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SUPERVISION

Cohesive model of supervision: An empirically based approach

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Abstract
Supervision models are fundamental to our supervision practices and criticized for lacking empirical support. As a data-driven approach based on research with expert supervisors, Cohesive Model of Supervision unifies existing models' central premises in a meaningful manner and emphasizes the understated areas of supervision practice.

KEYWORDS
conceptualization, doctoral preparation, empirically based model, ethical and legal issues, supervision

INTRODUCTION

Numerous scholars have studied clinical supervision over the last 40 years, solidifying the purpose and goals of supervision practices. As part of those efforts, some have identified supervision competencies (e.g., Neuer Colburn et al., 2016) and best practices across disciplines and among helping professionals, including counseling (Association for Counselor Education and Supervision [ACES], 2011; Borders et al., 2014), psychology (American Psychological Association [APA]), and social work (American Board of Examiners in Clinical Social Work, 2004). Borders (2014) clarified that both competencies and best practices are key to quality clinical supervision practice and training, and although they should be considered complementary, competencies offer *what* a competent supervisor needs *to know*, and best practices describe *what a supervisor does* during supervision (p. 3). Neither competencies nor best practices, however, offer us the answers for *how to* conduct clinical supervision.

At the root of the efforts to determine competencies and best practices for clinical supervision, models emerged as the backbone of effective supervision practices. Scholars have criticized supervision models for being based primarily on the theoretical approaches and clinical opinion and experiences of their authors, thus lacking empirical support and conceptual comprehensiveness (e.g., Ellis & Dell, 1986; Holloway, 1987; Milne & Reiser, 2012). Yet, models are also deemed to be informative tools for training supervisors and could be researched more thoroughly to create the

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necessary evidence-base (Bernard & Goodyear, 2019). Bernard and Goodyear also identified four main categories of supervision models: (1) psychotherapy-based, (2) developmental, (3) process, and (4) second-generation. The development and progress of supervision practice is discernable across the chronological presentations of these categories; each offers us a wide array of supervisory focus and practice, filling in the gaps previous models failed to address. For example, psychotherapy-based models focused on the supervisees' personal world and abilities, while being criticized for blurred boundaries between counseling and supervision and limiting supervisees' practice to one theoretical focus of therapy (Bernard & Goodyear, 2019). Developmental models expanded the focus of supervision by emphasizing supervisees' professional development needs in a pantheoretical manner, but they focused minimally on supervisees' individual characteristics (e.g., learning styles) and the supervision process (Corey et al., 2010). As supervision is both educational and relational, scholars subsequently focused on the processes of supervision in the third category of models.

Due to the nuanced and idiosyncratic nature of clinical supervision, none of these models could be applied on their own to address all the necessities of supervision (Bernard & Goodyear, 2019). Thus, second-generation models attempted to tackle limitations of previous models by blending models across categories, expanding on underemphasized areas (e.g., supervisees' multicultural competence as well as social justice advocacy, attachment to supervisors), and observing common factors across all good supervision practices (e.g., Bernard & Goodyear, 2019). Supervisors are increasingly turning to empirically based approaches, integrating the common aspects of existing models, to inform their supervision practice. Watkins (2017) reported 50 clinical supervision commonalities grouped in nine areas, building bridges across models, and detailing a trans-theoretical understanding of supervision practice. Still, neither Watkins's report nor other common factors models were based on empirical data. Although seasoned supervisors may be able to integrate common factors and shift gears between various supervision models in practice, I have observed beginning supervisors often feeling overwhelmed by the number of supervision topics presented by the current supervision models. To advance supervision pedagogy and supervisor training, comprehensive, integrated, and systematized descriptions of supervision practices that are evidence-based are warranted to develop empirically supported clinical supervision practices.

In this article, I present a cohesive and data-driven approach to supervision practice based upon results from three empirical studies conducted on expert and seasoned supervisors' supervision cognitions. The proposed model unifies existing supervision models' key premises in a meaningful manner, while uniquely highlighting the underemphasized areas of supervision practice. Representing declarative, procedural, conditional, and conceptual knowledge (Ambrose et al., 2010) structures of expert supervisors, the Cohesive Model of Supervision (CMS) exemplifies the complementary nature of supervision competencies and best practices.

METHODS

Research-base for the Cohesive Model of Supervision (CMS): concept mapping

The CMS is based on three empirical studies involved separate samples of expert supervisors' supervision cognitions (Kemer, 2020; Kemer et al., 2014, 2017). In all three studies, I utilized Concept Mapping (CM; Kane & Trochim, 2007), an exploratory sequential mixed-methods design, to examine the knowledge structures of expert supervisors (Kemer, 2020; Kemer et al., 2014, 2017). Being considered as a community-engaged and action research design (Thompson & Burke, 2020), CM emerged from education, public health, and organizational psychology field research (Kane & Trochim, 2007). Particularly peaking counseling scholars' attention in the last two decades (e.g., counseling alliance, Bedi, 2006; moral commitment, Pope & Cashwell, 2013), CM is an ideal design for theory development and program planning and evaluation research to form a common framework that represents ideas and/or experiences of diverse groups of stakeholders.

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CM includes six steps: (1) preparation, (2) generation of statements, (3) structuring of statements, (4) representation of statements, (5) interpretation of maps, and (6) utilization of maps (Kane & Trochim, 2007). Per CM procedures, researchers involve stakeholders in the process of developing (Steps 1 and 2), structuring (Steps 3 and 4), and finalizing the data (Steps 5 and 6) to ensure testimonial (Bedi, 2006) as well as internal and external representational validity (Rosas & Kane, 2012), which are critical premises (trustworthiness/validity) of CM research, safeguarding stakeholders' voice in the results than researchers' perspectives and/or perceptions of the data. Being optional, Step 6 was beyond the scope of the three studies' research questions, whereas current development study of CMS is a collective utilization of the three concept maps obtained from the studies (Kemer, 2020; Kemer et al., 2014, 2017). I offer brief descriptions for the study procedures as well as collected data leading up to CMS below.

Steps 1 and 2: preparation and generation of statements

In all three studies, preparation (selection of the participants and development of study focus) was the core of research procedures. Expertise in ill-defined fields, like clinical supervision, can be elusive (Tracey et al., 2014). Thus, the selection of *expert supervisors* (inclusionary criteria) was particularly critical for the targeted expertise and credibility of the results. Besides being diligent with defining and selecting experts from both academic and field settings, focus and prompt of the studies (e.g., *One specific thing I think about in planning for, conducting, and evaluating my supervision sessions is…*) aimed at obtaining a comprehensive picture of expert supervisors' supervision considerations. In each of the three studies, Institutional Review Board approvals were obtained prior to data collection.

A total of 39 expert supervisors of academe and site supervision (26 counselor educators, 12 counseling psychologists) participated once across the three concept mapping studies (Kemer, 2020; Kemer et al., 2014, 2017). With an average of 22.64 years of supervision practice, 29 academe experts from the two studies (Kemer, 2020; Kemer et al., 2014) conjointly published 32 books (not including different editions), 145 book chapters, and 464 peer-reviewed articles; provided 739 professional presentations and 134 workshops; and received 156 awards and/or award nominations on supervision and/or counselor training. For expert site supervisors, I sought out nominations from faculty (e.g., university supervisors) and supervisees in Arizona (see Kemer et al., 2017). Ten expert site supervisors reported an average of 8.75 years of supervision practice, all held master's degrees in counseling, and four also had doctoral degrees in counseling psychology, holding a variety of professional credentials (e.g., licensed professional counselor and licensed psychologist) and practicing at community mental health and college counseling center settings. Across the 3 studies, expert supervisors generated a total of 571 supervision cognitions; 195, 167, and 209 statements, respectively (Kemer, 2020; Kemer et al., 2014, 2017).

