al., 2021).

Self-Supervision

The goal is for clinicians to build their professional skills and knowledge to reach a level where they are capable of self-supervision. Self-supervision is a process

where therapists reflect on the intrapersonal, interpersonal, and clinical issues that influence their work. This may be accomplished through interpersonal process recall, self-critique, self-management, self-analysis, self-generated performance feedback, self-monitoring, self-instruction, and self-evaluation.

Self-supervision is not to be employed by beginning therapists or intended to take the place of seeking out the wisdom of experienced professionals. Supervisees can work toward the goal of self-supervision while they are under traditional supervision. This may take the form of learning how to monitor and evaluate their clinical and professional performance (Corey et al., 2021).

Interdisciplinary Supervision

Interdisciplinary supervision is receiving clinical supervision from a person who is not in the same profession as the supervisee. For example, a social worker receives supervision from a clinical psychologist. Mental health professionals are more alike than different in their supervisory practices, and many supervision skills and modalities are the same across professions. A positive aspect of interdisciplinary supervision is the exposure the supervisee has to different professional views and techniques.

Difficulties of interdisciplinary supervision include having limited knowledge of the supervisee's professional culture and the challenge of working with multiple codes of ethics (Bernard & Goodyear, 2019).

How to Decide What Method of Supervision to Use?

Supervisors must be knowledgeable in a variety of supervisory methods and techniques. In addition, they must have an understanding of their supervisees' strengths, deficiencies, and preferred style of learning. With this knowledge,

supervisors can narrow down what methods of supervision best suit their personalities and the needs of their supervisees. Beginner therapists will need more support and structure, requiring monitoring, observation, demonstration, and teaching from their supervisors. As supervisees become more knowledgeable, they can become more active participants in supervision and, with more confidence, bring issues to supervision and explore their own thoughts, feelings, and reactions to clients and to the supervision process. Toward the conclusion of a supervisory relationship, interactions are more collegial, and supervisees should feel empowered to be more in control of the supervision sessions. It is important to acknowledge that supervisees develop into competent therapists at their own pace, and it is impossible to standardize the timeframe that each developmental milestone is reached. The supervisor and supervisee must work together to assess the supervisee's professional developmental level and the best methods for the supervisee to successfully learn the skills they need to be competent providers (Corey et al., 2021).

Supervision methods will be much more effective if used within the context of a healthy supervisory relationship. Trust and respect are essential to a healthy supervisory connection, and these take time to develop. The supervisor fosters this relationship early and continuously throughout the supervision process. The use of supervision methods without the basis of a healthy relationship is like psychotherapy techniques applied mechanistically without an understanding of the context of the therapist-client relationship (Corey et al., 2021).

The supervisor must have a clear model of supervision, a rationale for the use of any particular method, and competence in training and experience with the particular method. Most professional association standards require supervisors to demonstrate they have the knowledge and skills to apply supervision methods. Supervisors do not increase their level of competence as supervisors simply by accumulating clinical and supervisory experience. They learn from courses,

workshops, readings, colleagues, and supervisees. Supervisors would do well to remain open to the growth and learning that occurs from each person they supervise (Corey et al., 2021).

Models of Supervision

A model of supervision is a theoretical framework of what supervision is and how the supervisee's learning and professional development occur. Most models focus on the process of learning and development, while others focus on the details of what occurs in supervision. A comprehensive model addresses how learning occurs and what supervisors and supervisees do to bring about that learning. Effective supervisors have a clear model of supervision, and they know where they are going with the supervisee and what they need to do to get there (Corey et al., 2021).

Supervisory models should:

1. Describe how learning and development occur for the individual.
2. Explain the role of individual and multicultural differences in the supervision process.
3. Contain elements that structure the goals of supervision.
4. Determine the role of the supervisor.
5. Indicate intervention strategies the supervisor will use to support the supervisee and the supervisor's style of supervision.
6. Describe the role of evaluation in supervision (Meier, 2019).

Supervisors must be knowledgeable in the model of supervision they are using and inform their supervisees of the goals, policies, and orientation toward

counseling, training, and supervision based on their model of supervision. A person's model of supervision often evolves as one gains clinical and supervisor experience; even personal life experiences beyond professional experiences can influence one's model of supervision (Corey et al., 2021).

Developmental Models of Supervision

Developmental models are some of the most widely accepted models of supervision. Central to developmental models of supervision is the belief that growth is ongoing and learning is a lifelong process. Developmental models view supervision as an evolutionary process, and each stage of growth has defined tasks, needs, and conflicts that the supervisee must work through. For example, novice supervisees are characterized by limited knowledge and skills and a lack of confidence in their therapeutic skills. Supervisees in the middle stage will have more skills and confidence and may also have conflicting feelings about their independence/dependence on the supervisor. Supervisees at the expert stage are more likely to use effective problem-solving skills and reflect on the therapy and supervisory process. As supervisees progress through the developmental stages, their confidence and skills increase, and they become self-sufficient therapists.

Supervisors using developmental models of supervision must identify what stage the supervisee is in and provide feedback and support that is appropriate for their stage of development when encouraging their readiness to progress to the next stage. The goal of supervision is to identify and maximize new areas of growth in a lifelong learning process. Through supervision, supervisees are able to identify their areas of growth and strengths and take responsibility for their lifelong growth as therapists (Corey et al., 2021 & Meier, 2019).

Two models of developmental supervision are the Integrated Developmental Model and the Lifespan Developmental Model.

Integrated Developmental Model

The integrated developmental model has three levels of supervisee development paired with the role of the supervisor for each developmental level. While development occurs on a continuum with different needs and interventions, the supervisee does not pass through each stage clearly. For example, the supervisee may be skilled in individual therapy and just learning group therapy techniques. Each level has three trends of the trainee's progress (the three trends that assess progress are self and other awareness, motivation, and autonomy). The following are the three levels of the integrated developmental model.

Level 1: Beginning

Supervisees at this level are entry-level therapists who typically lack confidence and skills. They are highly motivated but also fearful of evaluation. They need structure and direction from the supervisor and are dependent on the supervisor to diagnose clients and create treatment plans.

Level 2: Intermediate

Supervisees at this level have fluctuating confidence and motivation. They are beginning to rely on their own abilities for decision-making. Success or failure with a client often impacts the supervisee's mood. Supervisors may provide direction, but supervision is now focused more on process issues, such as how the supervisee's own reactions and issues affect their work as a therapist.

Level 3: Advanced

Supervisees at this level function independently, feel responsible for their decisions and seek consultation when needed. They are secure in their confidence, stable in their motivation, express empathy while remaining objective, and use therapeutic use of self in interventions. Supervision at this level may be more informal and more collegial.

Level 4: Integrated

At this level, practitioners have integrated their skills and knowledge across multiple domains. They have reached a master level, which is characterized by personal autonomy, insightful awareness, personal security, stable motivation, and an awareness of their need to address their own personal and professional problems. Essentially, the therapist has reached a level of self-supervision while continuing to strive for lifelong growth and learning (Corey et al., 2021 & Meier, 2019).

