INTERNATIONAL ASSOCIATION OF

PSYCHOSEXUAL THERAPISTS

Standards of Supervision

Supervision toward certification as an IAPST Certified Psychosexual Therapist

This document states the Association's requirement for supervision toward certification as an IAPST Certified Psychosexual Therapist.

It is published. It applies identically to every clinician in training and every supervisor, in every jurisdiction the Association serves, and it is written to be read by clinicians in training, supervisors, accredited programs, and anyone assessing what IAPST certification required.

The Documents Governing Supervision

Supervision is one of the two components that lead to IAPST certification. The other is the education accredited by the Association. The documents below govern the whole of it, and they do not say the same things.

Document	Written for	What it does
Bylaws of the Association	The membership	The constitution of the Association: the classes of membership, the constituent bodies, dues and lapse, and the right of appeal to the Executive Board. The Bylaws prevail over every standard.
Standards of Certification	Applicants, Certified Members, and the public	The credential itself: who is eligible, what the application comprises, how the Certification Board decides, and how certification is renewed, lapses, or is withdrawn.
Standards of Accreditation	Programs delivering education, and their students	The educational component. What a program must teach, how it is assessed, and what accreditation confers on a graduate.
Standards of Supervision	Clinicians in training, supervisors, accredited programs, and the public	The supervision component, and this document. The requirements themselves: what must be completed, who may supervise, what counts, how it is recorded, and what the reviews establish.

Two further documents are issued under these Standards:

Document	Written for	What it does
Supervision Agreement	One supervisor and one clinician in training	The contract between them, signed at the Agreement meeting and filed with the Office of the Executive Officer. It records their particular arrangement — schedule, fees, availability, consent — and the commitments both make.
Supervisor's Handbook	Registered Supervisors only	How the work is done: reviewing recorded sessions, covering the topics, writing the midpoint review, judging readiness. Guidance for carrying out these Standards. It does not create requirements of its own.

Which one governs

The Bylaws of the Association prevail over every standard. Where a standard differs from them, the Bylaws govern.

Subject to the Bylaws, the Standards of Certification govern the credential, the Standards of Accreditation govern the educational component, and these Standards govern the supervision component. None of them adds a requirement to another's subject.

Within supervision, these Standards govern. The Handbook cannot add a certification requirement, and the Agreement cannot remove one.

The IAPST Code of Ethics is not subordinate to any of them. It governs conduct, and where something otherwise permitted here would breach it, the Code prevails.

An unresolved conflict is referred to the Executive Board for clarification.

Three further documents are issued under these Standards and are referred to throughout: the IAPST Supervision Log, which the clinician in training keeps and both parties sign; the 150-hour review, written by the supervisor at the midpoint and filed with the Association; and the final review, completed by the supervisor at the close and filed in the Portal. Section 15.6 lists everything.

A Note on Terminology

Throughout these documents, the person receiving supervision is called the clinician in training. Most of the field calls that person the supervisee. The two words mean the same thing, and using one rather than the other does not change any requirement in this standard.

The choice is a practical one, made for these documents. Supervisor and supervisee differ by three letters in writing and by one syllable in speech, and both words appear in nearly every sentence of a document like this one. That makes them easy to misread, easy to mistype, and easy to mishear in dictation and in correspondence. Clinician in training carries no such risk, and it describes the person plainly: someone already licensed, or otherwise authorized to practice, who carries their own caseload while training toward a further competence.

This is a matter of clarity within the Association's own documents, and nothing more. Supervisee remains the standard term in the field and in the literature, and members are free to use it in their own practice, teaching, and professional materials.

The Requirement at a Glance

Psychosexual clinical work	300 hours
Completed within	Two years of the supervision agreement being filed
Supervision	50 hours
Of which individual	26 hours (minimum)
Of which group	24 hours (maximum)
Of which with a single supervisor	16 individual hours delivered within one unbroken supervisory relationship
The ratio	For every six hours of clinical work, one hour of supervision — 6:1, maintained throughout
Recorded clinical work	A minimum of six sessions reviewed, from at least three different treatment cases
Required topics	Fifteen, each covered against the clinician in training's own material
Midpoint review	At 150 clinical hours, the next individual session is the review. Ordinary individual supervision pauses until it is complete and filed, group supervision continues, and clinical hours past 150 do not count until filing.
Final review	At the close, on the Association's form. The supervisor rates the seven dimensions, writes the assessment, recommends or does not, and signs in the Portal.
Who may supervise	An IAPST Certified Psychosexual Therapist registered with IAPST as a Registered Supervisor
The agreement	Signed by both parties at the Agreement meeting, which counts as up to one hour, and signed by the Executive Officer before any further supervision
The log	Issued by the Association, kept by the clinician in training, checked by the supervisor at every session, and signed in the Portal by both at the end
Membership	The clinician in training holds IAPST membership throughout

> **Why 300 and 50 are one requirement, not two**

> Three hundred clinical hours divided by six is fifty. The two figures are not separate requirements that happen to sit beside each other. They are the same requirement — one hour of supervision to every six of clinical work — written out twice.
>
> Both are minimums, and both must be met. A clinician in training who needs more supervision than fifty hours to reach the standard receives it, and the pathway runs until they do.

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PART ONE

The Requirement

The clinical work, the supervision, the ratio between them, the recorded work, and the required topics, with the basis on which each figure is set.

1. Clinical Work and Supervision

1.1 What a clinician in training must complete

1.1.1 The clinician in training completes not fewer than 300 hours of psychosexual clinical work. Section 1.2 states what clinical work qualifies, and Section 1.3 states how an hour of it is measured.

1.1.2 The clinician in training receives not fewer than 50 hours of supervision of that clinical work. Section 1.4 states what contact counts as supervision.

1.1.3 Of those 50 hours of supervision, not fewer than 26 hours are individual supervision, which is supervision of one clinician in training by one supervisor, or by two supervisors under Section 1.4.5.

1.1.4 Of those same 50 hours, not more than 24 hours may be group supervision, which is supervision of a group of clinicians in training by one supervisor and may be delivered only by an IAPST-accredited program. Group supervision is permitted rather than required, and a clinician in training may complete all 50 hours individually.

1.1.5 Of the 26 hours of individual supervision, not fewer than 16 hours are delivered by one supervisor within a single unbroken supervisory relationship. Those 16 hours may fall at any point in the pathway, and they need not be the first hours completed.

1.1.6 The continuity requirement is satisfied once. A clinician in training who completes sixteen continuous individual hours with one supervisor has met it, and it does not restart if they later move to another supervisor. There is no separate requirement that any proportion of the individual hours sit with the supervisor who completes the final review.

The continuity requirement exists because supervision spread thinly across several supervisors never becomes a relationship, and much of what supervision does depends on one person watching a clinician over time. Sixteen hours is about four months of weekly one-hour sessions, or about eight months if the two meet every other week. Either way it is long enough for one supervisor to watch a clinician in training change.

1.2 What counts as psychosexual clinical work

1.2.1 Countable clinical work is time spent with the patient present, in psychosexual assessment or treatment, whether in person or by teletherapy.

Counts	Psychosexual assessment sessions

Counts	Individual psychosexual treatment
Counts	Couple or relational treatment, counted once per session rather than once per person present
Counts	Clinical psychosexual education delivered to a patient as part of their treatment
Counts	Therapy groups the clinician in training runs or co-runs, where the work of the group is psychosexual, counted at the length of the session
Counts	Co-therapy, counted once by each therapist for the session they jointly conducted
Does not count	Documentation, note-writing, and case recording
Does not count	Preparation, reading, and treatment planning outside the session
Does not count	Collateral contact, correspondence, and referral letters
Does not count	Case consultation with colleagues
Does not count	Administration, scheduling, and billing
Does not count	Supervision itself, in any form
Does not count	Any session that does not address sex, sexuality, or gender, including a session with a psychosexual patient that went elsewhere that week

1.2.2 A session is not multiplied by the number of people in the room. One hour with a couple is one hour; one hour with a group of eight is one hour.

1.2.3 The work must be psychosexual. General clinical practice does not count toward the 300 hours, however competent it is. A session counts where it addresses sex, sexuality, or gender: sexual function or difficulty, sexual identity or expression, gender identity, or a relational concern in which sex or sexuality is at issue. Work that does not deal with sex, sexuality, or gender falls outside this standard and produces no countable clinical hours. The log states what the session addressed.

1.2.4 A mixed caseload is the ordinary case. Few clinicians in training carry a caseload that is psychosexual throughout, and this standard does not ask them to. What counts is decided session by session rather than patient by patient. Where a patient ordinarily seen for psychosexual treatment is seen for something else in a given week, that session produces no countable hour, and the hours already accrued with that patient are unaffected.

1.2.5 Therapy groups count as clinical work. A group the clinician in training runs or co-runs counts where the work of the group is psychosexual. It is counted at the length of the session, is not multiplied by the number of members present, and each co-facilitator counts

the session once. A psychosexual therapy group is clinical work in the same way individual treatment is.

1.2.6 **A therapy group is not group supervision.** The group at Section 1.2.5 is treatment the clinician in training delivers to patients, and it counts toward the 300 hours of clinical work. Group supervision is supervision the clinician in training receives, it counts toward the 50 hours of supervision, and Section 13.2 governs it. The two are never counted against each other.

1.2.7 Three different patients, for the purposes of Section 3.2, means three distinct treatment cases. A couple seen together is one case. A group is one case however many members it has.

> **Why the indirect work does not count**
>
> Documentation, planning, and correspondence are real work and a substantial part of the job. Topics 8, 10 and 11 exist precisely because they are, and the supervisor reads the clinician in training's actual written output.
>
> They are excluded from the 300 because the number has to mean something specific and auditable. Three hundred hours of direct patient contact is a statement about clinical exposure. Three hundred hours of mixed direct and indirect time is a statement about how someone fills a week.

1.3 What counts as an hour

1.3.1 The standard appointment band is fifty to sixty minutes, and any session in it counts as one hour. This is the conventional clinical hour and it is what an ordinary appointment logs as.

1.3.2 Above sixty minutes, a session counts at its actual length, rounded down to the nearest quarter hour. Ninety minutes is 1.5; a two-hour group is 2.0; one hundred minutes is 1.5.

1.3.3 Below fifty minutes, a session counts at its actual length, rounded down to the nearest quarter hour, and is never rounded up into the band. Forty minutes is 0.5; twenty-five minutes is 0.25; a session under fifteen minutes does not count.

1.3.4 This section governs clinical and supervision credit toward the pathway. CE hours for the quarterly Registered Supervisor meetings are governed separately by Section 6.4.

1.3.5 **Partial attendance is an exception to the band.** Where a clinician in training attends only part of a session, the time actually attended is counted, rounded down to the nearest quarter hour, and it is never rounded up into the standard band. Fifty-five minutes of a two-hour group is 0.75, not 1.0. The band applies to a session attended in full, not to a fraction of a longer one.

Session	Counts as
A 50-minute appointment	1.0 — in the standard band
A 60-minute appointment	1.0 — in the standard band
A 40-minute appointment	0.5 — below the band, rounded down
A 25-minute appointment	0.25 — below the band, rounded down
A 10-minute contact	Does not count
A 90-minute session	1.5 — above the band, rounded down
A 2-hour group session, attended in full	2.0
A 2-hour group session, attended for 70 minutes	1.0 — partial attendance, rounded down
A 2-hour group session, attended for 55 minutes	0.75 — partial attendance does not enter the band

Outside the standard appointment band, rounding is down. Inside it, a session of fifty to sixty minutes is one hour. A supervisor who is unsure has the answer: take the lower figure.

1.4 What counts as supervision

1.4.1 Countable supervision is live contact between supervisor and clinician in training, in person or on a secure virtual platform, with both present at the same time and cameras on.

1.4.2 Individual supervision is one clinician in training with one supervisor, or with two under Section 1.4.5. Group supervision is one supervisor and a group of clinicians in training, delivered by an accredited program under Section 13.

1.4.3 **What does not count.** Written feedback returned between sessions; correspondence; the supervisor's own reading of written work between sessions; and consultation contact between sessions. All of these are part of the work and a supervisor may bill for them, but they are not countable supervision hours.

