Circular supervision model: Transitional phases

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Abstract

 In this article, the author identifies the need for a model of clinical supervision that features, a multidimensional, synergistic approach which aims to standardize the supervision field. Introducing the *Circular Supervision Model*; the new way to ensure clients are receiving the best possible care and the counseling field standards are held to the highest esteem. While the procurement of the supervisory status often means, the proverbial, glass ceiling, the implementation of this sensible model offers elasticity in its sequential circular flow through the six phases: simulation, supposition, reformulation, synthetization, possession, and solidification (SSRSPS). The role of the clinical supervisor is to exercise supervisory responsibilities in a culturally responsive and cultivating format. The philosophy and process of evaluation are described through the lens of the service definition. Unlike other current supervision models which feature levels and stages, the circular supervision model allows for continuous growth, through its systematic learning process where experienced professional provides guidance to a novice entering the profession (Bernard & Goodyear, 2004). Noticeable throughout the article is a call to action for supervisors to go beyond direct service with clients and supervisees but to extend themselves and the clinical supervision profession to teaching, research, leadership and political advocacy. It is here learning truly becomes a circle and here we find the definition of the name of the model.

 Introduction

 In recent years there has been a call for policymakers to do more to support mental health and substance abuse services by cultivating awareness, increasing access to evidence-based treatment, preserving families, and ensuring that policies are nonpunitive, with new legislation. The outcome of which stands to influence long-term health and welfare practices in our communities all over the world. In the era of managed care, all of the focus is placed on providing best-practice based service to the client consumer. While this is a well-supported and progressive route to the advancement of the counseling profession overall, there is a key element missing, a sensible counseling supervision model (Stoltenberg & Delworth, 1987; (Borders et al., 1991; Getz, 1999; Magnuson et al., 2000; Peace & Sprinthall, 1998). Clinical supervision serves a vital role as the equidistant bridge between the classroom and service delivery. Most students entering the field are unaware of the supervision models, practices, and interventions, that incorporates and integrates counseling theory and practice with a role-based supervision approach. Much like there has been a call for policymakers to make improvements in the counseling field, there is also a call for academic scholars and counselors alike, to contribute to the knowledge base and overall enhancement of the supervision profession (ACA, 2014; ACES, 1995). With this in mind, this article offers an addition to the counseling supervision field by way of a comprehensive approach to counseling supervision called the *Circular Supervision Model.* This model promotes a clearer understanding of the educational journey and developmental phases that lead to favorable clinical outcomes and ultimately a more just society.

Service definition

For this model, the clinical supervision definition remains the same; as an intervention which a more experienced professional provides guidance to a novice entering the profession, providing education for the trainee, and assurance that only trained and appropriate candidates enter the field (Bernard & Goodyear, 2004). Furthermore, supervision is a social process involving immersion in the professional culture through which the novice learns mores, attitudes, values, modes of thinking, and strategies for problem-solving that are embedded in that culture, thereby acquiring a professional identity (Auxier, Hughes, & Kline, 2003; O’Byrne & Rosenberg, 1998).

Philosophy and process of evaluation

The circular supervision model aims to standardize the supervision profession by ensuring consistency in the service definition, the methodology of clinical supervision training and service delivery. The development of the clinical supervisor is critical. As the supervisor is the ultimate responsible party for the wellness of the client as stated in the American Counseling Association *Code of Ethics* under standards “F.4. Supervisor Responsibilities” (ACA, 2014). However, this developmental process should begin while the supervisor is a counselor and is considered a novice in the field. When counselors without adequate preparation assume responsibility for supervising trainees, they may inadvertently portray supervision as a superficial requirement and miss the opportunity to adequately prepare individual members of the next generation of counselors (Magnuson, Norem, & Bradley, 2001, p. 214). The cycle of inadequate clinical supervision in counseling can be perpetuated when universities place interns in schools and these interns receive their on-site supervision from counselors who have had little or no formal education in supervision (Peace & Sprinthall, 1998). In the counseling profession, supervision should be considered is a rite of passage, the means by which skills are refined, theory and practice are integrated, and trainees explore their new professional identities in preparation for induction into their profession, so formal exposure to this process is paramount (Dollarhide & Miller, 2006; Pearson, 2006).

Theory of counselor development

The circular supervision model’s perspective on counselor development affirms a strength-based approach. In the process of becoming competent as a clinical supervisor, the individual would be edified of the outcome at the beginning of the process, while training to become a counselor. This evidence-informed course will allow the service providers (supervisors) and the service recipient (supervisee) to all have the same information thus ensuring accountability and reliability of circular clinical service delivery. The objective of this counselor development is to maximize and identify growth needed for the future thus continuously identifying new areas of growth in a life-long learning process (Stoltenberg & Delworth, 1987). The theory of counselor development clinical skill components of the circular supervision model can be synthesized through the acronym ASPECT:

Accountability – upholding the promise to deliver quality services.