Steps 3 and 4: structuring and representation of statements

In each study, next, expert supervisors (individually) organized the statements into conceptually meaningful groups. Supervisors' groupings of the statements were aggregated to obtain group similarity matrices (GSMs) as inputs to run two-dimensional, nonmetric multidimensional scaling (MDS) analyses, yielding point maps unique to each study. In all three studies, stress values for the two-dimensional MDS solution fit were within the range of obtained values in nearly 95% of CM studies (i.e., 0.205–0.365; Kane & Trochim, 2007), while staying below 0.396 to have robust outcomes (Sturrock & Rocha, 2000). Using the coordinate values for the statements from the MDS solutions, hierarchical cluster analyses resulted in dendrograms representing clusters of statements. In research teams, we utilized the point maps and the dendrograms to obtain statistically driven and

conceptually meaningful preliminary clusters and maps for each of the datasets to be interpreted and finalized in the last step, focus group.

Step 5: interpretation of maps—focus groups

Samples of expert supervisors in each study attended a focus group to review, examine, and finalize the clusters and regions/areas (clusters of clusters on the concept map). More specifically, I asked the participants to "(a) engage in dialogue on the reasonableness of statements in each of the preliminary clusters, (b) discuss the appropriateness of the labeling of each cluster, and (c) view all clusters and their locations on the map to look for areas of conceptually meaningful groups of clusters" (Kemer, 2020, p. 80). Across the 3 studies (Kemer, 2020; Kemer et al., 2014, 2017), experts finalized different numbers of clusters (25, 15, and 27, respectively) and areas (5, 3, and 3, respectively) representing major areas of experts' supervision cognitions and practices, revealing an almost identical underlying organization for expert supervisors' cognitions in conducting clinical supervision. For detailed descriptions of the CM methodology, samples, and results, readers can refer to the original sources (Kemer, 2020; Kemer et al., 2014, 2017).

Development of CMS via content analysis

To develop the CMS, I conducted a content analysis procedure utilizing the data and results obtained from the three studies. Content analysis is "a research technique for making replicable and valid inferences from texts (or other meaningful matter) to the contexts of their use" (Krippendorff, 2012, p. 24). As the three CM studies offered me frameworks that were very similar, I followed a *directed content analysis* paradigm in the current study (Hsieh & Shannon, 2005). According to Hsieh and Shannon, in directed content analysis, the codes or coding frame could be derived from theory or relevant research findings while being defined before and during analysis. As the coding frame (areas and clusters) as well as the units of analysis (respective statements) in the three studies were already established by each study's participants, the goal of the current content analysis was to align three frameworks adhering to the original findings. Two researchers involved in the data analysis process, where I served as the coder and other researcher was the auditor. Being familiar with two of the datasets from the previous three studies, the auditor was a full professor of counseling and counselor education with an expertise in clinical supervision and a substantial record of clinical supervision scholarship.

Examining the three frameworks, first, I reviewed the clusters (groupings of statements represent expert supervisors' cognitions) and the main areas (groupings of similar clusters) across the three concept maps for commonalities. Although similar at the cluster-level, three main areas were present in two of the maps (Kemer, 2020; Kemer et al., 2017), whereas the other map presented the clusters in five main areas (Kemer et al., 2014). Upon completing a detailed review, I observed the five-area framework to be more comprehensive and thorough for the general CMS framework (coding frame). Next, I merged conceptually similar clusters across the three datasets and kept the unique ones as separate clusters. As part of this process, I merged some of the statements to conceptually appropriate clusters, following the results from the original studies. Then, I sent the original and merged datasets to the auditor to review each cluster along with the statements from all three datasets. They made a wide variety of comments and observational points, with suggestions to move statements from one cluster to another, merge clusters, and reword some of the cluster labels. Out of 549 statements, the auditor made 27 specific suggestions to move statements to different clusters, marking the interrater reliability (consensus) between the two of us at 95%. Based on the auditor's comments, I agreed to move 15 of the 27 suggested statements. Per auditor's comments, I also revised the labels of eight clusters and merged four clusters to create a new cluster that represented a similar theme. I named

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each cluster in the final solution to represent the respective statements, utilizing original cluster labels. Finally, the auditor reviewed the final cluster solution, which included 5 main areas with 14 clusters and 20 subclusters, forming the conceptual map of the CMS (see Figure 1).

RESULTS

Cohesive model of clinical supervision (CMS)

Expert supervisors' clinical supervision cognitions were represented in five main areas of supervisory practice: (1) assessment of supervisees and their practice, (2) supervisory relationship, (3) conceptualization and interventions of supervision, (4) supervisors' self-assessment and reflection, and (5) administrative/logistical considerations of supervision. Each area included a variety of clusters, with subclusters in Areas 1 and 3 that also addressed different aspects of the specific supervision area. The areas and clusters of the CMS are distinct but interrelated, demonstrating that supervisors can focus on certain areas separately, yet continuously utilize all areas interactively for a thorough and comprehensive assessment of the supervisee, relationship progress, and supervisory process. See Table 1 for the overview of areas, clusters, subclusters, and subthemes of the CMS.

Area 1: assessment of supervisees and their practice

In the first area, supervisor assesses the supervisee through a comprehensive lens. Fundamental to all other areas of the model, this area establishes the basis of supervisor's work. Via their assessment of the supervisee, supervisor plans for, conducts, and reflects on supervision as they continue to reassess and reinform the supervisory process. This area targets two main presentations of the supervisee: 1A. supervisee's professional performance and 1B. supervisee's personal functioning. Supervisee's Professional performance cluster includes 12 subclusters that assess for a range of skills and dispositions that are integral to effective counseling practice with clients. Supervisee's Personal Functioning cluster involves important personal qualities of the supervisee that may not only affect their counseling practice but also the supervisory process. See Table 2 for detailed descriptions for each of the clusters and respective subclusters.

Area 2: supervisory relationship

In the second area, supervisor observes the supervisory relationship as a bridge between assessment of the supervisee and their work, and conceptualization and interventions of supervision areas, as they continuously assess, intervene, and reassess the relationship. Supervisory relationship area involves four main relationship considerations of the supervisory process: 2A. supervisor's assessment and experience of the relationship, 2B. supervisor's promotion of an open and supportive relationship, 2C. supervisor's establishment of a collaborative relationship, and 2D. supervisor's efforts to prepare for and address the barriers of the relationship. See Table 3 for detailed descriptions for each of the clusters.

Area 3: conceptualization and interventions of supervision

In this area, supervisor starts, structures, and informs their supervisory conceptualization and interventions based on the assessment and observation points from the first two areas. This area presents to supervisors with not only *what* to do but also *how* to do those in supervision. The area outlines and