Throughout the integrated developmental model, supervisors are assessing eight clinical practice domains to establish their supervisee's developmental level. These areas are:

1. Intervention skills competencies: Confidence and ability to carry out therapeutic interventions.
2. Assessment techniques: Confidence and ability to conduct psychological assessments.
3. Interpersonal assessment: This extends beyond the formal assessment and includes the use of self and conceptualizing client problems.
4. Client conceptualization: Diagnosis is based on the therapist's understanding of the client's circumstances, history, and characteristics and how those affect the client's functioning.
5. Individual differences: An understanding of ethnic and cultural influences on a person.
6. Theoretical orientation: The level of complexity and sophistication of the therapist's understanding of theory.

7. Treatment plans and goals: How does the therapist plan to organize their efforts in working with clients?
8. Professional ethics: How professional ethics intertwine with personal ethics (Corey et al., 2021; Bernard & Goodyear, 2019).

The integrated developmental model of supervision is helpful for supervisors to understand the developmental stages of the supervisee and the corresponding skills and approaches for the supervisor. The integrated developmental model allows for a wide range of supervision methods to be used to help the supervisee move through the stages of becoming a competent therapist (Corey et al., 2021).

Disadvantage

- The focus is on novice and graduate student development and does not address post-graduate professionals.
- It does not address supervision methods to be used at each level of supervision (Meier, 2019).

Lifespan Developmental Model

This model was developed in response to the fact that many models focused on student and novice therapists and did not expand into one's professional career. The lifespan developmental model provides a framework for development across the lifespan of the therapist's career. It covers six phases of supervisee development.

The Lay Helper

- Identifies a problem quickly
- Provides strong emotional support

- Gives advice based on their own experiences
- Prone to poor boundaries, becoming overly involved, and expressing sympathy rather than empathy

The Beginning Student Phase

- Feels dependent, vulnerable, and anxious
- Fragile self-confidence and value supervisors' encouragement and support
- Searches for the "right way" to operate
- Looks for models to emulate
- Perceived criticism from supervisor or clients have a severe impact on their self-confidence and morale

The Advanced Student Phase

- Functioning at a basic established professional level
- Feels pressure to do things "right"
- Conservative, cautious, and thorough style
- Supervision can be a powerful source of influence at this stage
- Internship stage

The Novice Professional Phase

- Increases integration of their own personalities into treatment
- Seeks compatible work roles and environments
- May find they were not as well prepared as they had imagined
- Post-graduate

The Experienced Professional Phase

- Develops a professional style that is authentic and congruent with values, interests, and personality
- Techniques used are flexible and personalized
- Understands it is impossible to have clear solutions for every situation
- Ability to be fully engaged with clients but then let go afterwards
- Looks to expand knowledge

The Senior Professional Phase

- Uses individualized and authentic approaches
- Feels competent but modest in regard to impact on clients
- Skeptical that anything new will be added to the field
- Loss is a recurrent theme. This is anticipatory regarding retirement and the loss of mentors in the field
- Usually, more than 20 years of experience (University of Colorado, 2020).

In the lifespan developmental model, there are fourteen identified themes in a therapist's professional development. They are as follows:

1. Professional development involves an increasing higher-order integration of the professional self and the personal self.
2. The focus of functioning shifts dramatically over time from internal to external to internal.
3. Continuous reflection is a prerequisite for optimal learning and professional development at all levels of experience.

4. An intense commitment to learning propels the developmental process.
5. The cognitive map changes: Beginning practitioners rely on external expertise, and seasoned practitioners rely on internal expertise.
6. Professional development is a long, slow, continuous process that can also be erratic.
7. Professional development is a life-long process.
8. Many beginning practitioners experience much anxiety in their professional work. Over time, anxiety is mastered by most.
9. Clients serve as a major source of influence and serve as primary teachers.
10. Personal life influences professional functioning and development throughout the professional life span.
11. Interpersonal sources of influence propel professional development more than 'impersonal' sources of influence.
12. New members of the field view professional elders and graduate training with strong affective reactions.
13. Extensive experience with suffering contributes to heightened recognition, acceptance, and appreciation of human variability.
14. For the practitioner, there is a realignment from the self as a hero to the client as a hero (NMBHP.org, 2018).

Advantages of Developmental Models of Supervision

- Goals are individualized based on the supervisee's needs and where they are developmentally in their clinical skills.

- Supervisors are aware of the different needs of the supervisees as they move through different levels of development.
- Development models are pantheoretical, and supervisees do not have to focus on a specific psychotherapy model too early in their training (Hudson, 2022; Bernard & Goodyear, 2019).

Disadvantages of Developmental Models of Supervision

- Does not take into account an individual's learning styles or divergent learning.
- Does not take into account cultural differences and how these may impact the supervisory relationship and evaluation (Hudson, 2022; Bernard & Goodyear, 2019).

Psychotherapy-Based Models of Supervision

Psychotherapy-based models of supervision are aligned with specific therapeutic approaches and are an extension of the psychotherapy treatment modality. One of the goals of psychotherapy-based supervision is adherence to the therapy model. One advantage to this model of supervision is that the supervisor and supervisee share the same orientation and theory of treatment (Meier, 2019).

Psychodynamic Model

Psychodynamic supervision is a therapeutic process focusing on the intrapersonal and interpersonal dynamics in the supervisee's relationship with clients, supervisors, colleagues, and others. The main focus of supervision is on the supervisee's development of self-awareness around these dynamics and on the development of the skills necessary to use a psychodynamic approach in therapy.

Supervisees' personal issues may be brought up in supervision if they are impacting the provision of therapy. Resistance, transference, countertransference, and conflict are themes explored in this model. Supervision focuses on understanding how client-therapist reactions influence the progress of therapy. In supervision, a parallel process is explored, where the supervisee's interaction with the supervisor parallels the client's behavior with the supervisee as the therapist. The supervisor's task is to explore these parallel relationships or processes with the supervisee as a means to learn how to become a better therapist. Through parallel processes, an understanding can emerge of how therapy may be stagnant due to the therapist's unresolved personal problems (Corey et al., 2021).

There are four categories of supervisee competence that supervisors must encourage in the psychodynamic model of supervision. They are:

1. The ability of supervisees to have relationships with clients and supervisors, as relationships are the key to psychotherapeutic change and are not just preliminary necessities to effective interventions.
2. The ability of supervisees to self-reflect, including their capacity to bear, observe, think about, and make psychotherapeutic use of their own emotional, bodily, and fantasy experiences when interacting with clients.
3. Assessment and diagnosis from a psychodynamic framework.
4. Using interventions that are theoretically consistent with psychodynamic theory and keeping the therapeutic relationship central to interventions (Bernard & Goodyear, 2019).

The supervisor is viewed less as an expert and more as an embedded participant in mutually influencing the supervisory process. There are three supervisory dimensions that are key to psychodynamic supervision.

