The Task-Oriented Developmental Model of Supervision: Facilitating Comprehensive Supervisee Development

Nathaniel Mason
William & Mary, wnmason@email.wm.edu

Patrick R. Mullen
William & Mary, prmullen@wm.edu

Follow this and additional works at: https://digitalcommons.sacredheart.edu/jcps

Recommended Citation

The Task-Oriented Developmental Model of Supervision: Facilitating Comprehensive Supervisee Development

Abstract

In this article, we discuss a meaningful synthesis of the integrated development model of supervision (McNeill & Stoltenberg, 2016) and cognitive-behavioral (Milne et al., 2011) supervision models that support supervisee development. First, we provide a review of the literature than a rationale for a new integrative model in addition to the specific interventions that can be used at each level of supervisee development. Finally, we discuss considerations for the model, including a case study, the new model's strengths and limitations, and implications for the field of counselor education.

Keywords: supervision, counselor trainees, developmental, cognitive, integrative

Keywords

Counseling is a unique profession involving complex emotional and psychological processes that necessitate clinical supervision during graduate training and post-graduate practice (Peake et al., 2002; Westefeld, 2009). The goals of supervision include enhancing the skills of novice counselors and offering guidance during early clinical work to ensure client welfare and skill development within empirically-supported theoretical approaches (Bernard & Goodyear, 2019). Models of supervision oftentimes complement existing counseling theories and approaches. Some examples include solution-focused supervision (Cutcliffe et al., 2010), narrative-based supervision (Kahn & Monk, 2017), and wellness-based supervision (Lenz & Smith, 2010). One such model, CBT supervision, provides structure and processes that enhance supervisees' understanding of CBT and its application to not only clinical work, but additionally when navigating complex thoughts and feelings that emerge as a counselor (Bearman & Sale, 2019). Each model of supervision has its own unique contributions and limitations regarding the art of supervision.

Compared to theory-based models, developmental models provide support for supervisees at various levels of skill acquisition (Barrett & Barber, 2005; Stoltenberg & Delworth, 1987; Westefeld, 2009). When supervisors bring attention to the cognitive-developmental needs of trainees in a holistic manner, they are better equipped in knowing when to introduce certain skills, respond to anxiety in supervisees, and how to vary interventions to promote counselor development (Barrett & Barber, 2005). For example, more directive models which include confrontation and teaching challenging skills to use with clients require supervisees to develop cognitive complexity and more nuanced interpersonal awareness. Simultaneously, developmental supervision models promote a working-supervisory relationship fraught with less frustration,

mistaken assumptions, or inaccurate expectations of supervisee behavior (Stoltenberg & Delworth, 1987).

In this article, we introduce a supervision model that ties components of the integrative development model of supervision (IDM; Stoltenberg & McNeill, 2010) with key facets of CBT supervision. The model described here emphasizes elements of supervision that focus on developmental interventions within the complementary structure of CBT supervision. We first describe elements of effective supervision and review the literature on these two models. Then, the Task-Oriented Developmental Model of supervision is described in detail. Finally, we review the implications of this new, additive model within the field of counselor education and supervision.

Integrative Developmental Model

The IDM includes the integration of specific skills and techniques, knowledge of theories and how to apply them, and general awareness of self and others for supervisees (Stoltenberg, 1981). As supervisees develop in the aforementioned areas, they will have different motivational factors, unique clinical needs, and possible resistances or obstacles at various stages (Stoltenberg et al., 1997). The framework of IDM consists of three overarching structures: (a) self and other-awareness (both cognitive and affective), (b) motivation of the counselor, and (c) autonomy. Supervisee's progress through three levels: Level 1, beginning; Level 2, intermediate; and Level 3, advanced. The fourth level of mastery, 3i, is where the supervisee has successfully integrated all skills across the domains and structures (McNeill & Stoltenberg, 2016).

Supervisee Disposition and Recommended Techniques by Level

Level 1 supervisees are characterized by higher levels of doubt, confusion, and anxiety in their counseling abilities. Level 1 supervisees are also highly motivated in clinical work and

require structure and directivity from supervisees (McNeill & Stoltenberg, 2016). Common techniques for Level 1 supervisees include facilitative (i.e., encouraging, praising), prescriptive (i.e., direct teaching and practice of skills) and in the later stages, catalytic (i.e., affect-exploring, relationship impact, exploration of transference, and countertransference) interventions. The interventions are delivered via role-playing, skills-training, observation, addressing strengths, and closely monitoring client progress (Stoltenberg & McNeill, 1997).

Level 2 supervisees focus more intentionally on clients and can complexly conceptualize their needs; however, this creates a sense of anxiety when supervisees realize there is *no one-size-fits-all* approach to every clinical situation. Level 2 supervisees can understand the emotional world of the client more effectively, process transference or countertransference, and pick up on clients' non-verbal cues. The wealth of new complexities in clinical work leaves Level 2 supervisees feeling less motivated and more hesitant in their confidence. Thus, there is a lesser need for session structure, concrete directives, or advice (McNeill & Stoltenberg, 2016). Level 2 supervisees begin employing confrontation and conceptualization exploration with the client (i.e., introducing more alternative views). Catalytic interventions, including process comments, countertransference, and affective reactions to the client and the supervisor are explored (Stoltenberg & McNeill, 1997).

Level 3 supervisees demonstrate higher levels of cognitive complexity in understanding the client's world. Level 3 supervisees develop a working memory of a schema with relevant details about the client as well as how to incorporate different therapeutic skills. Level 3 supervisees also demonstrate the ability to be intentionally self-aware of their reactions and feelings, show higher motivation, and are less anxious when faced with new situations. Additionally, they use sessions primarily for consultation (McNeill & Stoltenberg, 2016). Level 3

supervisees require few directive interventions, but conceptual interventions are utilized to continue honing their chosen theoretical framework. Catalytic interventions are used in response to blocks or stagnation (Stoltenberg & McNeill, 1997). Peer and group supervision are important at this level, to integrate skills with a theoretical framework and match theoretical approaches to their work with clients (Stoltenberg & McNeill, 1997).