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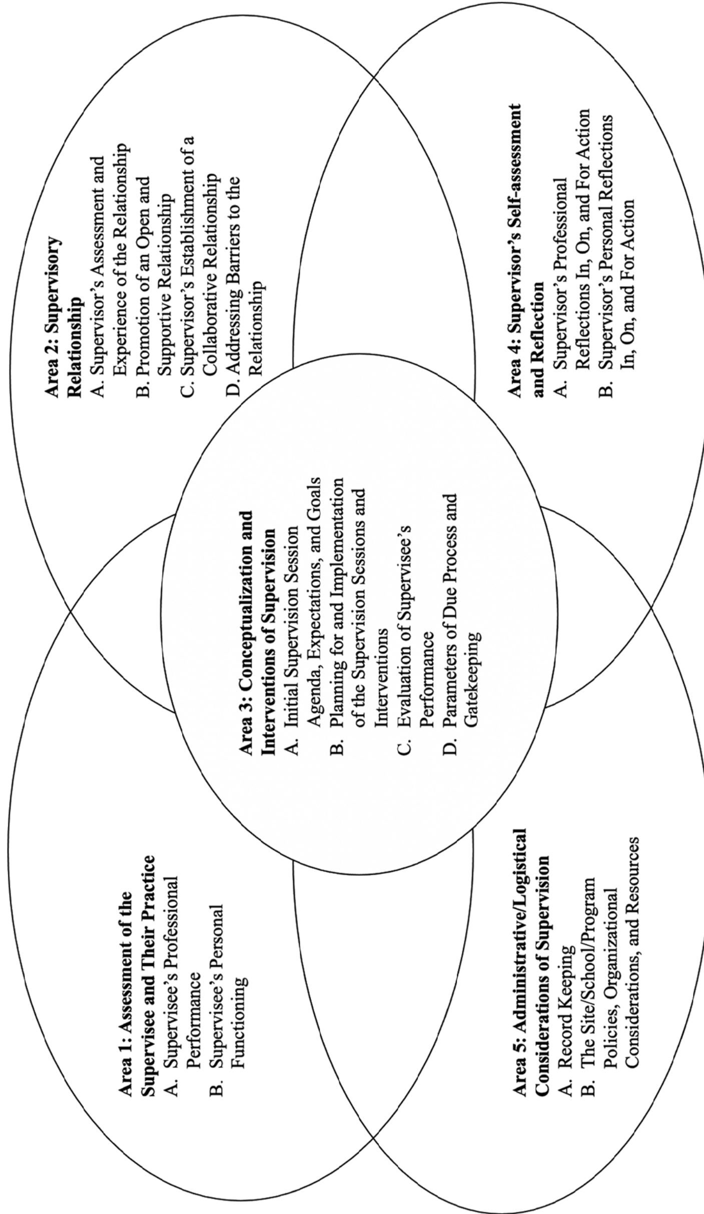

FIGURE 1 Conceptual map for cohesive model of supervision (CMS).

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TABLE 1 Overview of cohesive model of supervision (CMS)'s areas, clusters, subclusters, and subthemes.

Area 1: assessment of the supervisee and their practice
A. **Supervisee's professional performance**
1. The client and the counseling session
2. Supervisee's basic and advanced counseling skills
3. Supervisee's counseling relationship skills
4. Supervisee's theoretical knowledge and inclinations
5. Supervisee's assessment, diagnoses, and conceptualization skills
6. Supervisee's intervention skills
7. Supervisee's multicultural skills
8. Supervisee's developmental level, goals, and needs
9. Supervisee's systemic and organizational awareness
10. Supervisee's ethical and professional skills and behaviors
11. Supervisee's self-reflective practice
12. Supervisee's responsiveness to supervision and feedback
B. **Supervisee's personal functioning**
1. Supervisee's intrapersonal and cognitive-emotional qualities
2. Supervisee's cultural make-up
3. Supervisee's self-awareness
4. Supervisee's self-care and wellness
Area 2: supervisory relationship
A. **Supervisor's assessment and experience of the relationship**
B. **Supervisor's promotion of an open and supportive relationship**
C. **Supervisor's establishment of a collaborative relationship**
D. **Supervisor's efforts to prepare for and address the barriers of the relationship**
Area 3: conceptualization and interventions of supervision
A. **Initial supervision session agenda, expectations, and goals**
B. **Planning for and implementation of the supervision sessions and interventions**
1. Managing the supervision session
2. Planning supervision interventions for assessment and growth
3. Choice points/in-session intervention decisions needing immediate attention
4. Facilitation of specific areas of supervisee's growth
a. Assisting supervisee with expanding their counseling, client conceptualization, and treatment skills
b. Facilitation of supervisee's multicultural awareness and competencies
c. Assisting supervisee with developing reflective counseling and supervision practices
d. Facilitation of supervisee's self-awareness
C. **Evaluation of supervisee's performance**
D. **Parameters of due process and gatekeeping**
Area 4: supervisor's self-assessment and reflection
A. **Supervisor's professional reflections in, on, and for action**
B. **Supervisor's personal reflections in, on, and for action**
Area 5: administrative/logistical considerations of supervision
A. **Record keeping**
B. **The site/school/program policies, organizational considerations, and resources**

details four main clusters: 3A. initial supervision session agenda, expectations, and goals, 3B. planning for and implementation of the supervision sessions and interventions, 3E. evaluation of supervisee's performance, and 3D. parameters of due process and gatekeeping. Planning for and implementation of the supervision sessions and interventions cluster also outlines four subclusters one of which with four specific subthemes. See Table 4 for detailed descriptions for each of the clusters and respective subclusters as well as subthemes.

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TABLE 2 Area 1: assessment of the supervisee and their practice.

1A. Supervisee's professional performance **The supervisor uses a comprehensive lens to assess the supervisee's developmental progress based on the target areas in each subcluster**	
1. The client and the counseling session	*With the supervisee, the supervisor explores the supervisee's cases and work with clients, including the*: • Clients' psychosocial history, presenting symptoms level of functioning, welfare, safety, risk, and need for referrals • Clients' cultural backgrounds, intersections of identities, and values on presenting concern • Clients' strengths, blind spots, and investment in counseling • Supervisee's history with clients, including clients' progress across sessions and where the supervisee may be stuck or flowing with their clients during sessions
2. Supervisee's basic and advanced counseling skills	*Supervisor assesses the supervisee's appropriate and consistent use of*: • Basic counseling skills (e.g., open-ended questions, reflections of content, paraphrases, reflection of feelings, and summarizing) • Nonverbal responses (e.g., body language, voice tone, and voice inflection) • Advanced counseling skills (e.g., confrontation, immediacy, interpretation, and self-disclosure) • Session management skills (e.g., opening, closing, and pacing) skills
3. Supervisee's counseling relationship skills	*Supervisor assesses the supervisee's insight, abilities, and attitudes pertaining to the nature of counseling relationship and the supervisee's ability to* ***work with*** *their clients by observing different dynamics of the counseling sessions, including*: • Creating a safe therapeutic container for clients • Collaborating with clients through building rapport and working alliance • Setting and maintaining appropriate boundaries • Holding an awareness of here-and-now as supervisees engage and intervene in the present moment and discuss the process of counseling with clients • Efforts to balance power with clients by rolling with resistance and effectively addressing impasses and ruptures, as well as potential transference and countertransference issues
4. Supervisee's theoretical knowledge and inclinations	*Supervisor assesses supervisee's theoretical inclinations and knowledge, as they explore how supervisee's orientation may inform client's representation of events and supervisee's conceptualization*
5. Supervisee's assessment, diagnoses, and conceptualization skills	*Supervisor assesses supervisee's ability to take various factors into consideration to diagnose and inform the treatment planning, including*: • Developing insight into client's strengths and problems based on intake and their theoretical angles • Conceptualizing the client's *actual problem*, while taking other factors, such as family, intergenerational/current trauma, and particularly cultural makeup of the client • Aligning assessment, diagnosis, and treatment planning
6. Supervisee's intervention skills	*Supervisor focuses on supervisee's ability to articulate*: • Their treatment knowledge and understanding of empirically supported treatment planning • The reasons for utilizing and consistent application of interventions to address treatment goals • Use of strategies to measure treatment effectiveness and progress
7. Supervisee's multicultural skills	*Intersecting with all areas of supervisee's performance, supervisor assesses not only supervisee's demonstrations of multicultural and advocacy competencies, but also willingness to address cultural factors in counseling*
8. Supervisee's developmental level, goals, and needs	*Besides supervisee's own learning goals for the time of supervision, supervisor assesses for the strengths and potential growth areas, and the goals they observe supervisee needs to pursue, including*: • Whether the supervisee's performance is consistent with what they would expect based on supervisee's experience level (e.g., past counseling experiences and duration of those experiences) • Supervisee's growth toward the goals throughout the time of supervision with a specific attention to counselor identity development