1. The nature of the supervisor's authority in relationship to the supervisee.

The supervisor's authority exists on a continuum; at one end is authority derived from the knowledge the supervisor brings to supervision as the objective and uninvolved expert who will help the supervisee know what is "true" about the client and the "correct" technique to use. On the other end of the continuum is the authority that is derived from the supervisor's involvement in the process; while supervisors may have more expertise than supervisees, they make no claims to have absolute knowledge. The supervisor's authority is derived from the supervisory relationship process. It is at this latter end of the continuum that includes appropriate self-disclosure and open discussions of countertransference that are important to psychodynamic supervision.

2. The supervisor's focus.

   This dimension encompasses the supervisor's focus and attention on the client, the supervisee, and the supervisor-supervisee relationship.

3. The supervisor's primary mode of participation

   This concerns the roles and styles the supervisor may have, including didactic teacher, Socratic questioner, a container of supervisee affects, etc. (Bernard & Goodyear, 2019).

Person-Centered Supervision

As with person-centered therapy, which is based on the notion that clients have the capacity to effectively solve their life problems without direct intervention from the therapist, person-centered supervision believes the supervisee has the resources within to develop as a therapist. The supervisor is not an expert but a collaborator with the supervisee. The role of the supervisor is to create an environment where the supervisees can be open to their experiences and fully

engage with their clients. The supervisor's goal is to create a trusting relationship through empathy, warmth, and genuineness while developing an environment where the supervisee will grow and develop. When supervisees feel heard and understood by their supervisor, they are more likely to be motivated and open to feedback (Corey et al., 2021 & Meier, 2019).

The two foundational components of person-centered therapy and supervision are:

Reflective Practice

This includes self-reflection, which allows clinicians to immerse themselves in their client's experiences without bias while maintaining an appropriate distance at the same time. Self-assessment is another aspect of reflective practice and includes assessing one's professional strengths and skills as well as areas that may require additional professional development.

Relationships

This involves the therapist's capacity for interpersonal relationships and includes respect, caring, communication skills, and the capability to manage feelings during interpersonal interactions. Relationship competency is demonstrated through engaging with clients in a profoundly valuing and respectful way.

The person-centered supervisor focuses on:

Development of knowledge

This is accomplished through increasing the supervisee's knowledge of theory and technique, such as developing assessment and intervention skills and competency.

The person of the supervisee

This occurs when supervisees explore and develop an awareness of their personal characteristics through self-reflection and self-knowledge practices.

Use of self as an agent of change

This is done through growing one's capacity for genuineness, acceptance, and presence in the therapy session (Meier, 2019).

Cognitive-Behavioral Supervision

The main focus of cognitive-behavioral supervision is to teach cognitive-behavioral therapy techniques. Supervision sessions tend to be structured, focused, and educational. Both the supervisor and supervisee are responsible for the content explored in supervision. Part of supervision focuses on how the supervisees ‘cognitive pictures of themselves affect their abilities in therapeutic practice. This reflection parallels cognitive-behavioral techniques used in sessions with clients. Just as CBT sessions tend to be structured, so too is supervision. The following is an example of how a supervision session may be structured.

Check-in:

The supervisor asks, "How are you doing?" to break the ice and create a personal connection.

Agenda setting:

The supervisor teaches the supervisee to carefully prepare for the supervision session and asks, "What would you like to work on today?". The supervisee has the first opportunity for agenda setting, with the supervisor adding to the agenda should they choose to do so.

Bridge from previous supervision session:

The work of the last supervisory session is reviewed by asking, "What did you learn last time?" and "How was it helpful?".

Inquiry about previously supervised therapy cases:

Progress or particular difficulties with previously discussed cases are reviewed. This is a case management function.

Review of homework since the previous supervision session:

This is a key aspect of CBT supervision. Homework might include readings, writing about cases, or trying new techniques with a client. Homework is a collaborative assignment between the supervisor and supervisee.

Prioritization and discussion of agenda items:

The majority of CBT supervision revolves around this step. A review of the supervisee's tape-recorded therapy sessions is a major focus for the supervisory session. Teaching and role-playing are common supervision methods, as well as addressing supervisees' questions and concerns.

Assignment of new homework:

In response to the session, new assignments are given that will help the supervisee develop knowledge and skills in cognitive-behavior therapy.

Supervisor's capsule summaries:

The supervisor's reflections on what has been covered in the session keep the session focused and emphasize important points.

Elicit feedback from the supervisee:

The supervisor asks for feedback throughout the session and ends the session with questions such as, "What have you learned today?". While feedback is

encouraged throughout the supervision session, this gives supervisees a final opportunity to ask questions and have their opinions heard.

The above supervision process parallels the process of a cognitive-behavioral therapy session with a client. By using the above process of supervision, the supervise learns from the content of the supervision as well as from the supervisor modeling how to conduct a cognitive-behavioral session (Corey et al., 2021; Bernard & Goodyear, 2019).

While the focus of CBT supervision is on overt behavior, didactic learning, and cognition, the supervisee's affect is also addressed. Similar to CBT therapy, CBT supervision will address irrational and unhelpful thoughts the supervisee may be having as the stress and negative emotions these thoughts produce impact the supervisee's ability to learn, meet specific goals, and successfully interact with clients. CBT supervisors are concerned with the supervisee's mastery and fidelity to the CBT model of treatment (Bernard & Goodyear, 2019).

Solution-Oriented Supervision

The solution-oriented model of therapy does not address past issues but instead focuses on the present and future. The implications for supervision is that the focus is on an optimistic assumption that people are healthy, resourceful, and competent and have the ability to find solutions that can enhance their lives. In solution-oriented supervision, the basic assumption is that the supervisee is the expert and has the resources to problem-solve clinical situations. The supervisor's goals are to create a collaborative environment where supervisees can use their resources to achieve their goals (Corey et al., 2021).

A key concept of solution-focused therapy is the use of the miracle question. "If a miracle happened overnight, and your problem was solved, how would you know

what would be different?". Supervisors can use this question in supervision to model the technique.

Another question that is key to solution-focused therapy is that of the exception question. The clients are asked to remember a time in their lives when the problem did not exist. This intervention is to remind the client that since the problem was not always present, it does not necessarily have to be present forever. It provides an opportunity to explore resources, strengths, and possible solutions. In the supervision context, exception questions can be quite effective in assisting supervisees in realizing that their own issues do not have to control them and that change is possible.

A third questioning technique that is key to the solution-focused model is that of scaling questions. This is useful when something is not easily observable, such as feelings, moods, or communication. An example of a scaling question might be: "On a scale of 0 to 10, with 0 being how you felt when you first came to therapy and 10 being how you feel the day after your miracle occurs and your problem is gone, how would you rate your anxiety right now?". Even if the client only moves one number on the scale, it is still growth and change. In supervision, the supervisor may use a scaling question to determine the growth of the supervisee. Solution-focused supervision is an optimistic model that is empowering to supervisees (Corey et al., 2021).

Advantages of Psychotherapy-Based Supervision

- Each model has clear techniques, skills, and goals for the supervisee to meet and for the supervisor to monitor.
- Psychotherapy models are created to promote change and growth in clients, which can positively correlate with the supervision process and with change and growth in supervisees.

- Modeling in supervision allows supervisees to experience the therapeutic modality and build a better understanding of how their clients experience the intervention (Hudson, 2022; Bernard & Goodyear, 2019).