Benefits and Limitations of IDM

Researchers have confirmed the general effectiveness of developmental models such as the IDM (McNeill & Stoltenberg, 2016; Worthington, 1987). Additionally, authors have noted the adaptability of the IDM with multicultural clients in supervisory settings (Li et al., 2018). The tenets of developmental theories are apparent in supervisees' perceptions of supervisors, supervisor disposition changing as the developmental levels progress, and the qualitative shift of the supervisory relationship over time (Stoltenberg et al., 1994; Worthington, 1987). However, IDM as a specific model is limited in suggested interventions at each level of development (Haynes et al., 2003) and thus can require sometimes undue commitment and energy on the part of the supervisor (Bernard & Goodyear, 2019). Winter and Holloway (1991) noted that trainees who were higher in developmental levels still preferred to focus on the development of counseling skills and to request feedback; however, IDM-focused supervisors do not readily employ this for advanced supervisees. Additionally, while the execution of IDM requires decreasing the structure of sessions over time, supervisees from *all* levels wanted a high structure in supervision, including being more task-focused (Ladany et al., 2001). Jacobsen and Tanggaard (2009) found that supervisees were generally unhappy with the level of advice and guidance offered as they experienced new clinical problems. Thus, while developmental models appear effective, there are

still key elements missing that are important for quality clinical supervision and general supervisee development.

Cognitive-Behavioral Supervision

The CBT-based approach to supervision is built on the main tenets of CBT, including the identification and modification of core beliefs, conditional assumptions, and automatic thoughts (Liese & Beck, 1997). In pure CBT supervision, the theoretical framework has three important functions: (a) to teach CBT and related techniques, (b) to correct misinformation on CBT, and (c) to reduce the likelihood of therapists drifting from evidence-based approaches (Liese & Beck, 1997; Milne et al., 2011). Proponents of CBT supervision assert how individuals process information directly influences subsequent emotions, behavior, and physiology in predictable ways (Liese & Beck, 1997; Milne et al., 2011).

The CBT approach to supervision is structured, focused, and didactic in its ideal form (Liese & Beck, 1997; Sloan & Watson, 2002). Both supervisor and supervisee are influenced by their own beliefs, assumptions, and thoughts (Sloan & Watson, 2002). Supervisors and supervisees set an agenda including time spent summarizing content from previous sessions and a review of any new concepts that were practiced between sessions. Toward the end of the session, the supervisor summarizes the session, and feedback is elicited from the supervisee (Milne et al., 2011). CBT supervision heavily emphasizes such interventions as reviewing audio/videotapes of supervisees and assisting them in applying a consistent theory within their clinical work, although this theory does not have to exclusively be CBT. Supervisors also support their supervisees by helping them understand their assumptions about clients, the supervisor, or the therapy process itself (Pretorius, 2006). CBT supervisors are responsible for assisting the supervisee in seeing how these underlying assumptions influence supervisees' self-care, their application of cognitive

therapy, and their ability to identify blocks to meaningful therapeutic change (Sloan & Watson, 2002). Given the areas of foci within CBT supervision, it is reasonable to argue that this model is helpful as a mechanism of addressing the limited beliefs and complex feelings that emerge when beginning to work with clients.

Benefits and Limitations of CBT Supervision

Many facets of CBT supervision have been found to be beneficial for supervisees. Milne and James (2000) found through a meta-analysis that the use of CBT methodologies in supervision provides supervisees with significant benefits. In particular (a) close monitoring, (b) modeling competence through supervision, (c) providing specific instructions, (d) goal setting, and (e) providing contingent feedback were effective for supervisee development (Miller & James, 2000). Milne and Resier (2012) found that the aforementioned four guidelines were core components of CBT supervision and supported supervisee growth and should be recommended as supervisory interventions.

While CBT supervision has gained popularity in the past few decades, a fair number of misconceptions about its use exist. Critics of the model note the lack of emphasis on emotions, the therapeutic relationship, early experiences, and underlying motivations for the maintenance of problematic behaviors (Milne & Reiser, 2012). Additionally, CBT can be a difficult framework in which to incorporate cultural dynamics in supervision, while staying true to its foundations (Newman & Kaplan, 2016). This is due to CBT supervision's heavy reliance on challenging rational vs. irrational thinking, behaviors, and feelings without fully understanding underlying cultural context and value systems. (Bernard & Goodyear, 2019; Newman & Kaplan, 2016). Therefore, key elements of effective supervision (i.e., cultural competence, understanding power dynamics, emotional exploration, focusing on past behaviors with clients) are limited with the

delivery of supervision in a strictly CBT framework. Below we provide the rationale for why these supervision models can be integrated to create a more holistic model that meets the current needs of clinical supervision within counseling.

Rationale for the TO-DM

Researchers have asserted the importance of a developmental perspective within the competencies of both CBT therapy and CBT supervision (Prasko et al., 2011). Certain developmental markers were seen as gaining competence in counseling including a natural progression in acquiring increasingly complex skills, understanding the *process* of therapy, and acknowledging the need for continued self-reflection over time. Additionally, the use of conceptualizations and cognitive restructuring allows counselors to understand the core schema of themselves vs. clients, lead them through imagination work, and process different emotional issues of countertransference reactions (Prasko et al., 2011).