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TABLE 2 (Continued)

1A. Supervisee's professional performance **The supervisor uses a comprehensive lens to assess the supervisee's developmental progress based on the target areas in each subcluster**	
9. Supervisee's systemic and organizational awareness	*Supervisor assesses supervisee's knowledge and understanding of structure, policies, and other important considerations (e.g., client profile and resources) of the organizations they work within (e.g., clinical mental health agencies, hospitals, and schools) and insights into working within these organizations with other stakeholders (e.g., other helping professionals, parents, and teachers)*
10. Supervisee's ethical and professional skills and behaviors	*Supervisor assesses supervisee's professional attitude and behaviors by focusing on what would be ethically and professionally expected of a supervisee (e.g., attendance to ethical and legal guidelines, standards of client care, immediate client needs, client advocacy, resources, and appropriate referrals), including*: • Supervisee's ability to attend to informed consent, confidentiality, duty to warn, and other ethical dilemmas • The quality, accuracy, and timeliness of supervisee's documentation and record keeping (e.g., session notes, tracking direct/indirect hours) • Supervisee's interactions with peers and other health professionals and staff, particularly ability to set boundaries with clients and other professionals
11. Supervisee's self-reflective practice	*Supervisor assesses supervisee's willingness and ability to reflect on their professional performance and personal reactions, including*: • Self-assessment and accuracy of those assessments in terms of their metacompetence level (ability to assess what they know and do not know) through their identified challenges with the sessions, feelings about their work (e.g., confident and shameful), and desire to engage in ongoing clinical learning • Reflections in- and on-action (Schön, 1987), such as being able to recognize potential countertransference with client/s within or after a counseling session
12. Supervisee's responsiveness to supervision and feedback	*Supervisor assesses supervisee's response and willing to engage in the supervision process, including supervisee's*: • Personal style of receiving feedback as well as their *buy in* to the supervision process evidenced by their openness, preparation for supervision, and promptness and attendance in supervision • Feelings, thoughts, behaviors, and nonverbals as well as satisfaction as they receive feedback • How ready supervisee is for challenging feedback (e.g., to address the cultural factors and discuss the supervisory relationship) • View of the supervisor, specifically perceptions of their competencies as a supervisor, or whether supervisee is offering useful information for supervision or storytelling and checking a box
1B. Supervisee's personal functioning **Supervisor assesses supervisee's personal characteristics that may be directly enhancing and/or impeding their professional performance**	
1. Supervisee's intrapersonal and cognitive-emotional qualities	*Supervisor assesses for supervisee's developmental level as a person (e.g., cognitive, emotional, and moral) and personal ability to steer themselves toward growth, including supervisee's*: • General maturity level (e.g., genuineness), emotional stability (e.g., anxiety and stress), and affective attunement • Attitudes about professional practice (e.g., confidence, passion, and motivation) and personal growth (e.g., willingness to self-examine, take risks and/or to step outside of their comfort zone, and engage scholarly resources for evidenced-based practices) • Ability to operate independently
2. Supervisee's cultural make-up	*Supervisor focuses on supervisee's cultural background relevant to their practices, including*: • Their identities and intersections of those (e.g., age, gender, race, ethnicity, sexual orientation, SES, and religiosity) • Personal and cultural values

(Continues)

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TABLE 2 (Continued)

1B. Supervisee's personal functioning Supervisor assesses supervisee's personal characteristics that may be directly enhancing and/or impeding their professional performance	
3. Supervisee's self-awareness	*Supervisor assesses for supervisee's personal/internal stance and reactions to the clients, specifically patterns in supervisee's counseling sessions in terms of their self-identified and unidentified challenges including*: • Potential blind spots, biases, judgments/criticisms • Urges to impose their beliefs on the client/s • Attachment style in relation to interpersonal triggers evoked by their clients, and tendencies to take client's distress, challenges, or criticisms personally
4. Supervisee's self-care and wellness	*Supervisor attends to supervisee's wellness by exploring what they do to self-care, and how they are managing their stress and limitations*

Area 4: supervisor's self-assessment and reflection

Supervisor also assesses and reflects on their own professional performance and personal functioning in a detailed manner to inform their practices. This area represents two main clusters: 4A. supervisor's professional reflections in, on, and for action and 4B. supervisor's personal reflections in, on, and for action. See Table 5 for a detailed outline for each of the clusters.

Area 5: administrative/logistical considerations of supervision

Supervisor pays attention to administrative aspects of the supervisory work with variations based on the supervisory setting. This last area has two main clusters: 5A. record keeping and 5B. the site/school/program policies, organizational considerations, and resources. See Table 6 for the presentation for each of the clusters.

DISCUSSION

CMS is the first empirically based pantheoretical supervision model voicing expert supervisors' cognitions when providing and reflecting on their supervision practices. CMS offers a logical sequence of supervisor's assessment, conceptualization, planning, and intervention, yet is not a stage model. Each of the area considerations continuously recur throughout the supervisory contract as the supervisor tailors their supervision to address supervisee's needs and setting necessities. Including all nine common areas observed across the supervision models (Watkins, 2017), CMS unifies existing supervision models and literature in a systematized way. CMS particularly overlaps with the ACES Best Practices (Borders et al., 2014) and APA Guidelines for Clinical Supervision (APA, 2014). Such overlaps were not surprising as both ACES Best Practices and APA Guidelines for Clinical Supervision were created through comprehensive reviews of supervision research and literature. However, further operationalizing the best practices and competency guidelines, CMS also conceptualizes them in a concise and simpler structure. In this simplified organization of complex supervision work, the model translates the existing knowledge of supervision into a process- and action-oriented presentation, almost resembling the counseling process. Specifically, CMS provides us with a supervisory process, based on continuous assessment where the supervisor not only focuses on the supervisee and the supervisory relationship, but also scrutinize their own professional performance and personal responses as they inform their clinical and administrative supervision work. Although CMS sheds light on *what* (declarative knowledge), *how* (procedural knowledge), and the elaboration on *what* and *how* continuum (conditional

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TABLE 3 Area 2: supervisory relationship.

2A. Supervisor's assessment and experience of the relationship

Supervisor observes the supervisory relationship and their experience of the supervisee to better assess and understand the supervisee and their needs by

- Utilizing themselves and the relationship as tools of supervisory assessment and intervention as they explore the quality of rapport and their working alliance with the supervisee, and the matches and mismatches between the supervisee and themselves (e.g., clinically and personally)
- Assessing power and diversity considerations (e.g., age, gender, race, ethnicity, sexual orientation, privilege, and oppression) and how much these have been addressed in supervision, as they may be affecting the relationship and supervisee's learning
- Observing supervisee's verbal and nonverbal responses in supervision to understand supervisee's engagement, transparency, genuineness, defensiveness, and/or emotional residues from counseling sessions
- Attending to how they experience the supervisee personally in the here-and-now of the supervisory relationship
- Looking deeper into supervisee's potential transference and reactions to (e.g., intellectualization) as well as perceptions and expectations of the supervisor
- Paying attention to supervisee's presentations of their relationship with the other supervisors (e.g., triangulation)
- Assessing how they and the supervisee interact over these observations, particularly exploring the parallel processes between the counseling and supervision sessions of the supervisee to make informed supervisory decisions (e.g., how much autonomy to offer to the supervisee)

2B. Supervisor's promotion of an open and supportive relationship

To create an open and supportive environment, supervisor pays detailed attention to the supervisee and themselves as the supervisor, and the ongoing process of supervision from the beginning until the end by