Disadvantages of Psychotherapy-based Supervision

- It can be difficult to standardize supervision within a psychotherapy model.
- The field of psychotherapy has changed greatly since the creation of these models, and they have not changed with the times.
- If the supervisee's training in the therapeutic model is placed at a higher level than skills assessment and client care, this may lead to ethical and legal issues.
- When the focus is on a specific psychotherapy model, it can be challenging to assess a supervisee's competency in multiple areas as the focus is on specific therapeutic techniques and adherence to the model.
- There is a potential to blur boundaries between therapy and supervision, creating confusion for the supervisee regarding the supervisory relationship (Hudson, 2022; Bernard & Goodyear, 2019).

Integrative Models of Supervision

Integrative models of supervision are also known as social role models of supervision. This type of supervision is used by therapists and supervisors who integrate multiple theories into their therapy practice. While these models are not tied to a specific theory of practice, they do provide structure and theory for supervision. Integrative models of supervision include the Discrimination Model, Systems Approach to Supervision, Social Role Model, Critical Events Model, Feminist Approach to Supervision, and Systemic Supervision (Meier, 2019).

Discrimination Model

The discrimination model is so called since the supervisee's training needs determine the supervisor's approach. This model has a matrix of three focus areas and three supervisor roles.

The three focus areas are:

1. The supervisee's intervention skills.

   The supervisee's observable actions during sessions, what skills are demonstrated, and how effectively they are used.

2. The supervisee's conceptualization skills.

   How well the supervisee understands what happened in a session, is able to identify patterns and themes, understands interpersonal dynamics, chooses interventions, and organizes the multiple aspects of a counseling session.

3. The supervisee's personalization skills.

   What the supervisee's personal therapy style is, how the supervisee’s personality relates to the therapy process, and what attempts to keep therapy clear of personal issues and countertransference are made.

The three supervisor roles are:

1. Teacher

   A teacher role is taken when the supervisee needs structure, including teaching, instructing, giving feedback, and modeling.

2. Counselor

A counselor role is taken when supervisees need reflection around their own internal realities, including unresolved issues that are interfering with therapeutic relationships.

3. Consultant

   A consultant role is taken when supervisees need to trust their own insights and feelings about their work or when it is determined by supervisors that their supervisees may need to be challenged to think and act on their own.

Once the level of functioning in each of the three focus areas has been assessed, the supervisor chooses a role that will facilitate the supervisee's learning and growth. During supervision, the supervisor will select a focus area to evaluate the supervisee's skills and will then select the best role suited for the supervisee's level of function in that focus area (Meier, 2019).

The discrimination model is situation-specific, meaning that the supervisor's role and focus change not only across sessions but within sessions. The supervisor should attend to each focus as appropriate. Problems arise when the supervisor attends to one area at the expense of the supervisee's more pressing need or when the supervisor has a preference for one particular role or focus, and even worse if this preference is not in the realm of the supervisee's needs (Bernard & Goodyear, 2019).

Systems Approach to Supervision

The systems approach to supervision was specifically developed to guide the teaching and practice of supervisors. This model has a comprehensive matrix of five functions, five tasks, and four contextual factors that make up supervision.

The five functions of supervision are:

1. Monitor and evaluate
2. Instruct and advise
3. Model
4. Consult
5. Support and share

The five tasks of supervision are:

1. Counseling skills
2. Case conceptualization
3. Professional role
4. Emotional awareness
5. Self-evaluation

The four contextual factors are

1. The supervisor
2. The supervisee
3. The client
4. The agency or organization

The functions and tasks are the primary interaction of supervision, while the contextual factors influence the supervisory process. The supervisor will determine the task and function combination and proceed with supervision with that framework. Using one task and one function will inform the supervisor's intervention for that supervision session (Meier, 2019).

Social Role Model

The social role model of supervision focuses on the four roles of the supervisor.

1. Teacher

   The supervisor organizes the supervisee's didactic learning and in-service training.

2. Facilitator

   The supervisor helps supervisees build awareness of their personal and interpersonal functioning.

3. Consultant

   The supervisor discusses with the supervisees a variety of assessment and therapy approaches and techniques and helps supervisees implement those best suited to their personal and professional functioning.

4. Evaluator

   The supervisor evaluates with the supervisees their learning process and progress using a variety of tools available for the evaluation task (Meier, 2019).

Critical Events Model of Supervision

This model is also known as the Events-Based Supervision Model. This approach focuses on the small events of a supervisee's work and explores how these events were handled through the use of task analysis. There are three phases in this model, including:

1. Marker

The supervisee recognizes and expresses a problem or a critical event that occurred in therapy. There are seven critical events that commonly occur in the therapeutic process and are addressed in supervision that include:

1. Remediating skill difficulties and deficits
2. Heightening multicultural awareness
3. Negotiation role conflicts
4. Working through countertransference
5. Managing sexual attraction
6. Repairing gender-related misunderstandings
7. Addressing problematic supervisee emotions and behaviors.

2. Task Environment

A number of interactions involve supervisor operations and supervisee reactions to resolve the critical event. There are twelve interaction sequences that include:

1. Focus on the supervisory working alliance
2. Focus on the therapeutic process
3. Exploration of feelings
4. Focus on countertransference
5. Attending to parallel process
6. Focus on self-efficacy
7. Normalizing experiences

8. Focus on skill
9. Assessing knowledge
10. Focus on multicultural awareness
11. Focus on evaluation
12. Case review

3. Resolution

   This is the outcome of the specific event. Resolutions are rarely absolute and are more often one of four other types of resolution, which are:

   1. Self-awareness
   2. Knowledge
   3. Skills
   4. Supervisory working relationship

Processing of critical events is reliant on a positive supervisory relationship, without which a resolution can not be reached. A strong supervisory connection includes a mutual agreement between the supervisor and supervisee on the goals and tasks of supervision and the establishment of an emotional bond between the supervisor and supervisee (Meier, 2019).

Feminist Approach to Supervision

Feminist theory is rooted in the belief that the personal is political and that a person's experiences are a reflection of society's institutionalized attitudes and values. The feminist model of supervision is similar to psychotherapy-based supervision in that it focuses on feminist theoretical approaches, and the feminist

model of supervision integrates feminist ideas and values. The feminist model of supervision encourages a collaborative and egalitarian learning relationship. There are five feminist themes that are key to the supervision process, which are

1. Power inequities
2. Gender issues
3. Diversity issues
4. The role of emotion
5. The role of socialization in people's lives (Meier, 2019).

The feminist model of supervision involves working toward equal, balanced power between the supervisor and supervisee. Feminist supervisors are vigilant in analyzing the power dynamics between them and their supervisees and are proactive in their avoidance of any abuse of power. While supervisors are aware that the supervisory relationship can not be completely equal, the supervisee has shared power in creating a collaborative supervision relationship. Through this collaborative approach, the supervisory relationship is empowered with a sense of safety, trust, and security, which leads to increased risk-taking, higher levels of performance, and greater individual confidence. This positive and mutually agreed-upon approach that is modeled in supervision translates to the supervisee's work with clients (Corey et al., 2021).