IDM and CBT supervision contains core components that are similar in each theory, while simultaneously offering unique benefits when additive to one another. For example, development models and CBT models of supervision are based on ideas of challenging supervisees' existing schema and helping them accommodate these schemas for new information (Liese & Beck, 1997; Stoltenberg & McNeill, 2010) about the therapeutic processes, client needs, and supervisee reactions. Newman (2010) highlighted the importance of developmentally-appropriate scaffolding of supervisees while simultaneously supporting their skill development. However, CBT supervision is task-oriented and highly structured (Milne et al., 2011) and can provide more directiveness for a supervisor using IDM to promote supervisee development (Haynes et al., 2003). Additionally, this model addresses limitations of developmental models, which include supervisee

frustration with non-directive supervision, and less of an emphasis on technical skills as time progresses (Jacobsen & Tanggaard, 2009; Ladany et al., 2001).

Similarly, IDM offers an important developmental framework for CBT supervision in which to scaffold skill-mastery for counselors. The IDM framework within a new, additive CBT framework addresses the problem of understanding supervisee motivation based on their current clinical efficacy and core beliefs or assumptions about clients or therapy itself (Milne & Reiser, 2012; Stoltenberg & McNeill, 2010). CBT supervision also addresses key components within Schön's (1987) three recommendations for supervisees including noticing automatic behavior within sessions, reflections between sessions on interventions used, and how to incorporate new knowledge to effectively help their clients. This can be done with the use of homework, review of cases, and focus on core schema and beliefs during sessions. Finally, IDM bolsters the efficacy of CBT-supervision with cultural dynamics between clients, supervisees, and supervisors (Li et al., 2018), allowing for a supportive environment in which multicultural competence can organically develop. The additive model addresses these limitations of each model as explained below.

Overview of the TO-DM and Guiding Tenets

The TO-DM incorporates tenets from IDM, including typical supervisee dispositions as well as specific interventions for supervisors to employ based on the supervisee's development (Stoltenberg & McNeill, 2010). The TO-DM borrows structure, directiveness, and directly confronts limiting self-beliefs from CBT-Supervision (Liese & Beck, 1997). Increased awareness about counseling and multicultural considerations for developing counselors are proposed within this model. It's important to note that power differentials are inherent in supervision practices, and that multicultural concerns should be taken into consideration when asking for and eliciting feedback from supervisees (McNeill & Stoltenberg, 2010). Differences in racial, sexual

orientation, cultural, religious, and SES backgrounds are among the salient identities that play a role in supervision dynamics (Bernard & Goodyear, 2019).

Novice Supervisees Session Structure

Generally, each session will begin with a check-in to cultivate supervisor-supervisee rapport and build a warm, working relationship (Liese & Beck, 1997). Once this is established, the agenda will be set, including clarifying the guiding questions for the session (Gordon, 2012). Examples of appropriate questions include, 'What fears or anxieties came up for you during your work this week?', 'What worked well for you with this client in this past week?' and 'Did you have any lingering questions from the previous week?' The supervisor will then introduce the agenda for the rest of the session, including what will be covered and for how long (Milne et al., 2011). An example of a clinical problem will be requested, such as difficulty in using a certain skill, which will be reviewed in the form of audio/visual tape or role-play.

Novice supervisees will present as anxious, highly motivated, dependent on their supervisor for feedback and support, and engage in primarily black-and-white thinking about clients' problems. Interventions recommended to use at this level include a high level of support (i.e. encouraging and praise), didactic techniques (i.e. direct skill teaching), and process-oriented approaches (McNeill & Stoltenberg, 2016). Facilitative interventions include supervisors directly confronting negative self-talk through CBT interventions as well as challenging irrational beliefs from counselors (i.e., the need to be perfect, one mistake meaning 'I'm a failure'; Sloan & Watson, 2002). These interventions attempt to encourage supervisees' view of their progression and development as a counselor with rational and balanced thinking.

Sessions will almost always include a wrap-up summary of what was discussed, an opportunity for questions, and assigning homework to practice new skills between sessions. For

novice supervisees, this might include practicing challenging negative self-talk or cognitions during sessions, trying new micro-skills, or beginning to brainstorm case conceptualizations. The supervisees will rarely if ever, create homework topics and session agendas in this stage of development. Supervisors will closely monitor novice supervisees by offering directive, structured interventions that are developmentally appropriate, while still evaluating their acquisition of basic skills needed for effective counseling.

Didactic interventions aim to teach specific skills needed at particular development levels. These interventions include direct instruction, such as teaching basic counseling skills (i.e., reflections, open-ended questions, encouragers, summarizations, etc.). Role-play and observation through either audio/video recordings or live sessions are also beneficial. Other interventions focus on process-oriented methods of supervision. These interventions are usually introduced for later-stage novice supervisees and include reflections and processing on supervisees' thoughts and feelings about the dynamics in session as well as the clients' receptiveness to their interventions used. Regardless of the novice supervisees' status, the supervisor would do well to emphasize summaries of content covered at the end of the session while providing a safe, supportive environment in which lingering questions can be addressed.

Increased Awareness and Multicultural Considerations

Cultivating a safe environment free to explore trauma through establishing, trustworthiness, collaboration, and empowering supervisees will allow multicultural diversity within supervision and counselor-client dynamics to be addressed (Fong, 1994; Jones et al., 2019; Jones & Branco, 2020). Beginning conversations around the appropriateness of cultural humility through discussion of values, worldviews, and viewpoints are both appropriate and ethically mandated (ACA, 2014) at this level. Additionally, supervisees will engage in beginning exercises

about identifying both strong and subtle feelings that emerge as they begin clinical work. Supervisors will focus heavily on validating and normalizing these feelings while beginning conversations about how to cultivate awareness regarding emotional reactions and how these reactions might impact clients.