Stewardship – mindful use of all available resources.

Professionalism – consistent and ethical role modeling and application.

Excellence – the relentless pursuit to provide the best quality care.

Continuous Learning – a steadfast commitment to ongoing development.

Teamwork – active support of collective wisdom and energy to achieve great results (Center for Substance Abuse Treatment, 2009).

Model

The circular supervision model is considered the model of models as other models and their interventions function seamless within its gates. The circular supervision model focuses on standardizing the clinical profession through the portal of circular education. The model has two aim for standardization: educational regulation and postgraduate phases.

Starting with graduate education as the entry portal of clinical training, individuals who seek to provide clinical care will interact with the circular supervision model as part of their core requirement for successful completion of a graduate degree. The rationale is to educate the future service providers of what to expect from a supervisor and the supervisory process. To accomplish this the circular supervision model aligns itself with the Council for Accreditation of Counseling and Related Educational Programs (CACREP), as this accreditation body provides consistency in program parameters, stemming from core areas of mental health education including; diagnosis and psychopathology; psychotherapy; psychological testing and assessment; lifestyle and career development; supervised practicum and internship, to list a few, and introducing supervisory theories and intervention (CACREP, 2016).

Within this model, the academic program contains two sections. The first CACREP required section is for all individuals pursuing a counselor or mental health degree. This course comprises of general information exploring clinical supervision theories and interventions. Individuals who are interested in pursuing a clinical supervision license would engage in the CACREP required advanced course. This comprehensive course builds and the knowledge from the previous sequence as it integrates all other clinical supervision theories, models, interventions, practices in all recovery-oriented systems and administrative duties of a supervisor.

Post-course completion phases

The post-course completion phases hold consultation as a cornerstone to the model and require consultation for the life of the supervisor actively functioning under any professional capacity. To ensure adequate cultivate of the supervisor’s identity development, the professional acculturation emerging through guided participation of consultation would be used. By obtaining consultation the clinical supervisor gains advanced competency through ongoing feedback and guidance throughout their professional career (Henderson,1994). The responsibility of administering and enforcing consultation requirements will be given to the individual’s governing mental health and substance abuse board organizations, as part of the continuing education units, mandatory for licensure recertification.

Below is the other component of the circular supervision model being the proposed phases of supervision progression:

Phase one – Simulation (1-2 years)

New to the field supervisors would try to mirror theory academia counseling based on sheltered experiences through a process called *simulation*. Individuals in this phase have one to two years of post-graduate experience. The supervisor has selected a supervision model and is functioning under its theoretical approach. While working to develop a solid sense of supervisory identity, within this model, the supervisor is met with conflict and also disappointment as the selected model is not applicable to all situations. It is during this timeframe that the realization occurs that supervision inside of the classroom offers an academic snapshot of the outside world but it does not account for the unpredictability that is common through experiences only. Still striving for proficiency, the supervisor seeks consultation more frequently to help mitigate feelings of conflict. Subsequently, there is a noticeable misconception, stemming from simulation, that because the supervisor has received increased consultation, which can serve to model supervision, the supervisor gains a false sense of know-how. Although these previous experiences are enriching as it comprises of a reasonable facsimile, it does not adequately reflect the true perspective of what it is to be a supervisor, as the individual is on the receiving end of the intervention and not administering it. The supervisor’s knowledge is more like mimicking than a true implementation of knowledge-based skills.

Phase two- Supposition (2-4 years)

Once coming to terms with the misconception and disappointment caused by the unrealistic expectations from the sanitize theoretical perspective to the unpredictability of real-world supervising, the supervisor transitions into the *supposition* phase. Individuals in this phase have two to four years of experience as a clinical supervisor. This phase may cause the supervisor to encounter further feelings of uncertainty and may view clinical supervision with epistemic hesitance. This may be as a result of forming pressures to demonstrate competency within their selected supervision model with limited success. The natural cue to broaden the supervisory scope begins within this phase. The supervisor assumes greater responsibility for the content of supervision and learns how to be a self‐supervisor (Bernard & Goodyear, 2004). The supervisor becomes more experimental as the supervisor exposure to other supervision models increase. As the supervisor re-engage other supervision models and practice their interventions in the context of real-world supervision the feelings of supposition dissipate, transitioning them out of this phase.

Phase three- Reformulation (4-6 years)

The *reformulation* phase is characterized by a sense of clinical competencies. The supervisor has the capacity to flow in and out of supervision models. There is an ease of application, employing the appropriate interventions, seamlessly, from different models to enhance treatment outcomes and ensure best practice. The supervisor’s evolution may advance to a feeling of confidence in a specific model or an amalgamation of several models, here there is a clear reformulating of models and intervention utilization as it applies to practical implementations. Individuals in this phase have four to six years of experience. Other characterization of this phase includes the supervisor’s cemented sense of self and the supervisor’s eagerness to cultivate the counselor identity within their supervisee.