Social change is a key goal of the feminist approach, and feminist supervisors model the principles of advocacy and activism. Supervisors encourage their supervisees to think about their role and power in influencing the systems in which they work. Feminist theory-based supervisors challenge any sexist and racist attitudes and behaviors of their supervisees, including the negative use of stereotypes and the misuse of diagnoses. Feminist supervisors are aware of the fine balance between imposing their beliefs and being apolitical in supervision.

Hierarchical supervision methods are rarely employed, with exceptions for when clients risk harm to themselves or others or when a situation is beyond a supervisee's current abilities (Corey et al., 2021).

Systemic Supervision

Systemic supervision is rooted in systemic and family therapy theory. Systemic theories are aware of the dynamics of the different interrelated systems and how they impact relationships and actions. In systems models, the supervisee and the supervisor are active members of the system in which they are intervening. There is a constant awareness of the dynamics within the family system, among clients and their therapists, and between the supervisor and supervisee relationship (Meier, 2019).

Systemic supervision is very similar to family therapy; it is active, directive, and collaborative. The supervisor encourages supervisees to examine their intergenerational dynamics, values, and culture to further their awareness as they gain expertise in becoming a family therapist. The family therapy supervisor works with the supervisory relationship and the supervisee and his or her clients as a system. The systemic model of supervision encourages supervisees to explore their relationships with their family of origin, as this knowledge will enable them to relate to the family dynamics they experience with the families they work with therapeutically. Supervisors in systemic models assume that supervisor will likely encounter similar dynamics in families they work with and their own family of origin. If supervisees lack awareness of their own families of origin, they may experience strong emotional reactions to individuals they work with. This can then lead to supervisees projecting feelings they have regarding their own family onto their clients. Furthermore, supervision explores how supervisees' clinical work is impacted by their specific experiences in their family of origin. The supervisee may explore their family dynamics through genograms, family history, and family

sculpting. Through this work, supervisees can identify and acknowledge ways their family of origin may impact their work as a family therapist (Corey et al., 2021).

Essential components of systemic supervision include:

1. Developing a systemic formulation, such as conceptualizing the problem in terms of the family process.
2. Helping the supervisee forge a systemic therapeutic alliance, meaning a working alliance with each family member.
3. Introducing and reinforcing the process of reframing, meaning redefining the problem so it can be resolved in a productive manner.
4. Assisting the supervisee in managing negative interactions that occur within therapy, building cohesion among family members, and helping with family restructuring and parenting skills.
5. Understanding and applying existing evidence-based models (Bernard & Goodyear, 2019).

Advantages of Integrative Supervision

- All clients are unique, and the supervisorial and clinical interactions can be customized to meet their needs
- Integrative practice can be more flexible and imaginative
- Integrative models of supervision are more descriptive of the supervisory process
- It can be integrated into psychotherapy-based and developmental supervision

- It may counteract supervisory stagnation by giving the supervisor a new lens to view supervision (Bernard & Goodyear, 2019).

Disadvantages of Integrative Supervision

- Supervisors must have the ability and desire to supervise from multiple perspectives
- Time must be devoted to assisting supervisees in understanding the constraints and implications of integrated therapy
- Flexibility of the approach may cause confusion, anxiety, and frustration with supervisees
- This model may not place enough attention on theory or development (Bernard & Goodyear, 2019).

Other Models of Supervision

Reflective Supervision

The reflective developmental model starts with a therapy situation that is upsetting, surprising, confusing, or uncomfortable and that has become a trigger event. Assessing a supervisee's reaction in these situations starts the process of a critical review of the incident. During the evaluation, the supervisee's skills, strategies, personality issues, and conceptualization of the client or therapy process are explored. The supervisee will then critically reevaluate the situation based on his or her skills and knowledge, and the level of self awareness present. This leads to the supervisee acquiring a new perspective on the trigger event and establishing a new and deeper understanding of the situation. The assumption is

the supervisee will then implement this new understanding in future sessions with clients (Bernard & Goodyear, 2019).

Reflective supervision is built on three key concepts. They are:

1. Reflection

   Reflection happens after removing oneself from the situation and taking the time to question what the situation really means. Such questions may include: “What does it say about the client?” “What does it say about the therapist?” Using reflection, supervisees can examine their thoughts and feelings about the situation and determine interventions that best meet the client's needs and goals for growth, self-sufficiency, and development.

   For reflection to be successful in supervision, the supervisory relationship requires honesty and trust. Supervisees need an environment of safety, calm, and support to do their best thinking and learning.

   Reflective supervision focuses on experiences, thoughts, and feelings connected to the therapy work of the supervisee and is characterized by active listening and thoughtful questioning from the supervisor and supervisee. The role of the supervisor is to help supervisees answer their own questions and provide support and knowledge to support supervisees’ decision-making processes.

2. Collaboration

   There is an aspect of teamwork, shared responsibility, and control of power in reflective supervision. While sharing power is a goal of collaboration, the supervisor will need to set limits and exercise authority in certain situations. Collaboration also encourages open dialogue on issues impacting the supervisee.

3. Regularity

   Regular supervision is needed for reflection and collaboration to take place. Supervision should be provided on a consistent schedule and with enough time set aside to process the supervisee's concerns and needs. Scheduling conflicts and emergencies will arise, but overall supervision should be protected from cancelation, re-scheduling, and procrastination (NMBHPA.org, 2018).

Many supervisors, no matter what their preferred model of supervision is, use reflective process techniques with their supervisees. As supervisors assist their supervisees in reflecting on their therapy work, they are teaching supervisees skills they can utilize throughout their careers. The ability to reflect on one's work is part of one's ability to self-monitor and self-supervise. Supervisors should monitor the quality of the supervisee's reflections and ensure that the process goes beyond self-discovery and is linked to valid and quality professional practice (Bernard & Goodyear, 2019).

Competency-Based Supervision

Competency-based supervision is a method of supervision that challenges the idea that being a recipient of supervision in the past and having clinical therapeutic experience does not necessarily qualify a person to be a supervisor. Conducting supervision successfully requires clinical competence and the skills and qualities of a supervisor. Competence is the regular and successful use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served (Roberts, 2022).

Competence-based supervision goes beyond the assumption that competence has been achieved in formal education. This model focuses on upholding ethical

standards and accountability and establishing expectations to maintain professional standards that are beneficial to the development of the supervisory relationship. Having a shared understanding of training goals, supervisees' abilities to evaluate their learning needs, cumulative assessments, and lifelong career development are positive outcomes of this approach. The collaborative nature of this model relies on an effective supervisee-supervisor relationship (Roberts, 2022).

Competency-based supervision is a metatheoretical approach that explicitly identifies the knowledge, skills, and attitudes that comprise clinical competencies and meets criterion-referenced competence standards consistent with evidence-based practice. Because it is metatheoretical, it is very flexible and can include any model (including developmental, process-based, and psychotherapy-based models) or approach to clinical supervision. Competency-based supervision consists of tasks and benchmarks across multiple domains.