Intermediate Supervisee Session Structure

Intermediate supervisees in the TO-DM appear less anxious, less dependent, more client-focused, and ambivalent with motivation to improve skills. The lack of motivation and enthusiasm might arise for more difficult clients that require patience and guided support Supervisors working with supervisees at this level should focus on case conceptualization, clinical concerns, processing transference, countertransference, and how they impact the therapeutic alliance. Similar to novice supervisees, the supervisor will set the agenda, and do the check-ins in a similar, directive fashion. However, during this stage, the supervisor might consider positing multiple agenda items to choose from based on the supervisees' needs to develop autonomy and a sense of self-efficacy and ownership in fostering their professional growth.

The supervisor will set the expectations that these sessions will be more confrontative, particularly when challenging supervisees' lack of motivation with more difficult clients, and when assisting them in new ways to find intrinsic motivation for their growth (Sloan & Watson, 2002; Stoltenberg & McNeill, 1997). Conceptualization skills can include helping supervisees gather richer information about clients by teaching when to use more advanced skills such as immediacy, confrontation, and sharing counselor reactions when appropriate. This can be accomplished via role-playing, but can also include reviewing audio-video tapes.

Supervisors can conceptualize cases through a CBT framework to give counselors a concrete example of how to use a specific theoretical orientation when working with clients (Boyd,

1978; Stoltenberg & McNeill, 1997); however, this is just for practice and the supervisor must remind the supervisee that they develop their working theoretical orientation. Supervisees at this stage of development should be encouraged to continue reflective activities outside of sessions to better understand themselves and the impact they have on clients. Though/feelings logs and similar homework assignments about reactions to clients and evaluation of emotions in session help accomplish this goal.

In addition to homework, supervisees in the intermediate stage will still be allowed to discuss the practice of new skills in sessions; however, similar to agenda-setting, a few sessions should be devoted to encouraging supervisees' to create their assignments. In this way, supervisors are scaffolding their development while continuing to emphasize technical and skill mastery. Homework sessions that are appropriate for these supervisees would include topics related to understanding cases through a chosen theoretical framework, processing when to use and how to execute more advanced interventions, and addressing emotional reactions to clients. CBT interventions within the A-B-C model will be used to help supervisees understand how their actions, thoughts, and feelings during the session all impact the dynamics between themselves and clients (Gordon, 2012). Fears around feeling stuck with clients should be discussed by addressing core beliefs and feelings that contribute to those fears, and concrete ways to normalize while challenging these feelings in productive ways. CBT interventions regarding self-reflection and evaluation are more emphasized at this stage than the novice stage.

Intermediate Awareness-Building and Multicultural Understanding

Multicultural considerations at this stage include using a CBT framework for the supervisee to understand what dynamics might be occurring in sessions. For example, a counselor who is scared to address cultural differences or explore how these differences impact the client

would be guided through a role-play that demonstrates how fear impacts the thoughts and subsequent behaviors when working with a culturally diverse client (Fong, 1994). Homework might also include counselors practicing more advanced broaching, embodying cultural humility in case conceptualizations, and advocating for their clients on a community and national level. Supervisees will be encouraged to discuss their implicit biases and reflect on times when these biases were challenged. This allows supervisees to process issues of countertransference and transference while developing an understanding of their current clinical efficacy regarding theoretical orientation and overall clinical style (Milne & Reiser, 2012).

Advanced Supervisee Structure

Advanced-level supervisees are confident, appropriately self-and client-focused, more autonomous, and have fluid clinical skills. Agenda-setting will still be used as needed; however, supervisees will be given the responsibility to develop the session itinerary. Confrontative, conceptualization, and process-oriented interventions are less necessary than in previous levels. Conceptualization skills are primarily used to help the supervisees gain confidence within their theoretical orientation, while process-oriented interventions are used in responses to mental blocks or stagnation. These supervisees will benefit from imaginative work, experiential interventions, schema-oriented supervision, and a consultative approach to facing new obstacles. Conceptual interventions involve teaching more advanced counseling skills at this level, which can include formalized training. Counseling skill practice will be incorporated into homework practice to continue practicing technical mastery.

Additionally, supervisors can summarize the fluidity of skills and new abilities in case conceptualization to solidify learning. Using confrontative, CBT supervision-oriented interventions, supervisors can remind supervisees of times where anxieties were not warranted as

well as remind them of new cognitive or behavioral skills learned to synthesize information or process emotions within the self and client (Liese & Beck, 1997). Summaries of information covered toward the end of the session might include the opportunity for the supervisor to address confusing concepts in these more complex topics. Additionally, supervisees at this level can use this time to address a specific topic in more depth if they indicate that is more beneficial than a session overview. Table 1 on the next page shows a summary of the various supervisee dispositions, appropriate interventions, and multicultural considerations for different supervisee levels within the TO-DM.

Advanced Awareness and Multicultural Competence

Multicultural considerations at this stage would include counselors using the consultative nature of supervision to evaluate the impact of dynamics between themselves and clients. More process-oriented comments about supervision dynamics are appropriate for counselors at this stage of development (Fong, 1994; Jones & Branco, 2020). Counselors would be encouraged to continue growing in their cultural awareness and humility by actively seeking formalized training, webinars, and presentations at conferences. Counselors at this stage demonstrate a more comprehensive, nuanced understanding of how cultural humility is used within interventions and how this influences with clients and their treatment goals Moreover, they are encouraged to continue the personal reflection and achieve congruence with their personal and professional personas. They have a marked understanding of how this positively impacts their clinical work.