1.4.4 **A billable activity is not automatically a countable hour.** These are two different questions and the log answers only the second. What the supervisor charges for is a matter between the parties under Article XII of the agreement.

1.4.5 **Joint supervision.** A session attended by two supervisors and one clinician in training is individual supervision. The clinician in training earns the credit once, calculated under Section 1.3 on the length of the session — a ninety-minute joint session is 1.5, not 3.0, and not a fixed one hour. Credit is never multiplied by the number of supervisors present.

1.4.6 Each supervisor logs the session. The agreement states which of them holds the continuity requirement, the recorded work, and the 150-hour review, and a joint session counts toward the sixteen-hour continuity requirement only for the supervisor named as holding it.

1.4.7 The Agreement meeting. The supervisor and the clinician in training meet to complete and sign the supervision agreement together. Up to one hour of that meeting counts as individual supervision, although it takes place before the Executive Officer signs the agreement. It is held live, in person or on a secure virtual platform with cameras on, with the supervisor named in the agreement, and it is logged once the log opens. At it the parties go through the agreement, the log, and how the clinician in training will use supervision, and Topic 14 is introduced. The topic is initialed later, when the evidence its rubric describes has been demonstrated.

1.4.8 The Agreement meeting is not an extra or free hour. It counts because the meeting at which the agreement is made is part of supervision. It is the only supervision delivered before the filing date that counts, and it counts only once the Executive Officer has signed the agreement it was held to complete. One Agreement meeting counts for each agreement. Under the clinician in training's first agreement it needs no clinical hours behind it, because no clinical work can yet count. An Agreement meeting with a later supervisor is subject to the ratio at Section 2 like any other session.

1.4.9 Reviewing a recording is countable supervision. Recordings are watched together during a supervision session under Section 3.2.5, so the time spent on them is live contact and counts like any other supervision time. There is no separate category of review time, and a supervisor does not review recordings outside the session.

1.5 Hours must be current

1.5.1 Only clinical work performed after the supervision agreement is filed counts toward certification. Prior clinical experience, however extensive, does not.

1.5.2 Supervision is oversight of work as it happens. It is not retrospective review of work already done.

1.6 The two-year period

1.6.1 The 300 clinical hours and the corresponding supervision are completed within two years of the date the supervision agreement is filed with the Office of the Executive Officer.

1.6.2 A clinician in training who does not complete within that period begins afresh. Hours from the lapsed period do not carry forward.

1.6.3 Suspension. Where a clinician in training is prevented from continuing by illness, parental leave, or another substantial interruption, they may apply to the Certification Board to

suspend the period. Time does not run while a suspension is in force. Application is made in writing, with the supervisor's support, before the two years expire.

1.6.4 Extension for work the Certification Board requires. Where the Board defers an application and requires further supervised work, further assessment, or further evidence, and completing it would take the clinician in training beyond the two-year period, they apply to the Board in writing to extend or suspend that period. The application is made before the period expires, or before the date the Board set for completing what it required, whichever falls first.

1.6.5 What the extension does. The Board states the revised date by which the period runs, and that date is set so that completing what it required is realistic at the six-to-one ratio. Hours properly accrued before the extension remain valid and are not reworked. The Board cannot by extension recognize hours the ratio has already excluded, hours delivered while the supervisor was unregistered, or work performed before the agreement was filed.

1.6.6 A new supervision agreement is filed where the clinician in training has none in force when the further work begins, and the two-year period as extended continues to run from the original filing date rather than the new one.

1.7 Membership

1.7.1 The clinician in training holds IAPST membership for the entire duration of supervision. Student membership is where most clinicians in training sit while in training.

1.7.2 A clinician in training whose membership lapses during supervision cannot certify until membership is restored. Hours properly accrued before the lapse remain valid, and the Certification Board determines whether hours delivered during the lapse count. The clinician in training discloses the lapse at application rather than leaving it to be discovered.

1.7.3 This is not the position where a supervisor's registration lapses. Hours delivered while the supervisor was not on the Register do not count at all, and the Board holds no discretion over them. Section 14.3 states that rule.

1.8 When supervision may begin

1.8.1 The clinician in training is enrolled in an IAPST-accredited program, or has completed one, at the point supervision begins. This is a condition of entering supervision, and a person who is neither enrolled nor a graduate of such a program cannot begin.

1.8.2 Both are permitted. A clinician in training may begin supervision while still enrolled in the program, or may wait until they have completed it. Either satisfies this standard. Neither is preferred, and the choice carries no advantage or disadvantage in the certification decision.

1.8.3 A clinician in training who begins supervision while still enrolled completes the program before applying for certification. Supervision and the program may run alongside each other; the application waits for the program to finish.

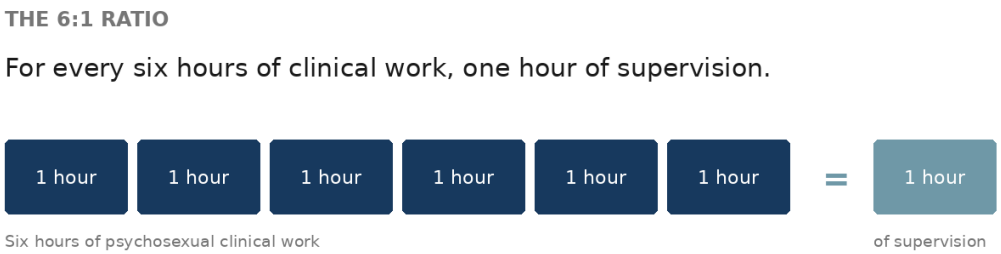
1.8.4 The requirements at Section 1.5 apply from the filing date regardless of which course is taken. Clinical work performed before the supervision agreement is filed does not count toward the 300 hours, whether or not the clinician in training was enrolled at the time.

Running the two together is the more common course, and the standard is written to allow it. A clinician in training who is learning the material while carrying a supervised caseload has somewhere to put what they are being taught, and the supervisor sees how the theory lands. Completing the program first is equally acceptable, and clinicians in training who want their full attention on coursework, or who are not yet carrying psychosexual cases, often prefer it.

2. The Ratio

2.1 The rule

Every six hours of clinical work supports one hour of supervision. Six completed hours of clinical work support one countable hour of supervision. Twelve support two. Sixty support ten. It is written 6:1 and it is read the same way everywhere in this standard: the clinical work comes first, and it is what makes the supervision count.



It is a pace, not a total. The pairing holds as the work goes along, not only at the end. Clinical hours run in excess of it do not count, and later supervision does not recover them.

300 clinical hours ÷ 6 = 50 hours of supervision

The two totals are this same pairing, written out once for the whole pathway.

2.2 Clinical work comes first

This is the provision most often misread, and the consequences of misreading it are not recoverable.

Supervision is counted against clinical work that has already been done. A supervision hour becomes countable when six eligible clinical hours stand behind it, and not before. A clinician in training cannot accumulate supervision early in the pathway and have later clinical work make it count.

2.2.1 Each hour of supervision counted toward certification is supported by six eligible clinical hours already completed within the pathway. The same clinical hours do not support more than one hour of supervision, under any agreement or from any provider. The one exception is the Agreement meeting under a first agreement, at Section 1.4.8.

2.2.2 Supervision delivered in advance of the clinical work supporting it does not count, and completing further clinical work afterward does not make it countable. It happened, it may have been valuable, and it is recorded in the log and marked as not counting.

2.2.3 Support accrues in whole hours. Six completed eligible clinical hours release one countable supervision hour. A seventh, eighth, or eleventh clinical hour releases nothing further until the twelfth, which releases the second. Partial hours of clinical work are logged as Section 1.3 provides and count toward the next six; they do not release a partial hour of supervision. A session of 1.5 hours therefore needs two released hours behind it, which is twelve completed clinical hours, and a session with only one released hour behind it does not count in part.

2.2.4 Clinical work may run ahead of supervision. The ratio caps the supervision that counts, not the clinical work. A clinician in training whose clinical hours are well ahead of their supervision is not in breach and loses nothing, because the clinical hours are what release the supervision. The brake on running too far ahead is the midpoint review at Section 11.1, which stops clinical hours counting at 150 until the review is complete and filed.

2.2.5 Clinical work before the pathway begins supports nothing. Only eligible clinical work performed after the clinician in training's first supervision agreement takes effect under Section 8.1 supports countable supervision. Work done before that date supports nothing, whenever the supervision is delivered.

2.2.6 Support is pathway-wide and carries across a transfer. Eligible clinical work completed under one supervision agreement and not yet used to support a supervision hour continues to support supervision delivered under a later agreement. A clinician in training loses no accrued support by changing supervisor. The Portal records which clinical hours have been used, under every agreement and by every provider of individual or group supervision, so that the same hours never support more than one hour of supervision.

2.2.7 How often supervision happens is for the parties. The supervisor and clinician in training agree the frequency and record the schedule in their supervision agreement. This standard sets no maximum interval between sessions, and a gap is not a breach by reason of its length alone.

2.3 How it is checked

2.3.1 The supervisor reviews the clinician in training's log at the start of every session after the Agreement meeting and confirms how much supervision the completed clinical work currently supports.

2.3.2 The ratio is auditable across the whole period from the log, not only at completion.

> **A worked example**
>
> A clinician in training completes 30 eligible clinical hours in their first weeks. That supports five countable hours of supervision, whenever those hours are delivered.
>
> If instead they had taken eight hours of supervision before doing any clinical work at all, none of those eight hours would count, and completing the 30 clinical hours afterward would not make them countable. The five hours those 30 clinical hours support have to be delivered after the clinical work.
>
> At 90 eligible clinical hours they have released 15 supervision hours. At 300, they have released the full 50.

2.4 What the ratio is not

It is not a cap on supervision received. A clinician in training may have more supervision than their clinical work currently supports, and early in the pathway they often should. Nor does it set a supervision minimum at any interim clinical-hour total. What the ratio governs is how much supervision counts toward certification.

It does not cap clinical practice. A clinician in training may see patients well beyond 300 hours, and every six eligible clinical hours continue to release a countable supervision hour however far past 300 they go. The minima are 300 eligible clinical hours and 50 countable supervision hours; neither is a ceiling on what may be counted. A clinician in training who completed 420 eligible clinical hours has released 70 countable supervision hours, and may count as many of them as they actually received.

What that is for. It matters where a pathway runs long, where the supervisor recorded at the midpoint that more than fifty hours would be needed, or where the clinician in training simply wanted more supervision than the minimum. It does not oblige anyone to take more supervision: 300 clinical hours and 50 supervision hours satisfy the numerical hour minima, every other requirement of this standard still applies, and clinical work beyond 300 raises no requirement by itself.

An uncounted supervision hour is not a wasted one. It is professional support the clinician in training received, and nothing in this standard discourages a supervisor from giving more

supervision than the clinical work completed currently supports. It is logged and marked as not counting, and it stays that way: later clinical work releases supervision delivered after it, never supervision delivered before it. A supervisor who intends to deliver such an hour says so before the session rather than after it.

3. Recorded Clinical Work

3.1 Why it is required

If the supervisor is not watching the work, they are not supervising it.

When a clinician in training describes a session, they report what they noticed and what they thought was significant. The supervisor responds to that account. That is consultation, and it has real value — but at no point was the clinical work observed.

An account can only contain what the clinician in training noticed. The question they did not think to ask, the moment they moved away from something uncomfortable, the hesitation in the patient's voice they read past — none of it reaches the supervisor, because none of it reached the clinician in training. A recording carries the session rather than the memory of it, which is why the standard requires one.

There is a second reason. The supervisor's final review tells the Certification Board that this person is competent to practice psychosexual therapy. A supervisor who has never observed them practicing is attesting to something they have not seen.

3.2 The requirement

3.2.1 **Six is a minimum, not a quota.** Over the course of supervision the supervisor reviews not fewer than six recorded sessions, drawn from not fewer than three different treatment cases. A supervisor may require more, and many should: six is the floor the standard sets, not the amount of observation good supervision needs.