Tasks

- Observation
- Collaborative Self-Assessment and Feedback
- Experiential Learning and Skill Development
- Instruction, Modeling, and Mutual Problem Solving
- Ongoing Assessment, Feedback, and Evaluation
- Role-Modeling

Benchmarks

- Accreditation standards (APA, ASWB)
- Regulations

- Ethical Standards
- Evidence-based (research, expertise, and client variables (or trainee variables).
- Organizational Standards / Requirements / Policies
- Best Practices across multiple domains

Multiple Domains

- Supervision Competence
- Diversity
- Supervisory Relationship
- Professionalism
- Assessment / Evaluation / Feedback
- Professional Competence Problems
- Ethical, Legal, and Regulatory Considerations (Heffner & Cowan, 2018).

A full list of supervision competencies can be viewed in Appendix C.

Evidence-Based Clinical Supervision (EBCS)

Evidence-based clinical supervision was created in response to research showing clinical supervisors lacked formal training and were often providing incompetent supervision, and there was a need to assess the supervisor's competence. By creating EBCS, there was a desire to build a supervisory model that was based on science and empirical data (Reiser, 2021).

Key elements of evidence-based clinical supervision are as follows.

1. The EBCS model relies on an empirical approach to assessing the effects of clinical supervision as a form of experiential learning. A foundation of EBCS is that the supervisee is an active learner and plays a key part in co-creating the supervision experience.
2. It uses principles of precision, specification, operationalization, and corroboration with empirical research to define clinical supervision.
3. The model calls for developing acceptable and effective supervision methods to meet the needs of stakeholders. This can be accomplished through action-oriented research with the goal of resolving practical problems faced by supervisors.
4. It recognizes how clinical supervision has changed over time and the impacts these changes have had on supervisees' experiential learning. Acknowledging and evaluating the effects of supervision on supervisees is essential.
5. It includes methods to observe supervision sessions directly, to evaluate, and to provide feedback in an acceptable, reliable, and valid manner. This has been accomplished through the creation of SAGE: Supervision Assessment and Guidance Evaluation (See Appendix B).
6. EBCS is a manualized program on how EBCS is best conducted with standardized and systemic training for supervisors.
7. EBCS draws from relevant theory, expert consensus statements, and theories from research-based literature in adjacent fields (such as goal-setting research).
8. EBCS, while empirically based, recognizes the constant need to reevaluate the model and make adjustments based on new research, openness to feedback from other models of supervision, and the recognition that the

EBCS model is ever-evolving and subject to amendments and change (Reiser, 2021).

Supervision Adherence and Guidance Evaluation (SAGE)

As part of evidence-based clinical supervision, as mentioned in key aspect number 5 above, a supervisor evaluation component is completed through the Supervision Adherence and Guidance Evaluation (SAGE). SAGE is a 23-item supervisory competency list or recording sheet. The evaluation is completed by an observer of the supervisory session, usually through listening to an audio recording. The supervisor is rated on a 7-point scale, with 0 being incompetent and 6 being expert. The observer can add qualitative data by including notes to explain high or low ratings, noting important contextual factors, summarizing the overall profile, or providing specific feedback on ways to improve supervision (Reiser, 2021). See Addendum B for the SAGE recording sheet.

How to Decide What Model of Supervision to Use?

In most of the single theory models, supervisors accept an underlying philosophy and incorporate key concepts and specific methods of supervision. If you adopt a primary model, you must adapt this theory to your supervisory style. If you are interested in using an integrative model of supervision, the task is more complex, for you need to draw from several approaches and integrate these perspectives with the person you are.

Steps toward developing your philosophy of supervision

- Reflect on the meaning of your own experiences when you were being supervised. What was especially helpful for you? What model of supervision enabled you to develop to the fullest extent possible? What kind of different experience might you have wanted from your supervision?

How would you characterize the theory each of your supervisors operated from, and what could you learn from each of them when designing your own supervision model?

- Select a theory that comes closest to your beliefs about human nature. Take steps to deepen your knowledge of the theory and be willing to change certain aspects to find what is the best fit for you. Look for ways to personalize the theory or theories of your choice.
- Commit yourself to a reading program and attend a variety of professional workshops. Reading is a realistic and useful way to expand your knowledge base and provide ideas on creating, implementing, and evaluating techniques. As you attend workshops, be open to ideas that seem to have particular meaning to you, and that fit the context of your work. Personalize your techniques so they adhere to your style, and be open to feedback from your supervisees about how well your supervisory style is working for them.
- As you practice, be open to supervision throughout your career and talk with other supervisors and colleagues about what you are doing. Discuss some of your interventions with other professionals, and think about alternative approaches you could take with supervisees. Be open to borrowing techniques from various theories, yet do so in a systematic way. Think about your rationale for the manner in which you carry out your supervisory role and functions with supervisees.

The practice of supervision can best be viewed as an evolving and developing process that will most likely continue to change throughout your professional career (Corey et al., 2021).

Conclusion

There are numerous supervision methods, including those specifically designed for use in supervision, and others are adapted from psychotherapy-based approaches. The case consultation method is the most frequently used method of supervision. Direct observation methods are most effective to assure that the supervisor sees the supervisee's clinical work. Group supervision is frequently used and is best facilitated by those with special training in group dynamics and methods. As technology is ever expanding in our everyday lives, it is also becoming part of supervisory method options. Selecting what supervision method to use should be based on the supervisory situation, the needs of the supervisee, the training goals, the clients, and the setting in which the supervision occurs. Even more important than what method is used is the need for a trusting and respectful supervisory relationship.

Just as there are many methods of supervision, there are also numerous models of supervision that describe what supervision is and how the supervisee's learning occurs. Although there are many different supervision models, the most common ones fall under the categories of developmental models, psychotherapy-based models, and integrative models. Developing one's own model of supervision is established through clinical experience, supervisory experience, and continuing education. How one approaches supervision, both in methods and models, will likely evolve and change throughout one's supervisory career.

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Addendum A: Informed Consent for Supervision and Recording

Counseling and Psychological Services. University of Central Florida.

Retrieved September 2023. https://caps.sdes.ucf.edu/wp-content/uploads/sites/7/2020/04/Supervisory-Disclosure-Group-Therapy-Summer-2020.pdf

Supervisory Disclosure & Consent Form for Live Observation and Recording of Group Sessions

SUPERVISORY DISCLOSURE

State of Florida Rules governing licensed mental health professionals, as well as the American Psychological Association Ethical Codes and the Association for Counselor Education and Supervision Ethical Standards, require that you be informed that a licensed or registered professional of the appropriate discipline is supervising the work of your therapist. The primary supervisor has full responsibility for the supervised work of their supervisees. In order to ensure the highest standard of care, supervisors monitor and review the progress of your work with your therapist. The limits of confidentiality delineated in Counseling and Psychological Services Informed Consent for treatment apply to this supervised practice. The responsible supervisor for your therapist is listed below and is available for consultation upon request. This form will be placed in your confidential CAPS file. If you have any questions about this supervisory relationship, we encourage you to talk to your therapist. Signing this form acknowledges your informed consent for treatment by a therapist under supervision.