Table 1

Summary of Task-Oriented Integrative Developmental Model Skills and Interventions

	TO-DM Interventions	Supervisee Description	Specific Techniques	Multicultural Development
Novice	• Supportive • Didactic • Process-oriented	• Anxious • Highly motivated • Dependent • Black and white thinking	• Teaching basic skills through role-play, instruction, observation • Challenge negative-self talk • Encouragement with progress • Assigning homework to practice new skills	• Addressing fears of broaching • Conversations about identity influences • Identifying and challenging assumptions and stereotypes
Intermediate	• Confrontative • Conceptualization-practice • Process-oriented	• Less anxious • Less motivated with clients • Client-focused • Somewhat dependent • Feels stuck with new situations	• Confronting persistent feeling of not being as motivated and implementing new behaviors to correct. • Teach more advanced confrontation skills, immediacy. • Conceptualize more complex cases through a theoretical framework to give a basis for practice • Video observation and feedback	• Utilizing A-B-C model to address thoughts and feelings around dynamics • Practice of advanced broaching, advocacy for clients • Logging thoughts and feelings to assess dynamic with client
Advanced	• Confrontative (occasionally necessary) • Conceptual (personal orientation) • Process-oriented (in response to blocks or stagnation) • Continued self-reflection	• Confident • Self and client-focused • More autonomous • Fluid clinical skills and conceptualizations	• Directly teach more advanced counseling skills • Elicit overall feedback about development (new cognitions learned, times where anxiety was not warranted) • Summarizing the fluidity of skills/ conceptualization abilities	• Understand nuanced dynamics with intersectional identities • Seek formalized training on working with marginalized groups • Process dynamics of supervision (i.e. identity differences)

Formative and Summative Evaluation

The TO-DM readily lends itself to both summative and formative evaluation of supervisees, which are paramount in gatekeeping, ensuring quality client care, and assisting supervisees with professional development while establishing their counseling identity (McNeill & Stoltenberg, 2016). Recorded videos of sessions, written examples of notes from cases, therapist feedback, and noted behaviors in supervision are appropriate sources of assessment. However, this model is also designed to assess for supervisee multicultural awareness, knowledge, and skills. For example, items from the *Multicultural Supervision Scale* (MSS; Sangganjanavanich & Black, 2011) and the *Multicultural Awareness, Knowledge, and Skills Survey—Counselor Edition— Revised* (MAKSS-CE-R; Kim et al., 2017), can be utilized to assess for the use of multicultural interventions and case conceptualizations.

Supervisors may also check for mastery of check-ins, bridging from previous sessions, agenda-setting, and completion of homework from an existing questionnaire related to CBT-supervision competence (Liese et al., 1995). This assessment can be considered with the supervisee's developmental level and thus, a corresponding need for structure. Evaluations would include a section for supervisors to explain reasons for less-than-adequate performance in any particular area. For example, a supervisee's lack of confidence in exploring why a client has not attempted homework assigned from the previous session might relate to anxiety with new skills, feeling stuck in case conceptualizations, or the lack of flexibility in clinical work. Because the TO-DM is inherently developmental and personalized to the journey of each supervisee, the aforementioned evaluation could readily identify different areas of growth for supervisees.

Case Illustration

The case illustration below is used to demonstrate how a supervisor employs TO-DM for a novice supervisee. Katrina is a 23-year-old, African American supervisee in beginning her master's program. Her supervisor, Jim, a 29-year-old white male, notices that at the beginning of their supervisory relationship that Katrina is nervous about starting clinical work. He validates her anxiety and facilitates a space where she can explore her thoughts and feelings about both supervision and cultural dynamics that occur in the session. Jim initially sets the agenda for the sessions, while assigning homework assignments for Katrina to try out between sessions, such as practicing reflections of meaning and effective encouragers. He also assigns her homework on broaching gender differences with her male clients, which causes her anxiety.

Toward the end of her first semester, Jim notices Katrina is a bit less anxious yet still highly motivated to learn new skills and ways of conceptualizing cases. The homework assignments now pertain to practicing basic case conceptualization skills, such as viewing a client's needs through a humanistic, person-centered framework. He also assists Katrina with understanding her fear of 'Not being perfect' with clients, by introducing ways to practice cognitively challenging her fears. These challenging interventions include grounding techniques before sessions begin and reframing obstacles in sessions as learning opportunities. Soon, Katrina can use these skills and can challenge her anxiety by reminding herself that she is still learning; her anxiety begins decreasing in sessions. She also begins to actively reflect on dynamics between herself and clients with different backgrounds and brings these conversations to supervision. Jim facilitates honest conversations around race and gender in session to emulate for Katrina how to respectfully broach differences in session. This also provides Jim an opportunity to check in with Katrina about how his supervision style is being received by her.

As Katrina progresses through her practicum and early internship, her independence is more evident. By the next academic year, she begins to lose some motivation to take on new clients but simultaneously has gained confidence with helping clients with anxiety and depression. Jim notices these changes and adjusts his supervision needs accordingly. Katrina feels stumped when she is given harder cases, including clients with personality disorders or substance use. Jim notices that she is ready for more advanced case conceptualization skills, such as actively choosing a theoretical framework that matches the clients' needs. As a result, Katrina becomes more skilled in CBT and Person-centered therapy and often uses them to help her clients. He intentionally encourages honest conversations around racial and gender-based dynamics within the session that also emulate how Katrina can talk about dynamics she experiences with her clients

Katrina is now demonstrating a stronger grasp of power differences between herself and the White clients she works with; she is often able to elicit a fruitful discussion about these dynamics in sessions. She finds that these discussions strengthen the relationship and working alliance with her clients and build her efficacy as a clinician. Part of Katrina's work now includes walking herself through the A-B-C model, particularly when she feels stuck with a new client or is overcoming periods of low motivation. She realizes that thinking that a client will be difficult causes her to be nervous and less confident, resulting in an awkward session. Together, both Jim and Katrina navigate ways for her to challenge these thoughts and apply new behaviors that contribute to Katrina's confidence in both her skills and ability to relate to clients.