3.2.2 Recordings are spread across the supervisory relationship rather than concentrated at its start.

3.2.3 The clinician in training records their own clinical sessions. Supervision sessions themselves are not recorded.

3.2.4 Each of the six recordings is a distinct session with a patient. Segments from one session count as that one session however many are shown.

How a recording is reviewed

3.2.5 Recordings are reviewed together, during a supervision session. The clinician in training brings the recording and plays it. Supervisor and clinician in training watch it at the same time, discuss it as they go, and the time spent doing so is countable supervision and is logged like any other supervision time.

3.2.6 The recording is not handed over. The clinician in training keeps it. It is not emailed, uploaded to a shared drive, sent through a messaging service, or transferred to the supervisor by any other means, and the supervisor does not hold a copy at any point. This is a requirement rather than a preference, and Section 3.4 states how the clinician in training holds and destroys it.

3.2.7 Sessions are reviewed in segments rather than end to end. A supervision session is not long enough to watch a full clinical session and discuss it, and watching one through is a poor use of the hour in any case. What is reviewed is a selection of moments from the session, stopped and discussed as they arise.

3.2.8 What is shown is agreed in advance, by either party. A supervisor may ask for something particular in the next session — how the clinician in training opens an assessment, where a named case has reached, how they handled a moment they described. A clinician in training may equally bring a segment they want to examine, and often should. Either is a proper use of the requirement.

3.2.9 A session counts as reviewed when the supervisor has seen enough of it to assess the work, which is a matter for the supervisor's judgment. A single brief segment shown in passing does not make a session one of the six.

Three patients matters as much as six sessions. Six recordings of one patient show one relationship, and a clinician can look competent in one relationship and struggle in others.

3.3 Patient consent

3.3.1 Before any recording is made, the clinician in training obtains the patient's written informed consent.

3.3.2 Consent is required. A particular form is not. The Association issues a Consent to Record form, and a clinician in training may use it. Equally, the consent may sit in the clinician in training's own intake paperwork, in their practice's standard consent documents, or in a separate form of their own. What matters is that the patient consented in writing, before the recording, to what Section 3.3.3 sets out.

3.3.3 The patient is told that the session will be recorded, that it will be viewed by a named supervisor for the purpose of the clinician in training's professional training, that it will not be

used for any other purpose, when it will be destroyed, and that consent may be withdrawn at any time without affecting their treatment.

3.3.4 Where a patient withdraws consent, the recording is destroyed immediately and is not reviewed further. A recording already reviewed does not require the supervision hour to be repeated.

3.4 Handling and destruction

3.4.1 The clinician in training stores each recording encrypted, on a device or account they control, and never on a shared or unsecured device. Because no stored copy is transferred to the supervisor under Section 3.2.6, there is no stored copy in the supervisor's hands to secure. Where supervision is conducted remotely the recording is shown live, screen to screen, and Section 8.3.1 states the platform requirements that apply to that session.

3.4.2 Each recording is destroyed within ninety days of the supervision session in which it was reviewed, or immediately on withdrawal of consent, whichever is sooner.

3.4.3 The clinician in training destroys every copy they hold and does not accumulate recordings. The supervisor holds none to destroy, and a supervisor who finds themselves holding a copy has departed from Section 3.2.6 and deletes it at once.

3.4.4 **Recordings never reviewed.** A recording not reviewed within ninety days of being made is destroyed. A recording still held when supervision ends is destroyed at that point, reviewed or not. There is no circumstance in which a recording outlives the relationship it was made for.

3.4.5 Audio or video is acceptable. Video is preferred, because what a clinician in training does with their face and body when a patient says something difficult is frequently the material.

3.4.6 Where supervision transfers, recordings are not passed to the incoming supervisor. The patient consented to review by a named supervisor. A new supervisor means new consent, for new recordings.

3.4.7 Where a clinician in training holds concurrent agreements and one ends, no supervisor holds a copy to destroy, because no copy was transferred. The clinician in training reviews what the ending agreement covered and destroys any recording retained solely for it. A recording may be retained where it remains in use for a live concurrent supervisory relationship and the patient's consent covers that continuing use, subject to the deadlines above.

3.4.8 The five-year retention requirement at Section 15.2 does not apply to recordings and never extends the life of one.

3.5 Where recording is not possible

3.5.1 Where a patient does not consent, or recording is clinically inadvisable, the requirement is met by live observation, or by a full verbatim transcript with the clinician in training's written process commentary.

3.5.2 The alternative chosen must be equivalently demanding of the clinician in training, and the reason for choosing it is documented in the log.

3.5.3 Live observation requires the patient's written informed consent on the same terms as a recording, including that a named supervisor will observe and for what purpose.

3.5.4 A verbatim transcript is produced from a recording made and then destroyed immediately after transcription, or contemporaneously during the session where the patient consents to that and not to a recording. A reconstruction written from memory afterwards is not a verbatim transcript and does not satisfy this section.

3.5.5 The transcript is de-identified, is handled and destroyed on the same terms as a recording, and the clinician in training's written process commentary accompanies it.

3.5.6 Where a patient cannot consent independently, the work is not recorded or observed and another patient is selected.

4. The Fifteen Required Topics

4.1 What they are for

These are the topics that education does not reach. A clinician in training comes to supervision from an accredited program, whether they have finished it or are still in it: they have the theory, the models, the physiology, the literature. What they do not yet have is the fifteen, because each is learned by doing the work, having someone observe it, and doing it differently.

4.2 How they are covered

4.2.1 Each topic is covered against the clinician in training's own clinical material. A general discussion of termination does not satisfy the topic; discussion of how this clinician in training will end treatment with this patient does.

4.2.2 Each topic is recorded in the log with the date it was covered and the identity of the supervisor who covered it, which the Portal records from the login that made the entry.

4.2.3 **Initialing a topic.** These documents use initial as shorthand for making that entry. There is no handwritten initial anywhere in the pathway; to initial a topic is to mark it off in the Portal, which records the date and the supervisor who did it.

4.2.4 Completion of the pathway cannot be certified until all fifteen topics stand at Evidenced, which is the highest of the three levels the Appendix sets out for each topic. There is no waiver.

4.2.5 Three of the fifteen topics require the supervisor to read something the clinician in training produced — written psychosexual education, an actual clinical note, and a drafted referral letter. A conversation about any of the three does not reveal what the clinician in training actually writes.

4.2.6 **This governs completion, not signature.** A supervisor signs an accurate log whatever it shows, including where a relationship ended with topics outstanding. Section 9.5 states the difference.

The topics are not a curriculum to work through in order. They arise from cases, and the best coverage is the topic that comes up because the clinician in training brought a case that raised it. The checklist exists so that nothing is missed, not so that the year becomes a syllabus.

The fifteen are set out in full in the Appendix.

PART TWO

Eligibility to Supervise

Registration as an IAPST Registered Supervisor, the conditions attaching to it, and the limits of what it signifies.

5. Registration

5.1 What registration is

Registration is something a supervisor does, not something the Association confers. IAPST does not approve, certify, or credential supervisors. A person registers themselves on satisfying the conditions below, and does so again every year. The Office of Membership verifies the conditions and enters the registration; no body deliberates.

5.1.1 The designation is Registered Supervisor, abbreviated RegSup. It indicates registration only.

5.1.2 The titles "IAPST Approved Supervisor," "Approved IAPST Supervisor," and "Supervisor Approved by IAPST" are not recognized and must not be used.

5.1.3 Registration is completed at iapst.org/registered-supervisors/apply, runs on the calendar year, and renews on 1 January alongside membership and certification.

5.2 What this means for a clinician in training

Because registration is self-declared, what the Register states is that a person holds C-PST certification, has completed the supervision training, has clinicians in training, and has undertaken to work to this standard. It is not an assessment of their practice by the Association.

What makes this standard bite is not the Register but the three things that generate a record: the 150-hour review, the log, and the requirement that recorded work is actually watched. A supervisor who is not doing those is visible, whatever the Register says.

5.3 Renewal, grace, and arrears

5.3.1 Registration renews on 1 January. A supervisor who renews by 15 January is treated as continuously registered, and hours they deliver in that window count.

5.3.2 Late renewal is accepted to 31 January, but registration is not continuous through that period. A supervisor who renews between 16 and 31 January is off the Register from 16 January until renewal is completed and confirmed, and hours delivered in that gap do not count toward any clinician in training's certification. Eligibility for January therefore depends on renewing on time, and the Verification System records the interruption.

5.3.3 A supervisor who has not renewed by 31 January lapses from 1 February. Section 14.3 states what a lapse costs.

5.3.4 The distinction is deliberate. Renewal by 15 January is for a supervisor who is renewing and has been slow about it. Renewal after that date is a second chance, and a second chance does not restore the period during which the Association could not confirm that anyone was

registered. The cutoff is the same date on which certification stops being current under the Standards of Certification, so a supervisor loses registration and certification from the same day.

5.3.5 What is assessed at renewal. Whether the supervisor has a clinician in training to supervise is assessed as at the renewal date. The CE hours earned from the supervisors' meetings are those of the year then ending.

5.3.6 Registering part-way through a year. A person may register at any point in the year, and a person returning to the Register need not wait for January.

5.3.7 Where fewer than three meetings remain after registration, the supervisor attends every remaining meeting and earns the CE hours available from them, subject to any excused absence. Where three or more remain, the ordinary annual requirements apply. The concession never asks for more than the ordinary requirement.

6. The Conditions

A person may register as an IAPST Registered Supervisor who satisfies all six.

6.1 Certification

6.1.1 The applicant holds current status as an IAPST Certified Psychosexual Therapist in good standing.

6.1.2 A supervisor supervises toward a credential they hold themselves. Where certification lapses, registration lapses with it.

6.1.3 Certification is the test. No further period of practice is required before registering, because certification already establishes that the applicant completed 300 hours of psychosexual clinical work under 50 hours of supervision and was assessed as competent at the close. A person who holds the credential may register.

6.1.4 A condition on the applicant's own authorization does not prevent registration. Where an applicant holds a provisional, associate, or similarly conditioned authorization that requires them to practice under a supervisor appointed by their own regulator, that condition is a matter for their regulator and does not bear on registration with the Association. The Association requires current certification and the conditions in this Section.

6.2 Training

6.2.1 The applicant has completed the IAPST Certificate in Clinical Supervision Training Program.

6.2.2 Being a good therapist and being a good supervisor are different skills. The course is taken once; it is not retaken at renewal, nor on returning to the Register after a lapse.

6.3 Clinicians in Training

6.3.1 The applicant has three individuals to supervise. Each is a person the applicant brought into psychosexual therapy, in the sense that the applicant is the reason they enrolled in an IAPST-accredited program, and each is someone the applicant intends to supervise within the first year of registration.

6.3.2 **Recruitment is the test, not retention.** The condition is satisfied by having brought three people into psychosexual therapy. A recruited person may choose to be supervised by a different Registered Supervisor, and they are free to do so; the applicant still satisfies this Section. Nobody is told, and no supervisor suggests, that enrolling or being supervised by a particular person makes certification more likely or assured.

6.3.3 **Bringing someone into the field is not the same as finding someone already in it.** The condition is that the applicant recruited the person into psychosexual therapy and that they enrolled in an accredited program as a result. An applicant who approaches people already enrolled and offers to supervise them has not satisfied it. The distinction is the point of the condition: a Registered Supervisor is expected to be building the field rather than drawing from a pool someone else filled.

6.3.4 **At renewal, the supervisor has at least one clinician in training to supervise.** This does not require a new recruit each year. A supervisory relationship may run for up to two years, so the clinician in training a supervisor recruited in one year is commonly still with them in the next, and that satisfies the condition. What the Association asks at renewal is that the supervisor is actually supervising someone.

6.3.5 A supervisor who has no one to supervise at renewal does not renew, and their registration lapses. They may register again under Section 6.7 as soon as they have someone.

6.3.6 Without someone to supervise, a person is not eligible to register. A person is not a supervisor if they have nobody to supervise.

At first registration the Association is asking for evidence that the applicant can bring people into the field. At renewal it is asking only that they are still supervising someone, because a supervisor with nobody to supervise is not a supervisor.