_____ (Client's Initials) Yes, I understand that my counselor(s) is/are under the supervision of a licensed professional.

CONSENT FORM FOR LIVE OBSERVATION AND RECORDING OF GROUP COUNSELING SESSIONS

The UCF Counseling and Psychological Services (CAPS) serves as a training site for graduate-level counselors-in-training receiving both individual and group supervision by professionals of CAPS. Every counselor-in-training will have their group counseling sessions recorded or observed live so that a more advanced therapist can monitor and oversee the quality of counseling. There are also times when a supervisor/ staff member may want to record a group session or have their counselor-in-training observe a live session for training or consultation purposes. It is also common for your counselor-in-training to discuss their cases as part of their academic training. In this context, your counselor-in-training would not reveal your name. Recordings are secured and never removed from the CAPS premises. Your participation is voluntary and confidential.

I understand that

- The purpose of recording and live observation is for training, supervision, and consultation only as stated above.
- My decision not to be taped will not affect my eligibility for services but may affect the timeliness of services.
- I may request that the recorder be turned off at any time during the session.
- All recordings will be safeguarded appropriately within CAPS under accreditation standards.

- I may discuss or clarify these issues with my counselor-in-training at any time.
- Note: If you know someone on staff, please let your counselor know so that your confidentiality can be protected.

_____ (Client's Initials) Yes, I give my permission for recording and, at times, live supervision of my group counseling sessions. Additionally, I give my permission for my counselor to have recordings viewed by their academic program chair(s) on premises here at CAPS for training purposes. I also give my permission for my counselor to discuss my deidentified case with their graduate professor & class if applicable.

_____ (Client's Initials) No, I do not give my permission for recordings or live observation of my group counseling sessions.

Clinician's Name:_____

Clinician/Primary Supervisor's Name & Credential:_____

Secondary Supervisor's Name & Credential:_____

Client Name:_____

Client Signature & Date: _____

Student ID UCF/PID_____

Addendum B: Supervision Adherence and Guidance Evaluation Recording Sheet (SAGE)

Reiser, R. P. (2021). An evidence-based approach to clinical supervision. *The Clinical Supervisor*, *40*(1), 8-28.

Date of Supervision Session: _____/_____/_____

Supervisor: _____

Supervisee: _____

Client(s) discussed: _____

Record sheet completed by (Rater/Observer):

_____

Date of rating: _____/_____/_____

Sage Items	**Please circle your rating:**		
The common factor	Incompetent	Competent	Expert
1. Relating (Interpersonally effective) Displays core conditions; social support – restorative, optimal learning environment; good rapport established, attentive, good interpersonal skills; skillful attention to supervisory relationship and interpersonal dynamics	0 1 2	3 4	5 6

2. Collaborating Active partnership encouraged, productive teamwork; learning alliance.	0 1 2	3 4	5 6
3. Managing Generally well- structured / 'scaffolded' (e.g., pace/ efficiency); appropriate challenge	0 1 2	3 4	5 6
4. Facilitating Enabling productive shifts in focus or more thorough/deeper experiential learning.	0 1 2	3 4	5 6
5. Agenda-setting (& adherence) Needs led; SMARTER goal- setting /objectives; Adherence to agenda or appropriate adjustment/re- negotiation.	0 1 2	3 4	5 6
6. Demonstrating Modeling skills or techniques.	0 1 2	3 4	5 6
7. Discussing Cognitive exploration, including reviewing, challenging, and offering ideas/possibilities; problem-solving effort.	0 1 2	3 4	5 6
8. Evaluating Summative, formal evaluation activities/discussion (e.g., supervisor rating supervisee; client outcome scores).	0 1 2	3 4	5 6
9. Experiencing Supervisor's emotional awareness /expression/facilitation of optimal arousal/processing of affect.	0 1 2	3 4	5 6
10. Feeding-back (giving) Defining the gap between the supervisee's current and desired proficiency/understanding/values (specific, contingent and constructive). Providing general summary of positives and negatives.	0 1 2	3 4	5 6

11. Feeding-back (receiving) Eliciting feedback from the supervisee (e.g., asking about helpful/hindering events).	0 1 2	3 4	5 6
12. Formulating Analysis/synthesis/explaining; integration; interpreting mode; mostly focused on case conceptualization.	0 1 2	3 4	5 6
13. Listening Summarizing; taking notes; genuine/authentic attention.	0 1 2	3 4	5 6
14. Observing Listening/viewing the supervisee's clinical work (e.g., co-working; audio recording).	0 1 2	3 4	5 6
15. **Prompting** Reminders/cues; encouraging fuller expression; aiding deliberation & recall.	0 1 2	3 4	5 6
16. Questioning Open/closed/Socratic; gather information; leads to effective supervisee processing.	0 1 2	3 4	5 6
17. Teaching Informing and educating (e.g., explaining/instructing/Q&A); instruction to build capability.	0 1 2	3 4	5 6
18. Training/experimenting Behavioral/enactive activity to build competence; (e.g., role-play/rehearsal).	0 1 2	3 4	5 6
The supervisee's learning			
19. Experiencing Supervisee identifies, expresses and recognizes own sensations and affect, positive or negative – showing self-awareness and self-regulation.	0 1 2	3 4	5 6
20. Reflecting Supervisee recounts/expresses and processes/makes sense of own experiences and ideas; showing enhanced personal understanding and meaning making.	0 1 2	3 4	5 6

21. Conceptualizing Supervisee shows comprehension and assimilation of theory/public information/supervisor's information/advice; showing enhanced reasoning or formulation.	0 1 2	3 4	5 6
22. Planning Supervisee engages in decision- making/planning activity.	0 1 2	3 4	5 6
23. Experimenting Supervisee enacts plans/ideas in supervision or carries out a live experiment (e.g., in-session rehearsal, role-play; trial & error learning tasks).	0 1 2	3 4	5 6

Notes (e.g., Clarify high/low ratings):

_____

_____

_____

_____

_____

Suggestions: Any ways to improve competence?

_____

_____

_____

_____

_____

0 - Incompetent: Absence of feature or highly inappropriate performance

1 - Novice: Inappropriate performance, with major problems evident

2 - Advanced Beginner: Evidence of competence, but numerous problems and lack of consistency

3 - Competent: Competent, but some problems and/or inconsistencies

4 - Proficient: Good features, but minor problems and/or inconsistencies

5 - Expert: Very good features, minimal problems and/or inconsistencies

6 - Expert+: excellent performance, or very good even in the face of difficulties

Appendix C: Supervision Competencies Framework

Falender et al. (2004)

Retrieved from: Practical Clinical Supervision for Psychotherapists: A Self and Relational Approach (Meier, 2019).