By the end of the program, Katrina has grown tremendously as a clinician and reports loving her supervision experience as it addressed her various professional needs depending where she was in her program. She reports that her current supervision structure is consultative and allows her to take ownership of sessions while allowing time for continued skill practice. Katrina tells

Jim in a feedback session that she appreciated his focus on counseling skills throughout the supervision relationship because she feels like she has higher efficacy as a clinician. The active CBT skills learned to address her irrational fears and beliefs about becoming a counselor coupled with practice in exploring multicultural differences leave her with a feeling of strong confidence to start a successful residency after graduation.

Discussion

Practical Challenges

The TO-DM model presents several practical challenges: (a) supervisor influence, (b) countertransference/transference, (c) confidentiality and informed consent and, (d) multicultural considerations. Supervisors must also be careful to allow for flexibility within the model to allow supervisees to develop their working style of counseling that feels natural to them. For example, a supervisor who is skilled in CBT therapy should emphasize other theoretical approaches and associated skills for supervisees to broaden their repertoire of knowledge.

Within a developmental context, supervisors should prepare for certain issues of countertransference/ transference for supervisees at all developmental levels (Thomas, 2010). For example, novice supervisees might experience over-dependence, admiration, and deference, which supervisors could internalize inappropriately. Intermediate supervisees and their supervisors should proceed with caution when discussing conflict or feelings around clients and carefully explore uncomfortable emotions that may arise. Additionally, advanced supervisees will still have clinical blind spots (e.g. theoretical bias) requiring careful consideration and from supervisors (Thomas, 2010).

Ethical considerations should be heeded when utilizing TO-DM in supervision. A written informed consent, with all expectations, should be drafted and agreed upon before the beginning

of the supervisory relationship (ACA, 2014). Clients should be made aware of the nature of the supervision that supervisees receive. Additionally, clients should be aware of the natural limitations with confidentiality that exist when the supervisee is under supervision (Bernard & Goodyear, 2019).

Multicultural considerations in supervisory relationships and clinical work are paramount throughout the supervision process (Li et al., 2018; McNeill & Stoltenberg, 2016). Supervisors should prepare for general trends towards rigidity in conceptualizing multicultural clients, naivete with cultural differences, and feelings of trepidation and overwhelm as supervisees learn about cultural awareness, particularly early on in their development. When facilitating awareness around discussing cultural differences, it is important to note that microaggressions and culturally unresponsive interventions are the norms rather than the exception (Burkard et al., 2006). Supervision requires intentionality and conscientious understanding of the inherent power differences and other dynamics in supervisory relationships.

Strengths and Limitations

The TO-DM is based on an integration of two supervision models with several studies supporting the efficacy of these two philosophical foundations of supervision (Prasko et al., 2011; Sias & Lambie, 2008). This integrated model suits to meet developmental needs of supervisees while simultaneously providing structure to enhance counselor competence, skill development, and multicultural proficiency (Jacobsen & Tanggaard, 2009; Ladany et al., 2001; Li et al., 2018; Pretorius, 2006). Finally, because the TO-DM provides a standardized structural framework for the IDM, it combines the benefits of both developmental and more directive supervision (Haynes, 2003).

Regarding limitations, some of the requirements for the TO-DM might not be transferable to clinical settings, particularly settings that utilize short-term, brief supervision methods. Also, the operationally defined, qualitative characteristics of the supervisee levels, which are integrated into the TO-DM, can be difficult to observe for supervisors. For example, it might be difficult to distinguish between a late-stage novice vs. an early-intermediate supervisee, particularly when their skill development and characteristics are so similar. Finally, the model's emphasis on CBT and the reputation that precedes CBT (Milne & Reiser, 2012) might render some supervisees nervous to observe and practice these skills. Supervisors should give due consideration to supervisee anxiety related to skill acquisition. Finally, the TO-DM has not been empirically supported thus far; however, conceptually, the TO-DM provides many strong implications for training and practice within the field of counselor education (ACA, 2014).

Implications for the Field

The TO-DM is an intentionally- structured framework of supervision with room for flexibility based on supervisee needs. The research-validated developmental framework modeled after the IDM coupled with the structure provided by CBT supervision creates an innovative and holistic approach to supervision. Notably, the authors assert that the model meets the developmental needs of supervisors by emphasizing the hallmarks of a professional counselor-knowledge of skills, understanding of the therapeutic relationship, and identifying nuances that enhance or decrease successful outcomes in counseling (Fairburn & Cooper, 2011). Perhaps most importantly, this model provides a concrete, developmentally appropriate way to gauge supervisee multicultural competence and supervisee-awareness of thoughts and feelings in sessions. While many supervision models emphasize some of these requirements for clinical success, these models

do not assess competence in all of these areas simultaneously and comprehensively (Bernard & Goodyear, 2019).

The TO-DM assists both supervisors and supervisees in understanding developmental needs in the areas of self-other awareness and competence in counseling practice. Supervisors can easily alleviate irrational doubts of novice counselors, while simultaneously teaching them skills on how to combat such thoughts that might arise and interfere with sessions (Gordon, 2012; Sloan & Watson, 2002). Thus, the model assists in developing the counselor as a professional through introspection and increased awareness, a mechanism that promotes long-term growth among developing counselors (Rønnestad & Skovholt, 2013). Future studies can help assess not only the empirical validity of this model in different environments but with a diverse group of supervisees to assure the model will thrive in diverse settings.