Phase four- Synthetization (6-8 years)

While in this phase, the supervisor’s wide range of experiences, allow for feelings of establishment in the field. Individuals in this phase have six to eight years of experience and have succeeded in *synthesizing* their position as a supervisor. There is also a heightened feeling of confidence in the selection of supervision model(s) and the supervisor’s ability to nurture future supervisors within the profession. The characterize features of this phase is the supervisor’s aptitude to influence politicians, public officials and other colleagues on issues impacting the mental health field through lobbying. The supervisor would have encountered several different supervisees from different clinical settings and cultural aspects which would allow for convenience sampling, data collection, and observation of professional gaps in service. The supervisor is open to investigating limitations to supervision and its interaction with the law and ethics, for example. This is accomplished by the supervisor’s willingness to offering leadership and advocacy contributions. There is now a desire to transcend this supervisory position to become a macro influencer.

Phase Five- Possession (8- 9 years)

Individuals in this phase have eight to nine years of experience and there are actively contributing to the clinical profession by conducting research and developing their own supervisory models. With the supervisor’s desires to conduct research, engage in scholarly writing, and overall contribution to the field’s knowledge and skills, the sense of *possession* becomes clearly defined. Through the supervisor’s work, there is the encouragement to build clinical teams, create cohesion, resolve conflict, and shape agency culture, while attending to ethical and diversity issues in all aspects of the process (Pearson, 2004). The supervisor’s work may lead to quality improvement and the successful implementation of consensus and evidence-based practices (Center for Substance Abuse Treatment, 2009)

Phase Six- Solidification (9 -10 years)

It is said that; you never really learn something until you teach it. Individuals in this phase have nine to ten years of experience. The highlight feature of the phase is the return to some form of academia to teach the future paraprofessionals, counselors, supervisors, researchers and macro influencers. Additionally, supervisors are recommended to positively enrich the field through conference presentations. It is here learning truly becomes a circle and here we find definition of the name of the model.

Role of the supervisor

The crucible specialty of supervision is the cornerstone necessary to the counseling profession as it is noted within the circular supervision model. The role of the supervisor in the model is to ensure client care, the upholding of ethical standards, as well as, the personal and professional development of its clinical junior clinical staff through preceptorship, apprenticeship, mentorship, sponsorship and peer-ship relationships (Pearson, 2006; Graham, Scholl, Smith-Adcock, & Wittmann, 2014; Center for Substance Abuse Treatment, 2009). Regardless of the type of functioning, the supervisory responsibility of the model remains the same. These duties include monitoring the quality of professional services offered and serving as a gatekeeper of the profession (Bernard & Goodyear, 2003, p. 9). The supervisor would use their experience and objective professional approach to help mitigate the potentially adverse effects of countertransference, compassion fatigue, and burnout (Pearson, 2004).

Advantages of the circular model

The primary strength of the circular supervision model is that it engages all existing supervision model interventions and emphasize the collaborative nature of the model. The circular supervision model offers adaptability through liberation as it interacts with all of the other supervisory models. Its ability to employ such techniques as modeling, role-playing, feedback, reinforcement, experiential engagement, managing rumination, intentional narrative, reducing emotional labor, individualized goal-setting, and evaluation for the purpose of teaching counseling skills, ensures best practice. Another strength of this model is that at any point the supervisor can re-engage a phase without it feeling like a regression to an earlier stage in the developmental process.

Limitation

 According to the Ethical Guidelines for Counseling Supervisors, established by the Association for Counselor Education and Supervision, articulates that the supervisor should inform the supervisee of the model of supervision that will be utilized in the supervisory process (ACES, 1995; Corey & Moulton, 2003). The Circular supervision model does not expressly require the articulation of a specific model as several of the phases includes experimentation and the discovery of all supervision models.

 Moreover, this model is newly developed and has yet to have the opportunity to be peer-reviewed. A apprehension for the advancement of the research process is that, even if, this model was to obtain the endorsement of supervisory peers and the support of the Mental Health, Developmental Disabilities and Substance Abuse (MHDDSAS) professional agencies and organizations, clinical supervision is not mandated by state, discipline and associations (Herlihy et al., 2002).

Conclusion

The circular supervision model makes suggestions to move the field forward by integrating clinical supervision into all recovery-oriented systems of care. This requires the increase of the clinical supervision value amongst policy makers, administrators, supervisors, and direct-line staff; retooling staffing patterns to support the provision of clinical supervision as a primary responsibility; and including a clinical supervisor certification (Herlihy et al., 2002). This is accomplished through the seamlessly incorporates education and practical implementation outlined the by circular supervision model.

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Appendix: Circular supervision model six phases diagram.