- Starting the supervisory relationship with a special focus on building trust and working alliance by broaching the differences between them and the supervisee
- Creating an open environment for the supervisee to talk about and explore how their identities (e.g., gender, race, ethnicity, socioeconomic/social class [growing up and current], sexual orientation, positionality of privilege, ability, religious/spiritual beliefs, language, nationality, worldviews, and values) and intersections of those may influence the processes of counseling and supervision
- Engaging in continuing discussions of multicultural considerations by allowing a safe space for expressing biases and prejudices that may affect supervisee's work with clients
- Maintaining a strong empathic connection with the supervisee by
  - Providing a supportive and encouraging environment (e.g., regularly listening to and addressing their concerns, pointing out positive skills and promoted change with clients)
  - Remaining calm and reassuring as they observe supervisee struggling
  - Delivering feedback (positive or negative) in the most direct, constructive, and kind way possible
  - Supportively challenging them to be intentional in their work with clients as they build their own voice and style
- Demonstrating willingness to take ownership of their mistakes and discusses those with the supervisee to show and model humility

2C. Supervisor's establishment of a collaborative relationship

Supervisor shares their power with the supervisee by involving them as an equal partner of a collaborative process by

- Not only developing and negotiating on the clinical goals but also evaluating the progress toward those goals with the supervisee
- Being diligent about teaching and counseling (e.g., keeping them limited to the therapeutic context) as minimal as possible
- Not wearing the expert hat, allowing the answers to flow from the supervisee, and letting them be the expert of their own experiences with the clients
- Asking supervisee what has been most helpful and what they might like to be different as supervision progresses, and being willing to trust the supervisee and the supervisory process

2D. Supervisor's efforts to prepare for and address the barriers of the relationship

Supervisor assesses and prepares for potential challenges with the supervisee and deals with those roadblocks in supervision by

- Practicing preventive preparation during the initial supervision sessions and addressing the power issues inherent to the hierarchical nature of supervisory relationship
- Broaching the issues of culture, diversity, and privilege within the supervisory and counseling relationships
- Monitoring for supervisee's anxiety and resistance, and self-care

TABLE 4 Area 3: conceptualization and interventions of supervision.

3A. Initial supervision session agenda, expectations, and goals	
Supervisor builds the foundations and parameters of the supervisory process and plans in accordance with the length of supervisory contract. Some of the main tasks of this initial session includes: • Introducing themselves and their professional background • Presenting expectations of supervision through a syllabus or a contract • Explaining typical structure of supervision sessions • Clarifying the roles and responsibilities of as well as collaboration among the involved supervisors of the supervisee • Exploring supervisee's expectations of supervision • Reviewing all supervision documents, crisis/emergency plans, and when and how to contact the supervisor in the case of an emergency • Overviewing unique challenges in supervision, such as boundaries of counseling in supervision, and how exploration of supervisee's personal issues affecting their professional performance is part of the supervisory process • Encouraging the supervisee to set three goals • Planning how to create a learning environment to steer the supervisee to the direction of those goals by the end of supervisory contract	
3B. Planning for and implementation of the supervision sessions and interventions	
1. Managing the supervision session	*For each supervision session, supervisor*: • Pays attention to the appropriate structure and pace of the supervision session • Prioritizes immediate goals over ultimate goals by choosing two or three things to focus on from what the client most needs that the counselor must do differently next time • Finds a balance between their feedback about what client/counseling sessions needs and supervisee's request for feedback and/or the supervisee's goals for the semester • Ends with planning for next supervision session with an awareness of number of supervision sessions left with supervisee

2. Planning supervision interventions for assessment and growth	*Supervisor prepares for supervision with interventions to assess supervisee's growth needs and/or to promote supervisee's growth, as they take various considerations into account (e.g., previous sessions, recording)*:
	• If supervisee cannot record their sessions, supervisor may:
	  ○ Conduct live observations and/or
	  ○ Work with supervisee's self-report
	• If supervisee can record, supervisor prepares for supervision with two prescheduled interventions:
	  ○ Observing a video/audio recording
	  ○ Reading supervisee's case presentation form
	• Supervisor plans for supervision by choosing intervention/s to address two/three things to focus on (e.g., patterns for the supervisee). To intervene, supervisor may utilize:
	  ○ Session segments with certain supervisee and/or client quotes
	  ○ A discovery approach to help supervisee come up with ideas (e.g., thinking aloud approach [Borders, 2009])
	  ○ Interpersonal process recall (IPR; Kagan et al., 1963) to increase supervisee's awareness
	  ○ A roleplay to practice certain counseling scenarios or different activities (e.g., breathing and movement)
	  ○ Assigning homework, readings, or other educational resources
	• Supervisor models counseling skills (e.g., attentive listening and immediacy) and attitude toward the client and counseling sessions (e.g., objectivity)
	• Supervisor pays special attention to be strengths-based and use developmentally and culturally appropriate supervisory interventions based on formative and summative assessments of the supervisee (e.g., supervisee's self-awareness, cultural competence, counseling performance skills, cognitive counseling skills, case conceptualization, and professional behaviors)
	• Supervisor also observes the supervisee and the process as they utilize these interventions to further inform their supervisory strategies

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TABLE 4 (Continued)

3B. Planning for and implementation of the supervision sessions and interventions	
3. Choice points/ in-session intervention decisions needing immediate attention	*At any given moment of supervision, supervisor chooses to intervene with the topic that seems most helpful to the supervisee. Such continuing assessment and conceptualization in the moments of supervision with the supervisee may yield different supervisory actions and/or interventions from those planned. Paying attention to how to balance their prepared foci for the session with what supervisee brings in and needs, supervisor may need to decide on which prepared points they can let go if supervisee asks for help with other critical topics (e.g., site issues, ethical or legal concerns, unexpected crisis). Based on what was addressed in supervision, supervisor intervenes (e.g., self-disclosure) and ends the session (e.g., affirmation/normalization of the process, summarization the work/homework until next session) intentionally*
4. Facilitation of specific areas of supervisee's growth	*Supervisor plans for and intervenes to enhance different areas of growth in supervisee's professional performance and personal functioning by*
a. Assisting supervisee with expanding their counseling, client conceptualization, and treatment skills	• Broadening supervisee's critical thinking and/or cognitive complexity regarding their clients, counseling sessions, and treatment approaches, while helping them develop the skills to intervene with those perspectives • Focusing on complexity of what to increase in supervisee's thinking, while thinking about how to address and/or intervene with those (e.g., developing a list of client-, diagnosis-, and treatment-related readings and community resources, preparing templates for case conceptualization and counseling plans linking diagnosis to treatment, and sharing pertinent examples from their own experiences) • Reviewing client progress and supervisee's work with the client and prompting the supervisee to think more broadly and deeply about client's circumstances by identifying unanswered questions and/or missing information from the counseling session (e.g., stressors, strengths, goals, themes, and culture) • Using various theoretical angles to help supervisee become aware of and integrate the client data for conceptualization and treatment planning, while discussing other counseling considerations (e.g., ethics, boundaries, interventions, parallel process) to create a holistic picture for the supervisee • Building connections between theory, empirically based strategies, and what supervisee does in practice • Encouraging the supervisee to brainstorm freely and creatively about the client and therapeutic intervention • Teaching new interventions to the supervisee • In all these encounters, continuously and appropriately stretching supervisee's thinking to a more complex level of counseling work, broadening their theoretically based conceptualizations and treatment interventions, and adding applied skills to supervisee's toolbox

b. Facilitation of supervisee's multicultural awareness and competencies	• Increasing supervisee's awareness of self and other cultures, identities, and intersections of those identities
	• Focusing on the breadth and depth of diversity in the presenting problems of supervisee's client load (e.g., race, ethnicity, gender, sexual orientation, disability, socioeconomic status background, and religion), while prompting the supervisee to assess their counseling work and discuss potential issues of diversity (e.g., power, privilege, and oppression) affecting their counseling process and relationship/s
	  ○ During this process, helping supervisee become aware of the cultural context they grew up in and their current cultural context in on multiple levels, and the influences of those on their counseling work
	  ○ Building on these discussions, helping supervisee identify potential issues of culture, power, and privilege that may serve as barriers to clients from diverse populations seeking or receiving services with them and/or where they see clients at
	• Developing their social justice and advocacy skills
	  ○ Assigning supervisee to develop advocacy plans to address any of the potential issues with their clients and/or clients at their site, as needed
	• Within the supervisor relationship, also broaching the cultural differences between the supervisor and the supervisee to deepen the cultural context of supervisory work while modeling effective broaching strategies to the supervisee