6.4 The quarterly meetings

6.4.1 Four Registered Supervisor meetings are held each year, two hours each, quarterly. Cameras on. Meetings are not recorded, so attendance cannot be made up afterward.

6.4.2 Attendance earns one CE hour per hour attended, counted in actual time and rounded down to the nearest quarter hour. A full meeting earns two. Attending all four in full earns eight CE hours in a year, which is the maximum available from this source.

6.4.3 What counts as attending a meeting. For the three-meeting condition, a supervisor has attended a meeting where they were present, camera on, for not less than ninety of its one hundred and twenty minutes. Shorter attendance still earns CE hours under Section 6.4.2; it does not count as an attendance.

6.4.4 What registration requires. The supervisor attends not fewer than three of the four meetings, counted as Section 6.4.3 defines an attendance, and those attendances yield not fewer than six CE hours. Attending three meetings in full satisfies both at once, because three full meetings is six hours.

6.4.5 Four meetings are held and supervisors are expected at all four. Three is the number below which registration is not renewed, not the number to aim for.

6.4.6 The CE hours are a measure of the same attendance, not a second requirement to be met separately. The figure is stated so that partial attendance cannot be presented as attendance. It cannot be made up from continuing education of any other kind: no course, conference, or reading substitutes for being in the room at these meetings.

6.4.7 Because they measure the same thing, the two can come apart, and both must still be satisfied. A supervisor who stays ninety minutes at each of three meetings has three attendances but only 4.5 CE hours, and needs part of the fourth meeting to reach six. A supervisor who drops into all four meetings for half an hour each has two CE hours and no attendances at all, because none of the four reached the ninety-minute threshold.

6.4.8 These CE hours also count toward certification renewal. A Certified Member needs five CE credits a year, so the six earned by attending satisfies that requirement in full. IAPST-approved continuing education earned elsewhere may satisfy the certification renewal requirement, but it does not replace the Registered Supervisor meeting requirement.

6.4.9 Where a supervisor cannot attend for reasons outside their control, they write to the Office of Membership in advance and the Executive Officer determines whether the absence is excused. The determination is given in writing and states the adjusted attendance requirement and the adjusted CE hours for that year, so the supervisor knows before renewal what they are held to. Notice must be given before the meeting. Where an emergency made advance notice impossible, the supervisor writes to the Office within five working days of the meeting explaining why, and the Executive Officer may excuse the absence on that basis. An absence explained afterward without such a reason is simply an absence.

Why the meetings are a condition

Supervision happens almost entirely in private. The clinician in training sees their patients, the supervisor sees the clinician in training, and nobody observes the supervisor at work. Part Four provides the Association's review of the records submitted to it, and Section 12.3 the action that can follow, but no one watches a supervision session.

These meetings are the only structure in which supervisors are accountable to one another, and the only place the standard stays consistent across a register spread over many countries.

6.5 The fee

6.5.1 The supervisor pays an annual registration fee of USD 300, or USD 150 at Tier II. This fee is additional to their Certified Member dues and does not replace them.

6.5.2 How the tier is determined. The Association operates two fee tiers. Tier I is the standard rate, and Tier II is a fifty percent reduction. The tier is determined by the country in which the supervisor practices, and the Association publishes the current tier assignment by country. A supervisor without an updated country on file is charged at Tier I.

6.5.3 Tier II applies to membership dues, to the certification application fee, and to this registration fee. The Standards of Certification state the full fee schedule, and the Association's published schedule governs where the two differ.

6.6 The undertaking

6.6.1 A supervisor does not supervise toward certification anyone they are also treating, anyone they employ in a role in which they assess them, anyone whose academic work they assess as faculty of that person's program, a relative, or a person with whom they are in a sexual or romantic relationship. These are prohibited, and declaring one does not permit it. Any other prior professional relationship between the parties is declared in the supervision agreement and to the Executive Officer. Because a supervisor registers on the strength of people they brought into psychosexual therapy, a prior professional relationship is the expected case rather than an exception.

6.6.2 The applicant signs an undertaking to abide by the IAPST Code of Ethics, the Association's supervision requirements including the IAPST Supervisor's Handbook, and the Association's policies governing member benefits, including the Listserv Guidelines and Moderation Policy, the Therapist Directory Listing Policy, and the Virtual Colloquium Participation Policy.

6.6.3 A Registered Supervisor is expected to have consultation of their own on their supervisory work. The Association does not set a quantity. A supervisor with no arrangement of any kind

is asked at renewal what they do instead, and the supervisors' meetings are part of this but are not a substitute for it.

6.7 Returning after a lapse

6.7.1 A person who has previously held registration and allowed it to lapse re-registers on the conditions above, save that the training course is not retaken and one clinician in training is required rather than three. That one need not be a new recruit; someone the applicant already supervises satisfies it.

6.7.2 They may register as soon as they have someone to supervise. They do not wait for the following January, and Sections 5.3.6 to 5.3.7 state how the requirements work for a partial year.

6.7.3 Where the certification lapsed as well. Registration depends on current certification, so a person whose certification also lapsed restores it first. The Standards of Certification govern that, and what it requires turns on how long the certification has been lapsed: reinstatement within a year, a fresh application after a year, and the accredited education completed again after three years. This Section applies once the certification is current.

7. Scope, Competence, and Verification

7.1 Language competence

7.1.1 Supervision may be conducted in any language the supervisor and clinician in training share. The Association does not require supervision to be delivered in English.

7.1.2 A supervisor takes on only clinicians in training whose clinical work they are competent to supervise. Where the clinician in training's clinical sessions are conducted in a language the supervisor does not work in, the supervisor cannot review the recorded work and therefore cannot supervise to this standard, however well the two communicate in another language.

7.1.3 Supervisor and clinician in training must share a working clinical language — the language the clinician in training's patients are seen in. Both satisfy themselves of this before the agreement is signed.

This is easily missed, because the two can discuss cases fluently in English while the clinical work happens in another language. Fifty hours of excellent English-language discussion about Arabic-language sessions does not meet this standard, because the recordings — the only place the supervisor sees what the clinician actually does — are unreviewable.

7.2 Evidence-based practice

7.2.1 Supervision promotes evidence-based psychosexual assessment and treatment, integrating the best available research with clinical expertise and the patient's characteristics, values, and context.

7.2.2 The supervisor reviews the rationale for interventions, the evidence supporting them, their limitations, and the patient's response, and addresses unsupported or ineffective practice.

7.2.3 This is a standing requirement across cases rather than a sixteenth topic. Covering the fifteen does not by itself establish that what the clinician in training is doing with patients has an evidence base.

7.3 Cultural responsiveness

7.3.1 Supervisors consider the cultural, religious, social, and legal contexts of the clinician in training and of the patients whose work is reviewed.

7.3.2 They examine how values, bias, power, and differences in practice context affect formulation, intervention, and evaluation.

7.3.3 A supervisor does not equate difference from their own background, training tradition, or practice context with lack of competence. The Association registers supervisors across many jurisdictions, and a clinician in training practicing lawfully and competently in a context the supervisor does not share is not thereby practicing badly.

7.3.4 Where a clinician in training's context raises a question the supervisor cannot answer — a legal restriction, a religious framework, a practice norm they do not know — the supervisor says so and the two of them find out, rather than the supervisor guessing.

7.4 Verification

7.4.1 Registered Supervisors appear in the IAPST Registered Supervisor Verification System at iapst.org/registered-supervisors, which is public.

7.4.2 **The Verification System shows effective dates, not only years.** It states the date registration began, the date it ends, and any interruption within a year, so that a clinician in training or a program can confirm whether a particular session fell inside a registered period. A year-only status cannot answer that, and the arrears rule at Section 5.3.2 makes part of January turn on it.

7.4.3 Registration is effective from the date renewal is completed and confirmed by the Office of Membership, not from the date payment is made. Payment is one of the conditions, not the whole of them. This is subject to Section 5.3.1: a supervisor who completes renewal by 15 January is treated as continuously registered from 1 January.

7.4.4 Clinicians in training are strongly encouraged to verify a supervisor's registration before beginning supervision. Accredited programs are required to verify at engagement and at the start of each academic year.

7.4.5 Hours delivered while a supervisor is not on the Register do not count toward certification. Section 14.3 states what happens where this occurs.

7.5 Confidentiality of the supervisory relationship

7.5.1 Patient material brought to supervision is de-identified, and a supervisor does not discuss a clinician in training's cases outside the supervisory relationship. This is subject to Section 3, which governs recorded and observed work: a recording is identifiable by nature, and the patient has consented to that.

7.5.2 **Professional consultation is not outside it.** A supervisor may take a question about their own supervisory work to their own consultation or to the Registered Supervisor meetings, provided both the patient and the clinician in training are de-identified. Supervision sessions are not routinely observed, and although the Association reviews the records submitted to it under Part Four, a supervisor working through a difficulty needs somewhere to take it at the time.

7.5.3 What may be disclosed about a clinician in training, and to whom, is set out in the supervision agreement. The agreement is the operative statement of it, and a clinician in training reads those limits before signing rather than discovering them later.

7.5.4 Disclosure without the clinician in training's authorization is permitted on five grounds, each with its own trigger:

(a) imminent danger to the clinician in training, a patient, or another person;

(b) disclosure compelled by court order or otherwise required by law;

(c) conduct requiring notification to the clinician in training's regulator;

(d) a concern about the clinician in training's fitness to practice; and

(e) the routine submissions the clinician in training has agreed to — the 150-hour review, the log, and the final review, each of which goes to the Association.

7.5.5 Imminent danger is the threshold for ground (a) alone. It does not govern the others.

7.5.6 Where a supervisor has raised an ethical or legal concern and the clinician in training persists in that course of action, the supervisor may report the matter to the clinician in training's regulator, to the Ethics Committee, or to both. Articles X and XIII of the supervision agreement state how these grounds apply between the parties.

PART THREE

The Documents

The supervision agreement, the supervision log, and the application for certification.

8. The Supervision Agreement

8.1 What the agreement is, and why it is filed

8.1.1 Supervision toward certification is conducted under an IAPST supervision agreement, signed in the IAPST Member Portal by both the supervisor and the clinician in training at the Agreement meeting under Section 1.4.7, before any other supervision takes place. It is the contract between them. It is not a formality, and supervision conducted without one does not count toward certification.

8.1.2 What it does. The agreement records the particular arrangement between these two people: who they are, what each has undertaken to do, when and how they will meet, what the supervisor charges, what happens to recorded work, what is confidential and what is not, and how either of them may end the relationship. The requirements of the pathway come from this standard and are the same for everyone; the agreement is where the two parties settle everything the standard leaves to them.

8.1.3 Why it is filed rather than kept privately. Filing fixes the date the two-year period begins, establishes that supervision was conducted under an agreement at all, and lets the Office of Membership confirm at application that the supervisor held registration throughout the period claimed. An agreement held only by the parties proves none of those things at the point they matter, which is usually two years later and often after a dispute.

8.1.4 The Association issues a template agreement, and the parties use it. A supervisor does not substitute an agreement of their own, and terms added by either party do not displace this standard where the two conflict.

8.1.5 The agreement is completed and signed in the IAPST Member Portal, and takes effect when the Executive Officer signs it. The parties sign it at the Agreement meeting under Section 1.4.7, and no further supervision takes place until the Executive Officer has signed.

8.1.6 What the Member Portal is. The Portal is the Association's member system. The supervision agreement, the supervision log, the 150-hour review, and the final review are completed and signed in it, and the Association holds them there. A document completed in the Portal is filed by that act, and neither party sends a copy to the Office of the Executive Officer.

8.1.7 What a signature in the Portal is. Each party signs under their own IAPST login, which identifies them. The Portal records who signed, what they signed, and the date and time, and that record is the signature. A paper copy is not required and is not filed.

8.1.8 Three signatures, in order. The supervisor and the clinician in training sign the agreement in the Portal. The Executive Officer then signs, which confirms that the agreement is on file and

that the parties may proceed. The Portal records the date and time of each signature and notifies both parties when the Executive Officer has signed.