Knowledge

1. Knowledge of area being supervised (psychotherapy, research, assessment, etc.)
2. Knowledge of models, theories, modalities, and research on supervision
3. Knowledge of professional/supervisee development (how therapists develop, etc.)
4. Knowledge of ethics and legal issues specific to supervision
5. Knowledge of evaluation, process outcome
6. Awareness and knowledge of diversity in all of its forms

Skills

1. Supervision modalities
2. Relationship skills—ability to build supervisory relationship/alliance
3. Sensitivity to multiple roles with supervisee and ability to perform and balance multiple roles
4. Ability to provide effective formative and summative feedback
5. Ability to promote growth and self-assessment in the trainee

6. Ability to conduct own self-assessment process
7. Ability to assess the learning needs and developmental level of the supervisee
8. Ability to encourage and use evaluative feedback from the trainee
9. Teaching and didactic skills
10. Ability to set appropriate boundaries and seek consultation when supervisory issues are outside domain of supervisory competence
11. Flexibility
12. Scientific thinking and the translation of scientific findings to practice throughout professional development

Values

1. Responsibility for client and supervisee rests with the supervisor
2. Respectful
3. Responsible for sensitivity to diversity in all its forms
4. Balance between support and challenging
5. 5. Empowering
6. Commitment to lifelong learning and professional growth
7. Balance between clinical and training needs
8. Value ethical principles
9. Commitment to knowing and utilizing available psychological science related to supervision

10. Commitment to knowing one's own limitations

Social Context Overarching issues

1. Diversity
2. Ethical and legal issues
3. Developmental process
4. Knowledge of the immediate system and expectations within which the supervision is conducted
5. Awareness of the sociopolitical context within which the supervision is conducted
6. Creation of climate in which honest feedback is the norm (both supportive and challenging)

Training of Supervision Competencies

1. Coursework in supervision including knowledge and skill areas listed
2. Has received supervision of supervision including some form of observation (videotape or audiotape) with critical feedback

Assessment of Supervision Competencies

1. Successful completion of course on supervision
2. Verification of previous supervision of supervision documenting readiness to supervise independently
3. Evidence of direct observation (e.g., audiotape or videotape)
4. Documentation of supervisory experience reflecting diversity
5. Documented supervisee feedback

6. Self-assessment and awareness of need for consultation when necessary
7. Assessment of supervision outcomes—both individual and group

Addendum D: Supervisor-Supervisee Contract: Institution

(Reproduced from Saint Paul University, Ottawa, Ontario, 2018)

Retrieved from: Practical Clinical Supervision for Psychotherapists: A Self and Relational Approach (Meier, 2019).

Student: _____

Clinical supervision period (Dates): _____

Clinical supervisor: _____

General description

Clinical Supervision is considered by many to be the most valuable learning experience of this program; the collaboration with your clinical supervisor and your colleagues about your client work creates the opportunity for awareness, insight, and competency growth in your clinical skills. Clinical Supervision is a mandatory part of your practicum in the Master of Arts and PhD in Counselling and Spirituality and is generally conducted in a group format on a weekly basis. (Please note that the first Clinical Supervision meeting each month will be conducted individually. The remaining Clinical Supervision meetings will be in the group format.)

Each counseling intern in your group will present his/her client(s) (e.g. discussing interventions used, countertransference, transference, etc.) during clinical supervision.

You will contribute the most to clinical supervision by offering questions and suggestions that are relevant for the conceptualization and treatment of each case presented. This will be done collaboratively with each group member and the clinical supervisor. That being said, it must be recognized that the clinical supervisor holds direct responsibility for the welfare of the client and has the right to instruct you to directly address an issue (e.g., suicide assessment) with a client.

You must comply with such requests from your clinical supervisor to ensure the best care is provided for your client.

Your clinical supervision goals:

•Understand the key elements of an intake interview and put them into practice;

•Learn how to write succinctly (clinically relevant details only) and integrate an intake report that contains the important elements of the initial interview;

•Learn and master the theories of the approach presented by your clinical supervisor and clinical professor(s);

•Learn and master the various tools / techniques used in clinical supervision by consulting articles and manuals and by practicing with your colleagues;

•Develop a good therapeutic alliance with your client, being aware of your limits as a professional, the boundaries of your role in the therapeutic process, and by respecting your client's limits;

•Learn the basics of keeping a professional file (e.g., organization of the file, writing and editing the progress notes, sessions, etc.);

•Learn to prepare and review your file(s) for the semester review that may occur at any time during the semester;

•Ensure proper and punctual monitoring with your file and promptly notify your clinical supervisor of serious problems with your client or yourself (e.g., health problems can interfere with your work);

•Demonstrate an understanding of ethics and standards of professional behaviour;

•Participate actively and appropriately in clinical supervision by developing and maintaining a spirit of collaboration with your colleagues and clinical supervisor; and

•Recognize your strengths and weaknesses and do not hesitate to discuss them when appropriate.

What we expect of you: Preparation for and during clinical supervision

•Be punctual and present for clinical supervisions;

•Being prepared is essential in order to fully benefit from clinical supervision (e.g.,

progress notes written, client recording preparation, etc.);

•Be respectful of your colleagues, your clients, your colleagues' clients, and your clinical supervisor to create a climate of collaborative clinical supervision and support;

•Be conscious / concerned with the ethics and standards of professional behaviour (including professional attire) and how they manifest themselves in your clinical work at many levels;

•Be self-reliant and independent in your work without compromising important aspects related to professional ethics (e.g., confidentiality, dual relationships, etc.);

•Consult your clinical supervisor when you are facing challenges, or have questions that you cannot solve alone;

•Keep all work related to your client strictly confidential. Client information is never to be communicated through e-mail;

•Present taped recordings of your client sessions to your clinical supervisor on a regular basis. You are required to show, at a minimum, a recording of each of your clients every two weeks. In the event that you do not have a recording of a client session to present in clinical supervision, you must record a role-play with a colleague(s) to present as an alternative; and

•Have timesheets signed by your clinical professor and clinical supervisor and submitted to the Counselling and Psychotherapy Centre administrative staff by the beginning of the following month (e.g. May timesheet due June 15).

What we expect of you: Attendance and holidays

•Absences are only accepted if they are justified for medical reasons or death (if you miss more than two clinical supervision meetings without justifiable explanation you automatically fail the practicum); and

•You are permitted to be away (holidays) up to three weeks during the Spring/ Summer semester and two weeks during the Fall or Winter semesters. You are not permitted to take holidays during the evaluation period of each semester. Please note that holidays away from client work with the Counselling and Psychotherapy Centre does not mean that you are excused from your commitment to the mandatory attendance with your coursework.

Cell phones, laptops, and others

•Cell phones are strictly prohibited during clinical supervision and you are not allowed to leave clinical supervision to make calls or take calls.

•Laptop computers are allowed only if they are used to take notes in clinical supervision (e.g., how to run an intake interview, etc.). If you are writing emails, personal notes, or working on your documents for other courses, your computer will have to stay closed.

•Other technologies (iPod, electronic games) are prohibited in clinical supervision.

Other rules created by the clinical supervisor, with the student:

1. _____

_____

2. _____

_____

3. _____

_____

My clinical supervision learning goals are:

1. _____

_____

2. _____

_____

3. _____

_____

Clinical Supervisor's signature: _____

Student's signature: _____

Date signed: _____

NOTE: One copy of this contract is for the student and one copy is for the student's file at the Counselling and Psychotherapy Centre. The clinical supervisor may also wish to keep a copy of this contract.

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