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TABLE 4 (Continued)

3B. Planning for and implementation of the supervision sessions and interventions	
c. Assisting supervisee with developing reflective counseling and supervision practices	• Exploring supervisee's counseling and previous supervision experiences to get a sense of what was helpful and what was not for them in supervision • Using supervision as a space for supervisee to explore and reflect on their internal processes (e.g., thoughts, feelings, and reactions) at any given moment of their counseling practice • Considering ways to address supervisee's countertransference effectively and ultimately help supervisee become more accepting of their clients and what they bring into counseling ○ During this process, fostering supervisee's self- and peer supervision strategies to develop self-reflective practice • Helping supervisee assess the areas in which they may have been miseducated or undereducated academically and develop strategies to improve different skills (e.g., clinical writing and reading)
d. Facilitation of supervisee's self-awareness	• Helping supervisee expand their awareness of self by facilitating their critical self-reflection • Increasing supervisee's emotional awareness is an important aspect of the supervisory work, especially when supervisee's personal functioning is affecting their professional performance • Considering ways to help supervisee become aware of their part in interpersonal dynamics and/or challenges with others, while fostering supervisee's presence and mindfulness with themselves and others ○ As part of this process, monitoring supervisee's mental health status on a regular basis to ensure supervisee's emotion is not clouding their judgment in their counseling work • Encouraging supervisee pursue professional help if supervisee's personal challenges consistently impact their counseling
3C. Evaluation of supervisee's performance	
Supervisor takes different aspects of evaluation and a wide range of informants into consideration. Supervisor: • Makes sure that there is a set of valid and reliable measures and criteria of evaluation for them to use, and this information have been made available to the supervisee • Schedules formal midterm and final evaluations in advance • Provides an evaluation ○ Adheres to the criteria (e.g., completion of required hours and submission of documents) determined at the beginning of the supervisory contract ○ Informed by supervisor's previous experiences with the supervisee (e.g., teaching a course), creating a baseline for their evaluation ○ Informed by feedback from other stakeholders of the supervisee's work (e.g., other supervisors) ○ Highlights supervisee's progress as well as directions for future skill enhancement ○ With a written summary that is reviewed with the supervisee	
3D. Parameters of due process and gatekeeping	
Supervisor evaluates supervisee's performance and functioning and intervenes with a due process, if necessary, as a gatekeeper of the profession. Supervisor diligently: • Considers and intervenes in the most effective ways to address gatekeeping issues involving professional performance (e.g., knowledge and skill deficits, malpractice) and personal functioning (e.g., impairment and personality) concerns • Consults with other colleagues (e.g., faculty colleagues and site supervisor) to inquire if they have any concerns with supervisee's performance and/or functioning • Inquires if the supervisee has ever had a remediation plan developed as part of their previous supervision to observe similarities and differences between the behaviors identified in the previous plan and current functioning and have an open conversation to hear supervisee's perception of that process	

and conceptual knowledge; Ambrose et al., 2010) across all five areas, when compared to the existing supervision literature, the supervisor's self-assessment and reflection area (see Table 5, Area 4) clearly and judiciously emphasizes the critical role of supervisor, their awareness, and intentionality in the supervisory process.

The first area, *Assessment of Supervisees and Their Practice*, details the supervisee-focus in a comprehensive manner. Not being a novel idea, split focus on supervisee's professional performance and personal functioning is a concise presentation of the two main areas of assessing the supervisee. Particularly, in the view of increasing focus on trauma-informed supervision (e.g., Berger & Quiros, 2014;

TABLE 5 Area 4: supervisor's self-assessment and reflection.

4A. Supervisor's professional reflections in, on, and for action

In their supervision practice with the supervisee, supervisor makes momentary (in action) and retrospective (on action) reflections regarding their work informing future practices (for action) with the supervisee. This process may be considered as circular where supervisor reflects on their supervisory actions (e.g., what happened) to inform their following supervision practices (e.g., what needs to happen and how will it happen) where they continue to observe/assess, reflect, and intervene (e.g., what is happening and how can I intervene now)

- *Throughout the supervisory work*, supervisor
  - Reflects on their role, clinical knowledge (e.g., disorder and treatment), level of competency in addressing the problems supervisee's clients are presenting or need for peer supervision and/or consultation as well as further reading and training
  - Regularly and selectively observes and points out the progress and positive change supervisee demonstrates
  - Beyond just making their point, stays diligent about making sure supervisee hears and understands what supervisor has to say, while nonjudgmentally responding to the supervisee, tracking their response and reactions, and giving the time and energy supervisee deserves
  - As much as they may not like it, as a gatekeeper of the profession, reflects on whether they have made supervision expectations clear to the supervisee and if they are holding the supervisee accountable for meeting them
- *Prior to a supervision session*, supervisor
  - Focuses on *what* went well and *what* did not go so well in the previous session, and *what* they can do similarly and differently in the upcoming session with the supervisee
  - May want to reflect on their experience (e.g., thoughts and feelings) of the supervisory work (e.g., fun and laborious) to further deepen this reflective assessment
  - May consider if they have been mainly offering positive or corrective feedback to the supervisee or consumed by certain emergencies (e.g., safety plans and client advocacy) at the expense of different areas of the supervisory picture; and how supervisee has been responding (e.g., defensive, discouraged, and ready for more growth)
  - Based on their reflective points, prepares with *what* needs to happen and *how* will it happen in the next supervision session (e.g., what do I need to keep exploring about the supervisee, how to further develop rapport and/or connect with the supervisee, how much teaching/counseling is necessary to do, how to give constructive criticism while still being supportive and encouraging)
- *During supervision* continues to reflect on *what* is happening and *how* they can intervene *in the here-and-now* (e.g., am I making sense to the supervisee, have I heard the supervisee's message, have I offered enough directiveness, if/how much humor or disclosure may be needed to help supervisee become comfortable and/or less anxious, how could I guide the supervisee without overtly telling them what to think or do, how hard could I push/stretch the supervisee, how could I give a negative feedback without crushing their confidence, if/how much could I model transparency (e.g., internal thought, feeling, reaction processes), which intervention/s could I use to break the disruptive parallel processes)
- *Ending the session* reflects on *what* happened again by focusing on how concrete their feedback was for the supervisee, how hard they stretched the supervisee, and how much "buy in" and investment they promoted with the supervisee for future sessions, etc.

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TABLE 5 (Continued)

4B. Supervisor's personal reflections in, on, and for action

Supervisor also reflects on their personal reactions momentarily (in action) and retrospectively (on action) to increase their awareness on their personal functioning in relation to their supervisory work. This process may also occur in a circular manner where supervisor reflects on their personal reactions (e.g., what is/was going on with me) to assess their influence on their supervision practices (e.g., what happened) and strategize to effectively handle those in supervision (e.g., what needs to happen and how will it happen) or outside of supervision.