8.1.9 Supervision beyond the Agreement meeting begins after the Executive Officer signs. The agreement takes effect on the date of that signature, and that date is the filing date. Clinical work before it does not count toward certification, and neither does supervision, save the Agreement meeting under Section 1.4.7. The loss is not recoverable.

8.1.10 The Executive Officer signs promptly, and the parties do not begin before that signature appears in the Portal. Where it has not appeared within five working days, either party writes to the Office of the Executive Officer.

8.1.11 The two-year period at Section 1.6 runs from the filing date.

This is the most common avoidable loss in the pathway and it is entirely within the parties' control. File first, then begin.

8.2 What the agreement covers

The agreement sets out the nature of the relationship, the requirements, recorded work and its handling, confidentiality and its limits, sessions and format, fees, the handling of ethical concerns, and termination. The Association issues the form.

8.2.1 The agreement states plainly that this is supervision toward certification and not licensure supervision, that the clinician in training practices under their own authorization, and that the supervisor assumes no clinical or legal responsibility for the clinician in training's patients.

8.2.2 It states that entering supervision does not guarantee certification or a positive final review.

8.2.3 It states that assisting the clinician in training with the application for certification is an obligation of the supervisor.

8.3 How sessions are conducted

8.3.1 Supervision may be conducted in person or virtually. Virtual supervision is conducted on a secure, encrypted platform meeting the data-protection and confidentiality requirements applying in both parties' jurisdictions.

8.3.2 Cameras on. Both parties keep cameras on throughout a virtual session. Supervision requires that each can see the other: the supervisor is watching how the clinician in training talks about a patient, not only what they say. A session conducted with cameras off does not meet this standard and is not logged as supervision.

8.3.3 Both parties join from a private space where they cannot be overheard and where a patient could not appear. Neither joins from a vehicle or while traveling.

8.3.4 The supervisor is reachable between sessions. This means responding to ordinary contact within a reasonable time. It is availability for consultation on the clinician in training's own practice, not an emergency or on-call service, and it does not transfer responsibility for a patient. The clinician in training is the treating clinician of record, manages clinical risk under their own authorization, and holds their own arrangements for urgent clinical cover. Section 15.3 states the limit of that availability.

9. The Log

9.1 Whose it is

9.1.1 The log belongs to the clinician in training. It is issued by the Association and is the principal record of supervision. The Association also holds the filed 150-hour review, the final review, and any group hours an accredited program recorded in the Portal under Section 13.2.15.

9.1.2 A clinician in training does not substitute a record of their own.

9.1.3 There is one log, held in the Member Portal. The supervisor does not keep a separate record and does not submit one. Their entries — the topics marked off, the recordings confirmed as reviewed, the ratio checked — are made in the clinician in training's log in the Portal, at the time.

9.2 What it records

Clinical hours	Date, duration, running total
Supervision hours	Date, duration, individual or group, supervisor name and registration number, running total
The ratio	Calculated from the two and visible at every session
The fifteen topics	Date covered, and the supervisor who covered it
Recorded sessions	Date presented, patient reference, date the supervisor reviewed it, date destroyed
The 150-hour review	Flagged when clinical hours reach 150; recorded when complete
Signatures	Supervisor and clinician in training, in the Member Portal

9.3 Checked at every session

9.3.1 The supervisor reviews the log at the start of each supervision session, before the work of the session begins. The Agreement meeting is the exception, because the log opens only when the Executive Officer signs the agreement, and the first review is made at the start of the next session.

9.3.2 They confirm that entries since the last session are complete, that hours are accurate, and how much countable supervision the completed eligible clinical hours currently support.

9.3.3 **How the check is made.** The supervisor calculates the whole hours of supervision released by the eligible clinical hours completed to that point, then deducts the supervision already counted from every source, including group hours delivered by an accredited program. What remains is the countable supervision still available. The session about to take place is not counted in that calculation.

9.3.4 **Where no support remains.** A clinician in training whose completed clinical work supports no further supervision is not in breach, and the session may still be held. It is logged as not counting, and later clinical work does not change that status. The supervisor tells them before the session rather than after it.

9.3.5 The supervisor records in the log that each recording has been reviewed, and marks each topic in the Portal as it is covered. The Portal records the supervisor who made each entry and the date, which is what the initials on a paper log did. These entries are the supervisor's and are made at the time.

A log checked at every session stays correct. A log checked once at the end is almost always wrong, and cannot be reconstructed.

9.4 Initialed at the end of every session

9.4.1 At the close of each supervision session, the supervisor and the clinician in training each initial the entries reviewed at the start of it. Both initials are applied in the Member Portal, each party under their own IAPST login, and the Portal records who initialed, what was initialed, and the date and time.

9.4.2 **What the clinician in training's initial says.** That the entries covered are their own record of work they did and supervision they received, and that they are complete and accurate to that date.

9.4.3 **What the supervisor's initial says.** That they reviewed those entries at the start of the session and found them complete and accurate so far as they can verify them, and that their own entries for the period — recordings confirmed as reviewed, topics marked — are made.

9.4.4 Three things are distinct. A session initial under this Section acknowledges the entries reviewed at that session. A topic mark under Section 9.3.5 records that a required topic has reached Evidenced and is made when the evidence appears, not at the close of every session. The signature at Section 9.5 attests to the complete log and is given once, at application or on transfer. One does not substitute for another.

9.4.5 A session not initialed is not void. Where an initial was not applied, the hours stand if the record is otherwise accurate, and the omission is corrected at the next session with the date of the correction recorded. A pattern of missing initials is a matter for the midpoint review and, where it persists, for the Office of the Executive Officer.

9.4.6 The initials do not replace the review of the log at the start of the session. The review is where errors are found; the initials are the record that it happened.

9.5 Signing the log

9.5.1 The log is signed at the point the clinician in training applies for certification. Both the supervisor and the clinician in training sign it in the Member Portal.

9.5.2 Each signs under their own IAPST login, and the Portal records who signed, what they signed, and the date and time. That record is the signature. The log is not printed, and no paper copy is submitted.

9.5.3 Both parties sign off on the hours. The clinician in training signs that the hours recorded are hours they worked and hours of supervision they received. The supervisor signs that those hours were delivered as recorded.

9.5.4 A supervisor attests to their own period. The supervisor's signature attests additionally that they personally reviewed the recordings attributed to them, that they covered the topics recorded against their name, against the clinician in training's own clinical material, and that the entries for the period they delivered are accurate as far as they can verify them. No supervisor attests to work another supervisor did.

9.5.5 Whether the requirements have been met overall is established from the signed logs taken together, with any group hours certified by the program that delivered them.

9.5.6 The signed log is already held by the Association in the Portal and is read with the application. The clinician in training does not submit it.

9.5.7 A supervisor does not sign for a period they did not review.

9.5.8 Signing for recorded work that was not reviewed is a false attestation and is a matter for the Ethics Committee.

9.5.9 Signature is verification, not endorsement. It states that the work recorded was done. Whether the clinician in training is ready is a separate judgment, made in the final review, and the Certification Board decides the application. A supervisor signs an accurate log whether or not they support it, and whether or not the pathway is complete.

> **What the signature carries**
>
> The log carries almost all of it. What the Certification Board knows about two years of clinical work and fifty hours of supervision comes from this record, the 150-hour review, the final review, and any group hours a program has recorded — and the signatures are the only thing standing behind the log.
>
> Signing in the Portal is done under the signer's own IAPST login, and the Portal records who signed, what they signed, and when. A supervisor is answerable for what their signature stands behind in exactly the way they would be for a signature on paper.

9.6 Where supervision transfers

A supervisor signs only for the hours they delivered. Where a clinician in training changes supervisor, the log does not carry forward for the next supervisor to sign at the end. It is closed and signed at the point of transfer.

9.6.1 The outgoing supervisor completes their entries to the date the relationship ends. That supervisor and the clinician in training then sign the log in the Portal, at that point rather than at completion.

9.6.2 A new log is opened for the remainder of the pathway and runs from that date. The incoming supervisor signs it at application, with the clinician in training, on the terms at Section 9.5.

9.6.3 The record therefore holds two signed logs where supervision transferred once, and one for each period where it transferred more than once. Each is signed in the Portal by the supervisor who delivered those hours and by the clinician in training.

9.6.4 Running totals carry across. The second log states the hours already accrued so that the ratio and the totals remain auditable across the whole pathway.

9.6.5 Concurrent individual supervisors. Where a clinician in training holds two individual supervision agreements at the same time, there is still one log. Each supervisor makes only their own entries, and each signs at application for the hours and topics that are theirs. The agreement filed for each states which supervisor holds the continuity, the recordings, and the 150-hour review.

9.6.6 Where one of two concurrent supervisors leaves, the log is not closed. The departing supervisor signs their own entries to the date of ending, and the log continues under the remaining agreement.

This is the practical reason the log is closed rather than handed on. A supervisor asked at the end of a pathway to sign a document covering a year they had nothing to do with will either sign something they cannot verify or refuse, and neither outcome is any use to the clinician in training.

10. The Application for Certification

10.1 The application comprises evidence of completion of an IAPST-accredited program, and a statement from the clinician in training. Everything else is already held by the Association in the Member Portal: the supervision agreement, the log or logs, any group hours the delivering program recorded, the 150-hour review, and the final review. The clinician in training does not submit any of them.

10.2 The final review

10.2.1 There is one final review, completed once, at the close of the pathway. It is the supervisor's assessment of the clinician in training at the close of supervision. Before completing it, the supervisor confirms that all required hours are complete and reviews the full log, including clinical work accrued since the last supervision session. Clinical work may remain to be considered when the last supervision session has been delivered, because clinical work may run ahead of supervision. What this requires is that the final state of the record is before the supervisor when they complete the review; it does not of itself require a further hour of supervision. It is made on the form the Association issues, it is signed in the Portal, and it is read with the application.

10.2.2 It is the record and the assessment together. There is no separate letter of recommendation, because this document does both jobs. The structured parts establish what happened; the written parts are the supervisor's account of this clinician in training as a clinician. Neither stands without the other, and a form that carries only the ticks is not a completed final review.

10.2.3 Why it is a form. The midpoint review is structured and for a period the close of the pathway was not, so the Certification Board received more organized information about a clinician in training halfway through than about the one it was being asked to certify. Putting the verifiable facts in a fixed place also means the supervisor's writing is not spent restating hours, and can be about the clinician in training instead.

10.2.4 It has six parts, set out at Sections 10.3 to 10.8: the record, the seven dimensions, where the clinician in training grew, what is still developing, the recommendation, and the declaration. A form returned with an applicable part blank is incomplete and the Office of Membership returns it to the supervisor. Two fields are not left blank but completed differently, and Sections 10.2.11 and 10.8.4 state them: the field describing what the supervisor did not see is completed as Not applicable where they delivered the whole pathway, and the recommendation declaration is left unsigned where the outcome is Not recommended at this time.

10.2.5 The supervisor who completes it is the clinician in training's individual supervisor at the close of the pathway. Where supervision transferred, that is the incoming supervisor, and Section 10.3.3 states what they do and do not attest to.

10.2.6 Where two individual supervisors remain engaged at completion. The supervision agreements state which of them completes the final review, as they state which holds the continuity requirement, the recorded work, and the 150-hour review. Where the agreements do not say, the supervisor who delivered the greater number of individual hours completes it, and the other may provide a transfer summary for their own period. The Office of the Executive Officer determines the question where it remains unsettled.

10.2.7 It carries no fee. A supervisor does not bill for completing it. Where the supervisor and clinician in training do go through it together, that contact is supervision, is logged and counted on the ordinary terms, and is not separately chargeable, as it is for the 150-hour review. Going through it is optional at the close whatever the outcome, and Section 10.9.3 states why.

The supervisor's share of the pathway

10.2.8 The form states on its first page how much of the pathway this supervisor personally delivered. The individual and group hours they delivered, set against the totals completed; the recordings they reviewed, set against the total reviewed; the topics they covered; and whether they were the sole individual supervisor or one of several. This is completed before any other part of the form.