Conclusion

The TO-DM offers a new perspective on existing supervision models by combining the developmental considerations of IDM with the structured support of CBT supervision to help promote supervisee development. The TO-DM assists supervisors in building supervisees' case-conceptualization skills, awareness of self, and how to employ cultural awareness and understanding in their clinical work. While some research studies help support the efficacy of the philosophical framework of the TO-DM, future investigations should include how to adapt the model for diverse supervisees and various clinical settings. We argue the TO-DM offers an intentional, helpful, and comprehensive model for conducting supervision to address both the professional and personal development of supervisees as they evolve into competent, ethical, and effective counselors.

References

Barrett, M.S., & Barber, J.P. (2005). A developmental approach to the supervision of therapists in training. *Journal of Contemporary Psychotherapy, 35,* 165–183. https://doi.org/10.1007/s10879-005-2698-8

Bearman, S.K., Bailin, A. & Sale, R. (2019). Graduate school training in CBT supervision to develop knowledge and competencies. *The Clinical Supervisor,* 1-19. https://doi.org/10.1080/07325223.2019.1663459.

Bernard, J. M., & Goodyear, R. K. (2019). *Fundamentals of clinical supervision* (6th ed.). Pearson.

Boyd, J. (1978). *Counselor supervision: Approaches, preparation, practices.* Accelerated Development.

Brown, R. D., & Dinnel, D. (1992). Exploratory studies of the usefulness of a developmental approach for supervising evaluation students. *Evaluation Review*, *16*(1), 23–39. https://doi.org/10.1177/0193841X9201600102

Burkard, A. W., Johnson, A. J., Madson, M. B., Pruitt, N. T., Contreras-Tadych, D.A., Kozlowski, J. M., . . . Knox, S. (2006). Supervisor cultural responsiveness and unresponsiveness in cross-cultural supervision. *Journal of Counseling Psychology*, *53*, 288–30. https://doi.org/10.1037/0022-0167.53.3.288

Cutcliffe, J. R., Hyrkas, K., & Fowler, J. (Eds.). (2010). *Routledge handbook of clinical supervision : Fundamental international themes*. Retrieved from https://ebookcentral-proquest-com.proxy.wm.edu

Fairburn, C. G., & Cooper, Z. (2011). Therapist competence, therapy quality, and therapist training. *Behaviour Research and Therapy*, *49*(6-7), 373–378. https://doi.org/10.1016/j.brat.2011.03.005

Fong, M. L. (1994). *Multicultural issues in supervision* ERIC Digest. (ERIC Clearinghouse on Counseling and Student Services No.CG025748). https://doi.org/10.3168/jds.S0022-0302(94)77044-2

Gordon, P. K. (2012). Ten steps to cognitive behavioural supervision. *The Cognitive Behaviour Therapist, 5*(4), 71–82. https://doi.org/10.1017/S1754470X12000050

Haynes, R., Corey, G., & Moulton, P. (2003). *Clinical supervision in the helping professions: A practical guide*. Brooks/Cole.

Jacobsen, C.H., & Tanggaard, L. (2009). Beginning therapists' experiences of what constitutes good and bad psychotherapy supervision with a special focus on individual differences. *Nordic Psychology, 61*(4), 59-84.

Jones, C. T., & Branco, S. F. (2020). Trauma-informed supervision: Clinical supervision of substance use disorder counselors. *Journal of Addictions & Offender Counseling, 41*(1), 2-17. https://doi.org/10.1002/jaoc.12072

Jones, C. T., Welfare, L. E., Melchior, S., & Cash, R. (2019). Broaching as a strategy for intercultural understanding in clinical supervision. *The Clinical Supervisor, 38,* 1 -16. https://doi.org/10.1080/07325223.2018.1560384

Kahn, S. A., & Monk, G. (2017). Narrative supervision as a social justice practice. *Journal of Systemic Therapies, 36,* 7-25. https:// doi.org/10.1521/jsyt.2017.36.1.7

Kim, B. S. K., Cartwright, B. Y., Asay, P. A., & D'Andrea, M. J. (2003). A revision of the Multicultural Awareness, Knowledge, and Skills Survey-Counselor Edition. *Measurement*

and Evaluation in Counseling and Development, *36*(3), 161–180. https://doi.org/10.1080/07481756.2003.11909740

Ladany, N., Walker, J. A., & Melincoff, D. S. (2001). Supervisory style: Its relation to the supervisory working alliance and supervisor self-disclosure. *Counselor Education and Supervision, 40*(4), 263–275. https://doi.org/10.1002/j.1556-6978.2001.tb01259.x

Li, D., Liu, Y., & Lee, I. (2018). Supervising Asian international counseling students: Using the Integrative Developmental Model. *Journal of International Students, 8*(2), 1129-1151. http://dx.doi.org.proxy.wm.edu/10.5281/zenodo.1250415

Lenz, A.S., & Smith, R.L. (2010). Integrating wellness concepts within a clinical supervision model. *The Clinical Supervisor, 29*, 228–245. https://doi.org/10.108007325223.2010.51811

Liese, B.S., & Beck, J. S. (1997). Cognitive therapy supervision. In C.E. Watkins, Jr. (Ed.), *Handbook of psychotherapy and supervision* (pp. 184–202). John Wiley & Sons.

Liese, B.S., Barber, J., & Beck, A.T. (1995). *The Cognitive Therapy Adherence and Competence Scale*. Unpublished instrument, University of Kansas Medical Center, Kansas City.

McNeill, B.W., & Stoltenberg, C. D. (2016). *Supervision essentials for the integrative developmental model*. Washington, D.C: American Psychological Association.