- *Throughout their supervisory work*, supervisor:
  - Regularly reflects on their own cultural background (e.g., gender, race, ethnicity, sexual orientation, SES, and religious beliefs) and values relevant to their practices with the supervisee
  - Consistently engages in an exploratory process of how their own cultural identities and intersections of those, including issues of privilege and power, along with their values intersect with those of supervisee and affect the supervisory relationship and process
  - Regularly monitors their biases, blind spots, and limitations that may affect their work with the supervisee (e.g., supervisory relationship and evaluation) and their impressions of client diagnosis and treatment planning
  - Pays attention to their reactions to the supervisee and supervision processes:
    - As they may develop or have developed negative or positive thoughts and/or feelings about the supervisee (e.g., disliked attitudes and enjoyed work with the supervisee), stays diligent about reflecting on those
    - Continues to monitor their supervisory effectiveness by staying alert with how they are managing their own reactions to the supervisee, possible parallel process and countertransference issues, and supervisory relationship dynamics
    - As challenging as some of these strategies may be, reminds themselves being human by being genuine and honest even when it is difficult to do so and doing what is the right thing to do with compassion no matter how much they squirm (or the supervisee squirms)
    - Assesses their comfort level with addressing certain topics in the supervisory process
- *Before, during, and/or after a supervision session*, supervisor may also ask themselves reflective questions to further examine their personal reactions (e.g., What is bothering me? Am I feeling any of my buttons pushed? Am I triggered by the supervisee? Am I triggered by the narrative? Am I being too careful? What am I avoiding saying that needs to be said?)

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TABLE 6 Area 5: administrative/logistical considerations of supervision.

5A. record keeping

Supervisor pays attention to supervisee's as well as their own record keeping throughout the supervisory term. Supervisor:

- Periodically reviews and offers feedback on supervisee's notes and requires timely documentation of logs and hours
- Makes sure all supervision forms and contracts are signed and dated
- Keeps regular track of their own supervision records that are within the scope of their practice (e.g., supervision notes and signed agreements)

5B. the site/school/program policies, organizational considerations, and resources

As they schedule regular supervision and keep them reliably, supervisor pays attention to supervisee's logistical and administrative needs in site-specific context. Supervisor pays attention to supervisee's caseload and clientele in relation to their compatibility with supervisee's specialty and timeline in the program/site, while focusing on supervisee's safety and risks as they start and continue at the site.

- *Faculty supervisor*:
  - Obtains the knowledge of supervisee's site (e.g., organization and context of the site, treatment expectations/constraints, and tape recordings allowed or not), as they make sure all supervisors have the relevant documentation and appropriate credentials
  - Contacts and conducts site visits (e.g., before, mid-, and/or at the end of the semester in person, or via by phone or online meetings) in compliance with professional standards
- *Site supervisor*:
  - Prepares supervisee to work effectively at the site by making sure they have the logistical (e.g., private office, computer, and phone connection), client-related (e.g., handouts for clients and referral information), and other site-related (e.g., policies and procedures) information and resources they need to perform their work
  - Considers creating opportunities for collaboration that will benefit the supervisee, the clients, and the site
- Regardless of being a faculty or site supervisor, they invest time and energy in contacting and collaborating with the other supervisors of the supervisee

Knight, 2018), supervisor's approach to supervisee's personal history as well as self-care and wellness in relation to their counseling practices are targeted in this area. Supervisee-focused points from ACES Best Practices (e.g., goal setting, diversity, and ethical considerations; Borders et al., 2014), APA Guidelines for Clinical Supervision (e.g., assessment/evaluation/feedback, professional competence problems; APA, 2014) and existing models (e.g., focus areas, discrimination model [DM; Bernard, 1979]; domains and structures, integrated developmental model [IDM; Stoltenberg & McNeill, 2010]; personhood of the supervisee, supervisee-centered psychodynamic supervision [Ekstein & Wallerstein, 1972]; social justice supervision [Dollarhide et al., 2021]; supervisee characteristics and change processes, common factors [Watkins, 2017]) are all represented in this area of CMS.

As a key ingredient of the process (e.g., Watkins, 2015), Area 2, *Supervisory Relationship* is very much in line with the literature while offering some nuanced information. What appears to be unique about CMS's supervisory relationship area is the clear emphasis on relationship being both an assessment and intervention tool of the supervisory process, where supervisor continuously assesses the relationship, intervenes accordingly, and reassesses to intervene again. Although experts of academe did not report this nuance, expert site supervisors described supervisory relationship as an intervention in their supervision process and practices (Kemer et al., 2017). Although all four clusters do, the supervisor's assessment and experience of the relationship and supervisor's efforts to prepare for and address the barriers of the relationship clusters particularly emphasize supervisor's need to trust, integrate, and model their counseling skills to create a rich and therapeutic climate within the supervisory relationship and process, attending not only to supervisee's professional performance but also personal functioning. This area of CMS is particularly in line with the supervisory relationship from ACES Best Practices (Borders et al., 2014), APA Guidelines for Clinical Supervision (APA, 2014), and the existing models (e.g., systems approach to supervision [SAS; Holloway, 2016]; mode five, seven-eyed model of supervision [SMS; Hawkins & Shohet, 2012]; psychodynamic [Frawley-O'Dea & Sarnat, 2001]; humanistic-existential [Farber, 2010]; social justice supervision [Dollarhide et al., 2021]; common factors [e.g., Watkins, 2017]).

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As if the pistil of a flower, Area 3, *Conceptualization and Interventions of Supervision* was the core of the CMS, through which all other areas come to life (see Figure 1). This area of CMS particularly addresses *what* (declarative knowledge) to focus on with the supervisee and supervisory process, and *how* (procedural knowledge) to do that. Under the Planning for and implementation of the supervision sessions and interventions cluster, subclusters of managing the supervision session, planning supervision interventions for assessment and growth, choice points/in-session intervention decisions needing immediate attention, and facilitation of specific areas of supervisee's growth and its subclusters (i.e., assisting supervisee with expanding their counseling, client conceptualization, and treatment skills, facilitation of supervisee's multicultural awareness and competencies, assisting supervisee with developing reflective counseling and supervision practices, facilitation of supervisee's self-awareness) depict a systematized picture for *what*-to-*how* continuum (conditional and conceptual knowledge; Ambrose et al., 2010) in the supervisory process. Clearly offering directions to develop and deepen supervisee reflexivity (e.g., Guiffrida, 2005; Neufeldt et al., 1996; Watkins, 2015) on professional and personal matters, this area parallels different aspects of the supervisory contract (i.e., initiating supervision, goal setting, conducting supervision sessions, providing feedback, and conducting evaluations) and other Best Practices' areas (e.g., diversity and advocacy considerations, documentation, and ethical considerations; Borders et al., 2014) and APA Guidelines for Clinical Supervision (i.e., diversity and professionalism; APA, 2014). Similarly, supervisor roles (i.e., teacher, counselor, consultant) from DM (Bernard, 1979) and supervision interventions from IDM (i.e., facilitative, prescriptive, conceptual, catalytic; Stoltenberg & McNeill, 2010) as well as certain common factors areas (e.g., supervisor tasks and roles, supervisor common practices; Watkins, 2017) are also represented in this area of CMS.

In Area 4, *Supervisor's Self-Assessment and Reflection*, Schön's (1987) premises on reflection-in-action and reflection-on-action, as well as reflection-for-action (Borders et al., 2017), were clearly stated by the experts. Emphasizing the critical role of supervisor's self-reflective practice in a detailed manner, this area offers depth and nuance to supervisor's practices when compared to the existing supervision models and is the main unique contribution of the CMS to the current supervision literature. This area provides a detailed guideline for self-assessment and reflection to each individual supervisor's unique practices as well as each supervisory dyad's idiosyncratic processes, while addressing *how* a supervisor's reflective practice may look at its finest. In this area, it is fair to say that expert supervisors' counselor identities merged with their clinical supervisor identities at an advanced level. Moreover, expert supervisors' intentional efforts on assessing supervisee's as well as their own reflexivity as they intentionally planned and intervened in supervision was one of the highlighted areas of CMS, affirming supervision as a reflective process all around. This area also supported the supervisor from the ACES Best Practices, APA Guidelines for Clinical Supervision (APA, 2014), SAS (Holloway, 2016), and SMS (mode six; Hawkins & Shohet, 2012) as well as Dollarhide et al.'s (2021) emphasis on supervisor self-evaluation for social justice supervision.