10.2.9 Why it comes first. A clinician in training may change supervisor partway through, may hold two individual supervisors at once under Section 9.6.5, and may take group hours from an accredited program the supervisor had nothing to do with. A supervisor who delivered twelve of the fifty hours is assessing on a narrower base than one who delivered all fifty. The Certification Board is entitled to know which it has in front of it before it reads the assessment, and not to have to work it out from the logs.

10.2.10 It is context, not a defect. Nothing in this Section reduces what the supervisor is asked for. A supervisor who delivered part of the pathway still rates all seven dimensions, still

writes Parts C and D, and still signs or declines the declaration. Supervising part of a pathway does not qualify an assessment; it describes its base.

10.2.11 Where the supervisor delivered only part of the pathway, they state what they did not see and how that bears on their assessment. Where they delivered the whole of it, they enter Not applicable rather than leaving the field blank, and the form is not returned on that ground.

10.2.12 The Certification Board weighs the assessment in light of the share stated. Where a supervisor delivered a small proportion of the hours, the Board may read the filed 150-hour review, any transfer summary an earlier supervisor provided, and the logs as carrying correspondingly more of the picture.

10.2.13 **Three documents are distinguished by name.** The 150-hour review is the midpoint assessment. A transfer summary covers an earlier supervisory period where a clinician in training changed supervisor, and it carries no recommendation. The final review is completed once, at the close. A second final review exists only where an application was deferred, further supervised work was required, and the pathway closed again after that work; the earlier one is read alongside it.

10.3 Part A: the record

10.3.1 Part A is divided. A supervisor attests personally to their own period, and reads the rest off the signed logs taken together. Nobody is asked to vouch for work another supervisor delivered.

A1 The supervisor's own period	**Attested personally**
Hours delivered	The individual and group supervision hours I delivered are entered in the log, are accurate, and are stated on this form.
The ratio in my period	Every supervision hour I delivered and counted is supported by six completed eligible clinical hours — or any hour not so supported is marked in the log as not counting.
Recordings I reviewed	Every recording attributed to me in the log I personally watched or listened to, and the review dates are accurate.
Topics I initialed	Every topic bearing my initials was covered against this clinician in training's own clinical material, at the level the published descriptor sets out.
My registration	I held IAPST certification and registration as a Registered Supervisor throughout the period I supervised.
The log for my period	My entries are accurate and were made at the time, not reconstructed afterward.

A1 The supervisor's own period	Attested personally
Ethics	I know of no unresolved ethics matter concerning this clinician in training that the Certification Board should be aware of.

A2 What the record shows	Read off the signed logs together
Clinical work	Not fewer than 300 hours of psychosexual clinical work.
Supervision	Not fewer than 50 hours of supervision, of which not fewer than 26 hours are individual supervision and not more than 24 hours are group supervision.
The ratio	Every supervision hour counted is supported by six completed eligible clinical hours, and no hour counted was delivered ahead of the clinical work supporting it.
Continuity	Not fewer than 16 individual hours delivered by one supervisor within one continuous supervisory relationship — or the Certification Board varied the requirement, and the decision date is stated below.
The window	All hours fall within the two-year period running from the filing of the first supervision agreement — or the Certification Board suspended or extended it, and the decision date and revised deadline are stated below.
Recorded work	Not fewer than six recorded sessions, or permitted equivalents under Section 3.5, reviewed across not fewer than three different treatment cases.
The topics	All fifteen topics at Evidenced, each dated and recorded against the supervisor who covered it.
The midpoint review	Conducted at 150 clinical hours and filed with the Association.
Midpoint conditions and concerns	Where the midpoint outcome was Continuing with conditions or Serious concern, each condition or concern is named below as resolved, partly resolved, or unresolved, with the evidence for that and its effect on this recommendation.
Signatures	Every log is signed in the Portal by the supervisor who delivered the period and by the clinician in training.

10.3.2 A1 is a personal attestation. Attesting to work not done is a false attestation rather than an error, and goes to the Ethics Committee under Section 12.3.8.

10.3.3 A2 is a reading of the record. The supervisor confirms what the logs show and marks any item they cannot confirm, rather than leaving it blank or answering for a period they did not supervise. An item marked as unconfirmed does not by itself defeat an application; it tells the Office of Membership where to look.

10.3.4 Where the midpoint outcome was Continuing with conditions or Serious concern, each condition or concern is named at Part A, with what the clinician in training did about it, the

evidence for that, and whether it is resolved, partly resolved, or unresolved. Its effect on the recommendation is stated at Part E. A resolved concern is recorded as fully as an unresolved one. It is the part most often left out, and it is worth a great deal to a clinician in training.

10.3.5 Part A carries a comment field, for anything the ticks do not explain: an item marked unconfirmed, a period supervised by someone else, an excluded run of hours, a dispute about the record.

10.4 Part B: the seven dimensions

10.4.1 The clinician in training is rated on the same seven dimensions the 150-hour review rates — formulation, self-observation, scope, recovery, openness and accurate reporting in supervision, psychosexual clinical competence, and independence — against the same descriptors, which Section 11.4 sets out.

10.4.2 The scale does not change between the two reviews. That is deliberate. Because the descriptors are identical, the Certification Board can read the midpoint review and the final review side by side and see movement rather than two unrelated snapshots. A different scale at the close would make the two documents incomparable, which is the main thing rating twice is for.

10.4.3 Insufficient evidence. A fourth entry is available on each dimension where the work it describes has not arisen or has not been seen. It is not a low rating, and it is not a neutral one. The supervisor states what evidence is missing and why it could not be obtained. A supervisor who took over part of the pathway is not asked to imply firsthand evidence they do not have.

10.4.4 It does not satisfy the benchmark. An unrated dimension is not an On track dimension, so a dimension marked Insufficient evidence rules out an unqualified Recommended, whatever the reason for the gap. Either the evidence is obtained before the review is filed, or the supervisor records the gap at Part B, states its consequences for the recommendation at Part E, and recommends with reservation at best. The Certification Board determines what follows.

10.4.5 The basis of each rating is recorded. Against each dimension the supervisor records what the rating rests on — a recording or live observation, written material the clinician in training produced, the clinician in training's own report, or an earlier supervisor's documented assessment.

10.4.6 The midpoint rating is shown alongside. Each dimension carries the rating recorded at the 150-hour review, so that movement is visible, and the supervisor gives one concrete example of what changed where a rating has moved. A change in rating is not on its own evidence of readiness.

10.4.7 Every rating carries a written comment. Against each of the seven the supervisor writes what they saw that supports the rating. This is required for all seven, including the ones rated On track, and a rating entered without a comment is incomplete. The comment is where a rating stops being a tick and becomes evidence the Board can weigh.

10.4.8 What readiness means. A clinician in training is ready when they are at the On track level on each of the seven.

10.4.9 That is the supervisor's benchmark, not the Board's test. Where a clinician in training is not at On track on a dimension, the supervisor says which, and what they have seen. The Certification Board decides the application and may certify a clinician in training below the benchmark on a dimension, subject to the conditions the Standards of Certification impose on that decision: every mandatory requirement satisfied in full, the evidence relied on identified in writing, and the recorded concern found not to bear on competence within the applicant's lawful scope. A recommendation with reservation does not waive any requirement as to hours, topics, recorded work, or the ratio where the evidence as a whole supports it. The benchmark tells the supervisor what to assess and the clinician in training what is expected; the decision remains the Board's.

10.4.10 The clinician in training does not rate themselves again. They do so at the midpoint, before seeing the supervisor's ratings, and their statement is their own voice in the application. A second self-rating at the close would duplicate both.

10.5 Part C: where the clinician in training grew

10.5.1 The supervisor sets out how this clinician in training developed over the course of supervision. This is a required part of the review and it is the part the Certification Board reads most closely, because it is the only account anywhere in the application of what supervision actually did.

10.5.2 It is held to a standard of detail. For each area of growth the supervisor states what the clinician in training was like at the start, what changed, and the case, session, recording, or piece of written work that shows it. Dates where the record carries them. "They grew in confidence" is not an answer to this part, and neither is a restatement of the Part B ratings in sentences.

10.5.3 Growth is written about this clinician in training. An account that would read the same about any competent clinician in training has not been written about this one. The test the Certification Board applies is whether the clinician in training could be identified from Part C with the name removed. The Office of Membership checks that Part C is present and completed; whether what it says is specific enough is a judgment for the Board.

10.5.4 Where a clinician in training has grown little, the supervisor says so and says why. That is a finding about the supervision as much as about the clinician in training, and Section 12 sets out what follows where the supervision is the cause.

10.6 Part D: what is still developing

10.6.1 The supervisor names at least one area in which the clinician in training is still developing, whatever the recommendation. This is required.

10.6.2 It is what makes the rest of the review mean anything. A review that says only good things about everyone is of no use to the Certification Board and of no use to the clinician in training. Every clinician certified under this standard has something still developing, and a supervisor who cannot name it has not looked.

10.6.3 Part D is held to the same standard of detail as Part C, and states what the clinician in training should do about it after certification. It is written to be read by the clinician in training, because it will be.

10.6.4 Naming an area at Part D is not a reservation. A supervisor may recommend a clinician in training without qualification and still name what is developing. Where the supervisor does intend a reservation, it is recorded at Part E.

10.7 Part E: the recommendation

10.7.1 The supervisor records one of three outcomes.

Outcome	When	What follows
Recommended	The clinician in training is at On track on each of the seven dimensions and the record at Part A is complete. A dimension marked Insufficient evidence does not satisfy this, whatever the reason for the gap.	The supervisor signs the declaration at Part F. The application proceeds to the Certification Board with the recommendation.
Recommended with reservation	The supervisor recommends certification but rates a dimension below On track, marks one Insufficient evidence, or a matter in the record is incomplete or disputed.	The supervisor signs the declaration at Part F and states the reservation in full at Part E: the dimension or matter, what they have seen, and what the Board should weigh. Where the reservation is a dimension marked Insufficient evidence, they state what is missing, why it could not be obtained, and what they would need to see. The Board may certify below the benchmark where the evidence as a whole supports it.

Outcome	When	What follows
Not recommended at this time	The supervisor does not judge the clinician in training ready to exercise independent clinical judgment in psychosexual therapy, within the scope and conditions of their own lawful authorization.	The declaration at Part F is not signed. The supervisor gives reasons and sets out what would change it. The clinician in training may apply regardless, may respond in writing, and may ask the Certification Board to review the refusal under Section 11.11.

10.7.2 Completing the hours does not produce a recommendation. It is a professional judgment about readiness to exercise independent clinical judgment in psychosexual therapy, within the scope and conditions of their own lawful authorization, it is not a formality, and it is not a function of hours completed.

10.7.3 A supervisor who wrote at the midpoint that on present course they expected to be able to endorse this clinician in training, and who now does not, accounts for what changed. A supervisor who wrote "not yet, and here is why" has already done the difficult part.

10.7.4 Where the outcome is a reservation or a refusal, the supervisor states what would change it, and by when if a period can be named.

10.8 Part F: the declaration

10.8.1 Every final review carries a signed statement of record:

> **Signed on every final review**
>
> I certify that this review is a true and complete record of my assessment of this clinician in training, that the attestations at Part A are accurate, and that I completed it myself.

10.8.2 Where the supervisor recommends the clinician in training, whether or not with reservation, they also sign the declaration:

> **Signed where the supervisor recommends**
>
> I would refer a patient to this clinician.
>
> I consider this clinician in training competent to exercise independent clinical judgment in psychosexual therapy, within the scope and conditions of their own lawful authorization to practice, and ready for certification as an IAPST Certified Psychosexual Therapist.

10.8.3 The declaration is the whole of what certification asks of a supervisor, put in the plainest terms available. A supervisor who would not send a patient to this clinician is not recommending them, whatever the ratings say, and should record Not recommended at this time and give their reasons.

10.8.4 Where the outcome is Not recommended at this time, the declaration is left unsigned. The statement of record is still signed, because the review is still the supervisor's true account and still goes to the Board. A review completed this way is complete, and the Office of Membership does not return it for the unsigned declaration.

10.8.5 Both the statement of record and the declaration are signed in the Member Portal, as the log is signed, under the supervisor's own IAPST login.