McNeill, B.W., Stoltenberg, C. D., & Pierce, P. A. (1985). Supervisees' perceptions of their development: A test of the counselor complexity model. *Journal of Counseling Psychology*, *32*, 630–633. https://doi.org/10.1037/0022-0167.32.4.630

McNeill, B., Stoltenberg, C., & Romans, J. (1992). The Integrated Developmental Model of supervision: Scale development and validation procedures. *Professional Psychology: Research and Practice, 23*(6), 504-508. https://doi.org/10.1037/0735-7028.23.6.504

Milne, D.L, & Dunkerley, C. (2010). Towards evidence-based clinical supervision: The development and evaluation of four CBT guidelines. *The Cognitive Behaviour Therapist, 3*(2), 43–57. https://doi.org/10.1017/S1754470X10000048

Milne, D.L., & James, I. (2000). A systematic review of effective cognitive-behavioural supervision. *British Journal of Clinical Psychology*, *39*(2), 111–127. https://doi.org/10.1348/014466500163149

Milne, D., Reiser, R., Cliffe, T., Breese, L., Boon, A., Raine, R., & Scarratt, P. (2011). A qualitative comparison of cognitive-behavioural and evidence-based clinical supervision. *The Cognitive Behaviour Therapist, 4*(4), 152-166. https://doi.org/10.1017/S1754470X11000092

Milne, D. L., & Reiser, R. (2012). A rationale for evidence-based clinical supervision. *Journal of Contemporary Psychotherapy, 42,* 139–149. https://doi.org/10.1007/s10879-011-9199-8

Newman, C. F. (2010). Competency in conducting cognitive–behavioral therapy: Foundational, functional, and supervisory aspects. [For the Special Section on Psychotherapy Competencies and Supervision of Trainees]. *Psychotherapy: Theory, Research, Practice, Training*, *47*(1), 12–19. https://doi.org/10.1037/a0018849

Newman, C. F., & Kaplan, D. A. (2016). *Clinical supervision essentials series. Supervision essentials for cognitive-behavioral therapy.* American Psychological Association. https://doi.org/10.1037/14950-000

Peake, T.H, Nussbaum, B.D, & Tindell, S.D. (2002). Clinical and counseling supervision references: Trends and needs. *Psychotherapy (Chicago, Ill.), 39*(1), 114-125. https://doi.org/10.1037//0033-3204.39.1.114

Prasko, J., Vyskocilova, J., Mozný, P., Novotny, M., & Slepecky, M. (2011). Therapist and supervisor competencies in cognitive behavioural therapy. *Neuroendocrinology Letters*, *32,* 101–109.

Pretorius, W. (2006). Cognitive behavioural therapy supervision: recommended practice. *Behavioural and Cognitive Psychotherapy, 34*(4), 413-420. https://doi.org/10.1017/S1352465806002876

Rønnestad, M. H., & Skovholt, T. M. (2013). *The developing practitioner: Growth and stagnation of therapists and counselors*. Routledge.

Sangganjanavanich, Varunee Faii, & Black, Linda L. (2011). The initial development of the Multicultural Supervision Scale. *Journal of Professional Counseling, Practice, Theory, & Research, 38*(2), 18-36. https://doi.org/10.1080/15566382.2011.12033869

Schön, D.A. (1987). *Education a reflective practitioner.* Jossey-Bass.

Sias, S. M., & Lambie, G. W. (2008). A integrative social-cognitive developmental model of supervision for substance abuse counselors-in-training. *Journal of Teaching in the Addictions, 7*(1), 57–74. https://doi.org/10.1080/15332700802072282

Sloan, G., & Watson, H. (2002). Clinical supervision models for nursing: structure, research, and limitations. *Nursing Standard, 17*(4), 41–46. https://doi.org/10.7748/ns2002.10.17.4.41.c3279.

Stoltenberg, C. (1981). Approaching supervision from a developmental perspective: The counselor complexity model. *Journal of Counseling Psychology*, *28*(1), 59–65. https://doi.org/10.1037/0022-0167.28.1.59

Stoltenberg, C.D. & Delworth, U. (1987). *Supervising counselors and therapists: A developmental perspective.* Jossey-Bass.

Stoltenberg, C. D., & McNeill, B.W. (1997). Clinical supervision from a developmental perspective: Research and practice. In C.E. Watkins, Jr. (Ed.), *Handbook of psychotherapy and supervision* (pp. 184–202). John Wiley & Sons.

Stoltenberg, C.D., & McNeill, B.W. (2010). *IDM supervision: Developmental Model for Supervising Counselors and Therapists* (3rd ed.). Brunner-Routledge.

Stoltenberg, C.D., McNeill, B.W., & Crethar, H.C. (1994). Changes in supervision as counselors and therapists gain experience: A review. *Professional Psychology*: *Research and Practice*, *25*, 416–449. https://doi.org/10.1037/0735-7028.25.4.416

Stoltenberg, C. D. , McNeill, B. W., & Delworth, U. (1997). *IDM supervision: The integrated developmental model of supervision*. Jossey-Bass.

Thomas, J.T. (2010). *Ethical and legal issues in supervision and consultation.* Washington, DC: American Psychological Association.

Westefeld, J. S. (2009). Supervision of psychotherapy: Models, issues, and recommendations. *The Counseling Psychologist*, *37*(2), 296-316. https://doi.org/10.1177/0011000008316657

Winter, M., & Holloway, E.L. (1991). Relation of trainee experience, conceptual level, and supervisor approach to selection of audio-taped counseling passage. *The Clinical Supervisor, 9*(2), 87-103. https://doi.org/10.1300/J001v09n02_09

Worthington, E. L. (1987). Changes in supervision as counselors and supervisors gain experience: A review. *Professional Psychology: Research and Practice*, *18*(3), 189–208. https://doi.org/10.1037/0735