Finally, *Administrative/Logistical Considerations of Supervision*, Area 5, of CMS offered unique considerations for university and site supervisors. Supervision models and literature frequently speak to clinical supervisors without offering much direction regarding the factors driven by their settings. Therefore, the parallel but also nuanced information regarding site and university supervisors' administrative considerations were also a unique presentation of the CMS. This area was in line with the documentation and some aspects of the supervisor areas from ACES Best Practices (Borders et al., 2014), and ethical, legal, and regulatory considerations domain from APA Guidelines for Clinical Supervision (APA, 2014).

Practice implications of CMS

Supervisors, counselor educators, as well as counselor and supervisor training programs may benefit from utilizing CMS and its premises. CMS was built on the results obtained from seasoned supervisors

of counselor trainees from master's and doctoral programs in counselor education and counseling psychology. Yet, obtaining a parallel structure to CMS from supervisors of residents in counseling (Kemer et al., 2024a), we also observed residency supervisors' supervision thoughts addressing all five areas and respective 14 clusters and 20 subclusters, with an additional cluster (Kemer et al., 2024b). Thus, CMS emerges to offer an overarching framework for supervisors of counselor trainees and counselors pursuing licensure to (1) assess specific aspects of supervisee's professional performance and personal functioning, (2) utilize supervisory relationship as a bridge between their assessment and supervisory conceptualizations and interventions, (3) intentionally start, conduct, and intervene in the supervisory process based on their comprehensive assessment, (4) assess and reflect on their practices and personal reactions, and (5) attend to the administrative aspects of their work.

Using CMS, supervisors may begin with a specific area and its clusters to continue with the other areas and respective clusters in a circular manner in their supervisory practices. For example, supervisors may consider starting with assessment of the supervisee's professional and personal qualities (Area 1), yet supervisory relationship (Area 2) factors may be available to the supervisor earlier for assessment in the supervisory process. Thus, as they attend to the initial supervision session agenda, expectations, and goals (Area 3, Cluster 3A), supervisors may also focus on their experience of the relationship and the supervisee from the very first interaction (e.g., email, first session; Cluster 2A). As the supervisory relationship progresses, supervisors may specifically focus their attention to differing needs of the supervisee not only related to professional performance (Cluster 1A) but also personal functioning (Cluster 1B). Based on their assessment of supervisee's needs (e.g., Clusters 1A2. basic and advanced counseling skills, 1A6. intervention skills, 1B3. self-awareness) or supervisory process necessities (e.g., Clusters 2B. promotion of an open and supportive relationship, 2D. Efforts to prepare for and address the barriers of the relationship), supervisor intentionally conceptualizes and prepares for the practice of supervision (e.g., Cluster 3B4. facilitation of specific areas of supervisee's growth, such as expanding their counseling, client conceptualization, and treatment skills, multicultural awareness and competencies). Intending to utilize supervisory strategies relevant to their conceptualization (e.g., roleplays, interpersonal process recall), supervisor must also be ready to intervene when the supervisory process requires more urgent assessment and interventions (e.g., Cluster 3B3. choice points/in-session intervention decisions needing immediate attention), such as ethical/legal concerns or crisis with the client and/or the supervisee. In a parallel process, supervisor must regularly reflect on their own contributions to the supervisory process prior to, during, and/or after supervision (i.e., Area 4: professional and personal reflections in, on, & for action) for further intentional preparation for supervision (e.g., use a different supervisory strategy to help supervisee in a specific area, receive consultation/supervision to compartmentalize personal reactions to the supervisee). Based on their supervisory process and context, though, each supervisor may configure different areas and clusters of the CMS based on their supervisee's needs (e.g., developmental level), their own supervisory style, and practice setting considerations, whereas all areas and respective clusters would continuously come into the supervisory picture as the supervisory term progresses.

Counselor educators may also consider using CMS as they supervise doctoral internship. Besides offering CMS as a framework in their didactic supervision courses, during supervision-of-supervision, CMS's outline from Table 1 may be utilized as a supervision form for the supervisor trainees to highlight the emphasis of their work and training as they present supervisory cases. What supervisor trainees focus on and where they may be struggling and thriving may offer the necessary training opportunities for the supervisors of supervisors to deepen that area of trainees' practices. Similarly, CMS's five-area framework may also be applicable to other internship areas of CACREP-accredited doctoral level training (e.g., teaching, research, and leadership). For example, as they pay attention to the supervisory relationship (e.g., research mentorship), supervisors of researchers in training (RiTs) may consider assessing RiTs and their research practices, conceptualize, and intervene intentionally to promote research competencies and researcher identity development, reflect on their own biases and practices (e.g., qualitatively/quantitatively oriented) as a research supervisor, and consider administrative aspects of the work (e.g., institution-specific IRB procedures). Counselor educators, particularly,

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supervisors of supervisors may also consider CMS for their own practices with supervisor trainees as a general outline for supervision of supervision practice as well as training.

Finally, CMS may be useful for counselor trainees as well as fully and partially licensed counselors to assess their own practice and clarify supervision needs for continuing professional growth and consider their goals for becoming a supervisor. Particularly, assessment of the supervisee and their practice area outlines a professional and personal considerations checklist for counselors from any developmental level to set up intentional goals for supervision. Merging these considerations with the reflective practices from supervisory relationship and supervisor's self-assessment and reflection areas, counselors may embrace their own progress and process, while creating a conscious parallel process for their clients in counseling sessions.

Limitations and further research needs of CMS

First and foremost, the samples from all three studies mainly represented white cisgender female participants. Therefore, despite continuous presentations of multicultural and social justice focus, the datasets CMSs were collected prior to 2020 and may be limited in directions for socially just, anti-racist, and anti-oppressive supervision practices; thus, supervisors utilizing CMS would still benefit from further reflecting on and including social justice advocacy and action (Dollarhide et al., 2021) in their practices. Similarly, further research is needed to deepen CMS's focus on social just, anti-racist, and anti-oppressive counseling and supervision practices. Second, in all three studies, I asked supervisors to primarily focus on their individual supervision sessions with their supervisees. Thus, research on what aspects of the CMS is transferrable to and what else is critical to consider in triadic and group supervision modalities are warranted. I did not ask the participants to focus on a specific supervisee developmental level (e.g., master's level practicum, doctoral internship, and licensure), and participants from all three studies reported working with a range of supervisees offering a comprehensive picture. However, further research is needed to understand whether supervisors would focus on specific clusters and subclusters of the model with different supervisee profiles. For example, researchers may examine if supervisors prioritize any of the clusters and subclusters from the assessment of the supervisee and their work or supervisor's self-assessment and reflection areas as they work with supervisees from different developmental levels (e.g., master's level practicum, licensure). As the focus of all three studies was on counseling supervision, participants included supervisors from counselor education and counseling psychology fields. As the CMS is a data-driven model with a general framework that may be applicable to other areas of CACREP-accredited doctoral level training (e.g., teaching, research, and leadership) as well as to other disciplines, future replication studies with supervisors of other training areas and disciplines may further our understanding on the common and distinct aspects of supervisory practices across training areas and fields. Particularly, future research may involve supervisors of supervisor trainees to test versatility of the model as the general outline of the CMS may particularly be applicable to supervisor training. Finally, CMS offers an outline that may allow researchers to utilize nested models for supervision and counseling outcome research via quasi-experimental and/or analogue designs to test connections between supervisory and counseling processes and the contribution of CMS-outlined supervision on counseling and client outcomes.

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