10.9 The clinician in training's copy and response

10.9.1 Delivered automatically on filing. The supervisor completes the review and files it in the Member Portal. The Portal then sends it to the clinician in training, in full and including Parts C, D, and E. No act of the clinician in training is required before or after filing: they do not acknowledge it, and they do not sign it.

10.9.2 The delivery date. The Portal records the date and time the review was sent to the clinician in training, and that record is the evidence of delivery. It does not state that the clinician in training has read the review or agrees with it.

10.9.3 Going through it together is optional in every case. The 150-hour review is discussed with the clinician in training in their next supervision session, because supervision continues after it. The final review is delivered and read, and going through it together is open to the parties in any case and required in none, whatever the outcome, because the pathway has ended. An optional discussion is not a condition of completion, of filing, or of the application proceeding.

10.9.4 Where the parties do go through it, that contact is supervision, is logged and counted on the ordinary terms of Section 2, and is not separately chargeable. Nothing in this Section entitles it to count where those terms are not met.

10.9.5 The clinician in training may submit a written response, which is filed with the review and read by the Certification Board. The final review is the document that can end the pathway, and it is not the one document the clinician in training cannot answer.

10.9.6 Where the outcome is Not recommended at this time. Section 11.11 sets out the clinician in training's right to ask the Certification Board to review the refusal, and the thirty days in which to do it. The thirty days run from the date the Portal delivered the review under

Section 10.9.2. The supervisor's written reasons at Part E are what the clinician in training reads and answers; no conversation is required before or after delivery, and the supervisor may offer one.

10.10 The clinician in training's statement

10.10.1 The statement is written by the clinician in training in their own voice, addressing why they seek certification, their educational journey, what they have learned, and how they have developed as a clinician. The supervisor does not write or edit it.

10.11 The supervisor's part in the application

10.11.1 Assisting the clinician in training with the application is an obligation of the supervisor, not a courtesy.

10.11.2 A clinician in training may apply against the supervisor's advice. The supervisor completes the final review covering the period supervised, records Not recommended at this time, and states their reasons. A supervisor does not decline to complete the form, and withholding it does not stop an application; where a supervisor will not complete it, the clinician in training writes to the Office of the Executive Officer, which determines how the period is evidenced.

PART FOUR

The 150-Hour Review

The midpoint assessment, the rubric against which it is conducted, and the outcomes available to it.

11. The Midpoint Review

11.1 When, and who conducts it

11.1.1 At 150 hours of clinical work — the halfway point — the clinician in training's individual supervisor conducts a formal review.

11.1.2 A session that crosses the threshold. Where a single clinical session takes the clinician in training from below 150 hours to above it, that session counts and is logged. The clinician in training is not in breach for having completed the one that crossed the line, and the exclusion at Section 11.1.6 begins with the next clinical session.

11.1.3 The next individual session is the review. Once the clinician in training reaches 150 clinical hours, the next session of individual supervision is the midpoint review. The individual supervisor does not deliver further ordinary individual supervision until the review is complete and filed with the Association. The review may take more than one session, and Section 11.1.12 governs that contact.

11.1.4 Why it is put this way. The individual supervisor conducts the review, and the obligation binds the one person who can defer it. Without this rule a supervisor could continue billing ordinary individual sessions for months while the review went unwritten, and the clinician in training would have no remedy but to stop paying for supervision they need.

11.1.5 Group supervision is not affected. A clinician in training enrolled in group supervision with an accredited program continues to attend it, and those hours count on the ordinary terms. The pause reaches the individual supervisory relationship only, because that is where the review sits.

11.1.6 Clinical hours past 150 do not count while the review is outstanding. Clinical work may continue, and the clinician in training is not in breach for continuing it, but hours accrued beyond 150 before the review is filed do not count toward certification. This is subject to Section 11.1.2, which allows the session that crosses the threshold, and the hours it allows remain subject to every other counting rule.

11.1.7 This is not a consequence of the ratio. The ratio caps the supervision that counts, not the clinical work, so it would never stop a clinician in training from continuing to see patients. The pause exists for a different reason, and it is the only brake the standard places on clinical work running ahead. The review is the only point at which the standard can shape the second half of the pathway, and hours accrued before it is done are hours the review cannot shape.

11.1.8 Consultation continues. The supervisor remains available for consultation on live cases, and on any matter of patient safety. That contact is not countable supervision, is not logged

as such, and is chargeable like any other consultation between sessions. Nothing in this Section leaves a clinician in training without a supervisor to reach.

11.1.9 Where the delay is the supervisor's. A review not filed within thirty days of the clinician in training reaching 150 hours is overdue. The clinician in training writes to the Office of the Executive Officer, which may direct that hours accrued during the delay count, appoint another Registered Supervisor to conduct the review, or both. A clinician in training is not made to lose hours because their supervisor was slow.

11.1.10 The two deadlines. In the ordinary case the review is filed within thirty days of the clinician in training reaching 150 clinical hours, and the escalation at Section 11.1.9 becomes available on the thirty-first day. Where supervision transferred close to the midpoint, the incoming supervisor has the sixty days at Section 11.1.16, and the escalation becomes available on the sixty-first day after they took over. Neither period runs twice.

11.1.11 What the relief covers. A direction under Section 11.1.9 lifts the midpoint exclusion only. Those hours must still satisfy every other counting rule: they do not count if delivered while the supervisor was unregistered, outside the two-year period, or ahead of the clinical work supporting them. The Executive Officer cannot waive those.

11.1.12 Conducting the review may take more than one session. The supervisor and clinician in training may meet as often as the review requires — to go through the log, to review a recording the reviewer has not yet seen, to discuss the ratings. Each such session is individual supervision and is logged and counted on the ordinary terms of Section 2, because that is what it is. This Section creates no exception to those terms and no entitlement beyond them. The consultation contact at Section 11.1.8 is not supervision and is not logged as such.

11.1.13 The review carries no fee. Neither does a review conducted by a second supervisor under Section 11.1.9, nor the sessions at Section 11.1.12, whether or not those sessions qualify for credit under Section 2.

11.1.14 Who conducts it. The clinician in training's individual supervisor at the time the 150 hours are reached. A clinician in training may be receiving both group and individual supervision, sometimes through a program; the individual supervisor holds the continuous relationship, the recordings, and the log.

11.1.15 Where a clinician in training has more than one individual supervisor at that point, the supervisor named in the supervision agreements as holding the 150-hour review conducts it. Where the agreements do not name one, or where the parties wish to change the allocation, the clinician in training nominates one in writing to the Office of the Executive Officer before the review falls due, and that supervisor conducts it with access to the whole log. A nomination made this way is the later record and governs over the agreements, and the Office of the Executive Officer records it against both.

11.1.16 A supervisor who has already ended the relationship does not conduct the review. Where the change happens close to 150 hours, the incoming supervisor conducts it once they have enough of the clinician in training's work to say something true, and in any event within sixty days of taking over. The deadline is measured in time rather than in clinical hours, because hours accrued while the review is outstanding do not count and a clinician in training should not have to burn them waiting.

11.2 Why it exists

The review serves two purposes, and both matter equally.

It protects the clinician in training financially. A supervisor sets their own fee, is paid by the session, and writes the assessment of readiness that carries the most weight with the Certification Board. Without a midpoint, a clinician in training can pay for fifty hours across two years and be told at the close that they will not be endorsed. The review moves that judgment to a point at which the clinician in training can still act — by addressing what is missing, by extending, by changing supervisor, or by stopping. The clinical midpoint is not necessarily the financial one: agreed frequency, fees, uncounted sessions, and any additional supervision all vary, so 150 clinical hours fixes the timing and not the amount still to be paid.

It protects the credential. Not everyone who completes supervision qualifies for certification, and the credential means something because that is so. The review is the only point at which the standard can shape the second half of supervision rather than merely judge the whole of it. By the time an application reaches the Certification Board, it may confer, defer, or deny. Deferral can require further supervised work, but it does so after the clinician in training has completed the minimum pathway and paid to apply, and at a cost the midpoint could have avoided.

> **The two purposes hold each other up**
>
> Financial protection is what makes rigorous gatekeeping fair — nobody pays in full for a verdict that could have been given while they could still act on it.
>
> Rigorous gatekeeping is what makes the financial protection worth having — a credential anyone can buy is not worth protecting anyone's investment in.

11.3 What the review covers

The arithmetic

The review falls at 150 clinical hours whatever the supervision total stands at. There is no supervision figure to be reached by this point and none to be checked against: the trigger is the clinical work. The supervisor records the clinical and supervision hours to date, confirms that each

supervision hour counted is supported by six completed eligible clinical hours, and confirms that no hours fall outside the two-year window.

The recorded work

Not fewer than three recorded sessions, or permitted equivalents under Section 3.5, have been reviewed by now, from not fewer than two different treatment cases. This is a threshold rather than guidance, and it is the figure the compliance table uses. A clinician in training at 150 hours with none reviewed is the clearest possible sign that something has gone wrong, and it is the supervisor's failure before it is the clinician in training's.

The topics

Not fewer than seven of the fifteen are at Evidenced, dated, and recorded against the supervisor who covered them. That is the threshold. Which seven is guidance rather than requirement: topics arise from cases, so a spread matters more than an order.

The log

Complete, current, and internally consistent.

Clinical development

The substantive part. Can the clinician in training formulate rather than only describe? Do they notice their own reactions during a session, or only afterward when it is pointed out? Do they bring the difficult case or the successful one? Have they changed in ways the supervisor can name?

11.4 The rubric

The review is conducted against a rubric, so that a clinician in training knows what is being assessed before it happens, and a supervisor is not left to characterize a person they may like or dislike. It has two parts, and they work differently.

Part A is factual. Seven compliance items, each met or not met. They are read off the log and are not a matter of judgment.

Part B is judgment. Seven dimensions of clinical development, each at one of three levels. These are the same seven on which readiness is judged at the end, so the midpoint says something real about the likely ending rather than being a separate exercise.

Part A — Compliance

Item	Met where
The ratio	Each supervision hour counted is supported by six completed eligible clinical hours. Clinical work running ahead of supervision is permitted and is not a breach.

Item	Met where
The window	No hours fall outside the two-year period, and the period has not expired — or the Certification Board has suspended or extended it, and the decision date and revised deadline are stated below.
Recorded work	Not fewer than three recorded sessions, or permitted equivalents under Section 3.5, reviewed — from not fewer than two different treatment cases.
The topics	Not fewer than seven of the fifteen at Evidenced, dated, and recorded against the supervisor who covered them.
The log	Complete, current, and internally consistent.
The agreement	Signed in the Member Portal by both parties and by the Executive Officer, and so filed, before any supervision other than the Agreement meeting.
Registration	The supervisor held certification and registration throughout the period.

A compliance item not met does not by itself end the pathway. It sets a condition, and Section 11.6 states how.

Part B — Clinical development

Each dimension is rated Not yet, Developing, or On track. A fourth entry is available on each: Insufficient evidence, where the work the dimension describes has not arisen or has not been seen. It is not a low rating, and it is not a neutral one: a dimension so marked is not an On track dimension, so it rules out On track and requires at least Continuing with conditions, the condition being to obtain the evidence. Where the criteria for Serious concern are also met, or the evidence warrants it, Section 11.6.1 applies and that outcome is recorded instead. The supervisor records what evidence is missing and how it will be obtained, and the basis of every rating entered — recording or live observation, written material, the clinician in training's own report, or an earlier supervisor's documented assessment — is recorded with it.

Formulation

Not yet	Describes what happened. Cannot say why this difficulty is occurring in this person.
Developing	Offers a formulation, and revises it once the supervisor points to what contradicts it. Does not yet notice the contradiction unprompted.
On track	Says why this difficulty is occurring in this person, notices when the case contradicts the formulation, and revises it without prompting.

Self-observation

Not yet	Reports no reactions of their own, including where the supervisor identifies one in reviewed material.
Developing	Names a reaction after the session, or once the supervisor raises it, and can say what it did in the room.
On track	Names a reaction during the session, and can give an example of using it — a question asked differently, a pace changed, something left unsaid.

Scope

Not yet	Does not identify limits of their own competence, or treats every presentation as within them.
Developing	Identifies a limit after reaching it, or when the supervisor raises it, and acts on it then.
On track	Identifies a limit before reaching it and acts — refers, seeks consultation, or acquires the competence — and can say how they knew.

Recovery

Not yet	Does not bring errors, or presents them as unavoidable outcomes.
Developing	Brings an error and can say what it was. Repairs it with supervisory guidance, or identifies the repair without having made it yet.
On track	Repairs it, in the room where that is possible and by another route where it is not, and can say what the repair required of them.

Openness and accurate reporting in supervision

Not yet	The account given in supervision does not match the reviewed material — work is omitted, or described more favourably than the recording shows.
Developing	Reports accurately, and brings difficult work when asked for it rather than on their own initiative.
On track	Brings work they are not proud of without being asked, and their account of a session matches what the reviewed material shows.

Psychosexual clinical competence

Not yet	Assesses and intervenes without reference to the sexual, relational, and medical factors the presentation calls for. Does not identify a risk the case carries.
Developing	Takes an adequate assessment and selects a defensible intervention. Tracks the treatment response or adjusts course with supervisory guidance rather than on their own reading of it. Identifies risk when it is evident.
On track	Takes an accurate psychosexual assessment, selects interventions the formulation supports, tracks the treatment response and changes course on it unprompted, and identifies and manages the risk the case carries.

Independence

Not yet	Asks what to do without having formed a view of their own.
Developing	Asks what to do, then checks their own answer against the reply.
On track	Reports what they did and why, and asks about the reasoning rather than the action. Seeking advice before acting on a difficult case is part of this, not a departure from it.

> **Developing is the normal midpoint reading**
>
> At 150 clinical hours most clinicians in training sit at Developing on most dimensions. That is what the halfway point of a training pathway looks like, and a supervisor who rates everyone On track at the midpoint has not understood the instrument.
>
> The reading that matters is Not yet. One is a condition to work on. Two is a serious concern.
>
> Developing describes partial or supported competence — the clinician in training does the thing with prompting, or after the session rather than during it. Not yet is reserved for the behavior the descriptor names.

11.5 The clinician in training rates themselves first

11.5.1 Before the review, the clinician in training completes Part B independently, without seeing the supervisor's ratings.

11.5.2 The two sets of ratings are then compared, and the comparison forms part of the review conversation.

11.5.3 Both ratings are recorded. The clinician in training's rating and the supervisor's rating are entered against each dimension in separate fields in the Portal, and the supervisor records what they make of any difference. Neither replaces the other.

11.5.4 The clinician in training's self-rating is recorded in the filed review alongside the supervisor's.

The gap between the two is often the most useful thing the review produces, and it is a prompt to examine the evidence rather than a finding in itself. Where the two differ, both sets of ratings are tested against what is actually in the log and the reviewed work; a difference does not establish which rating is right. Sometimes it shows a clinician in training not yet seeing their own work clearly, sometimes a supervisor who has not seen enough of it, and sometimes a clinician in training underrating themselves out of caution.

It also changes what the meeting is. A supervisor delivering ratings to a clinician in training who has not formed a view is delivering a verdict. A supervisor comparing two sets of ratings is having a conversation, and the clinician in training has already done the work of thinking about their own practice.

11.6 The outcome

Every review states one of three outcomes. The outcome is recorded in the filed review and in the log.

On track

When	All compliance items met, no dimension at Not yet, no dimension marked Insufficient evidence, and not fewer than four of the seven dimensions at On track.
Effect	Supervision continues. The supervisor states that on present course they expect to be able to endorse this clinician in training.

Continuing with conditions

When	Anything short of On track that is not a Serious concern. A dimension marked Insufficient evidence rules out On track and requires at least this outcome, the condition being to obtain the evidence; Serious concern is recorded where its criteria are met or the evidence warrants it.
Effect	Supervision continues. The supervisor names each condition, what would satisfy it, and by when. Conditions are revisited at a stated point, and each is recorded at Part A2 of the final review as resolved, partly resolved, or unresolved.

Serious concern

When	Two or more dimensions at Not yet, or no recorded work or permitted equivalent reviewed at all, or the supervisor judges that the clinician in training is not on a path to certification on present course.
Effect	The supervisor says so with reasons, sets out what would change it, and notifies the Office of the Executive Officer. Supervision continues unless the supervisor ends it. The clinician in training may address the concerns, seek another supervisor, apply to extend, or stop.

11.6.1 The decision rule sets the floor, not the ceiling. A supervisor may record a Serious concern where the arithmetic would allow Continuing with conditions, and states why. They may not record On track where the rule is not satisfied.

11.6.2 Continuing with conditions is not a failure and is not a finding against the clinician in training. It is the review doing what it exists to do, at the point where something can still be done about it.

11.6.3 A clinician in training who disagrees with the outcome may say so in writing, and their response is filed with the review.

11.7 What the supervisor writes

A written review, given to the clinician in training and filed with the Association. It states:

- Hours to date — clinical, supervision, individual — and how much countable supervision the completed clinical work supports
- Recordings reviewed to date, and from how many patients
- Topics covered, and which remain
- The supervisor's assessment of the clinician in training's clinical development
- Anything that must change in the second half, stated plainly
- Whether the supervisor expects the clinician in training to need more than the minimum hours, and if so roughly how many
- Whether, on present course, the supervisor expects to be able to endorse this clinician in training

11.7.1 The review is released to the clinician in training in the Member Portal when it is filed, and the supervisor goes through it with them in their next supervision session. It is given in writing and discussed; it is not delivered only in conversation, and not left only on a screen.

11.7.2 The statement about additional hours is a financial disclosure as much as a clinical one. It is the point at which a clinician in training learns that the cost is rising, while they can still respond to it.

11.7.3 The statement about endorsement is the provision that keeps the final review honest. A supervisor who wrote "on present course, yes" and then saw no change has to account for it; one who wrote "not yet, and here is why" has already done the difficult part. Without a midpoint commitment, the path of least resistance at the end is always the soft yes.

11.8 Where the answer is not yet

Many reviews are neither a clean yes nor a no. They are “not yet, and here is the work” — formulations that are thin, a clinician in training who brings only successful cases, someone who has not yet been pressed on their own reactions. These are people who should continue, and who have 150 hours in which the problem can actually be addressed.

Where that is what the evidence shows, the review is working as intended. It is not an off-ramp, and it is not the expected result either; it is the point at which supervision becomes formative. Rate what you saw, not what you expect a review to produce.

11.9 Where the answer is no

11.9.1 The supervisor says so, in the review, with reasons, and identifies what would change it and by when.

11.9.2 Extending supervision is available and is almost always better than an endorsement the supervisor does not mean.

11.9.3 A clinician in training may continue against the supervisor’s assessment. The supervisor notes it and continues supervising to the same standard.

11.10 Remediation

11.10.1 Where a review sets conditions, the supervisor records for each one: what must change, what evidence would satisfy it, the date by which it is to be met, and the date it will be reassessed.

11.10.2 Where meeting the conditions is likely to require hours beyond the minimum, the supervisor estimates how many, in the review. This is a financial disclosure as much as a clinical one.

11.10.3 At the reassessment date the supervisor records the outcome in the log and gives it to the clinician in training in writing. Where conditions were met, that is stated. Where they were not, the supervisor sets out what remains and whether the pathway continues.

11.10.4 Whether the conditions were met is recorded at Part A2 of the final review, whatever the answer.

11.10.5 Nothing here delays action where patient safety requires it. A fitness concern about the clinician in training goes to the Office of the Executive Officer at once, and to the clinician in training’s own regulator where the conduct is licensable, under Article XIII of the supervision agreement. It does not wait for a reassessment date.

11.11 Review of a decision

11.11.1 A clinician in training may ask the Certification Board to review an outcome of Serious concern, or a supervisor's refusal to endorse, on the ground that it was reached without regard to this standard or without the evidence the standard requires.

11.11.2 The request is made in writing to the Office of the Executive Officer at info@iapst.org, with the review and the clinician in training's response to it.

11.11.3 The thirty days run from the date the clinician in training receives the written outcome, or the supervisor's written refusal to endorse. A verbal statement does not start the period; the written document does.

11.11.4 The Office acknowledges within five working days and tells the clinician in training what happens next and by when.

11.11.5 The Board does not substitute its own clinical judgment for the supervisor's. It determines whether the process was followed, and may direct that a review be redone, appoint a second reviewer, or vary a requirement under Section 14.5.7.

11.11.6 A clinician in training does not need this route in order to apply against their supervisor's advice, which Section 10.11.2 permits in any event. An appeal against a certification decision itself lies to the Executive Board.

12. Oversight

12.1 Why the review is filed

The review is filed with the Association, and this is deliberate. It is the only point in the pathway at which the Association sees how supervision is actually being conducted while there is still time to act on it.

Registration is self-declared; nobody vets a supervisor going in. The quarterly meetings surface only what a supervisor chooses to bring. Without the 150-hour review, the first evidence of a supervisor's work would arrive with the certification application — two years and fifty hours too late.

12.2 What the Association looks for

Marker	What it indicates
No recorded sessions or permitted equivalents reviewed at 150 hours	Case consultation, not supervision
All topics marked on a single date	Retrospective sign-off; the log was reconstructed
Ratio badly out and uncorrected	The log was not being checked at sessions

Marker	What it indicates
Supervisor entries thin or made in a batch	Not kept session by session
Review filed late, or not at all	The obligation was not taken seriously

None of these require judgment. They are visible from a document the Association already receives.

12.3 Where a supervisor falls short

12.3.1 The Office of Membership writes to the supervisor identifying what is missing and what must happen before completion. Most cases end here.

12.3.2 Repeat or serious findings may carry conditions on registration — for example, filing the log quarterly rather than at completion, or attending all four meetings.

12.3.3 A supervisor who does not correct, or whose failings are systematic, may be removed from the Register.

12.3.4 How removal happens. The Office of Membership removes an entry on lapse, and on notification of a finding of the Ethics Committee affecting registration. Neither is a decision about the supervisor.

12.3.5 Revocation is a decision. Where a supervisor fails to meet the Association's requirements or to comply with its supervision policies, registration may be revoked by the Executive Officer. Revocation is made on notice, with reasons given in writing, and the supervisor may respond before it takes effect.

12.3.6 A revocation may be appealed to the Executive Board. The appeal is made in writing within thirty days of the date the supervisor receives the notice.

12.3.7 Hours already delivered by a supervisor whose registration is later revoked are not invalidated by the revocation itself, and a clinician in training affected is assisted under Section 12.4.

12.3.8 Where a supervisor has attested to work they did not do, that is a false attestation rather than a deficiency, and goes to the Ethics Committee.

12.3.9 Patterns matter more than instances. One thin review is a note; the same supervisor appearing repeatedly is the finding. The Office holds review outcomes by supervisor as well as by clinician in training.

12.4 The clinician in training is protected

A clinician in training does not lose hours because their supervisor failed. Where a review finds the supervisor deficient, hours already delivered stand, the Association assists the clinician in training in continuing with another Registered Supervisor, and the two-year period is suspended for the transition.

This protects otherwise eligible hours. It does not reach hours the standard excludes outright, and those exclusions are absolute whoever was at fault: supervision delivered while the supervisor was not on the Register or after a prohibition under Section 15.3.11 took effect; supervision not supported by completed eligible clinical work; clinical work performed before the agreement was filed; and clinical work performed while the clinician in training was not lawfully authorized or was uninsured. The Certification Board cannot recognize any of them. Sections 14.5.8 and 15.3.14 state these exclusions, and Section 7.4 states how a clinician in training protects themselves against the first.

A negative review of the clinician in training is not a finding against the supervisor. These are separate determinations. A supervisor who reports honestly at 150 hours that a clinician in training is struggling has done the job well, and the review records it as such.

Extending supervision is legitimate. A supervisor who extends one clinician in training has made a clinical judgment. Where a supervisor extends most of their clinicians in training, the Office examines the reasons recorded for each extension and the evidence supporting them. A pattern is a reason to look, not a finding in itself, and it is visible only across reviews.

Nothing in the midpoint review obliges a positive final review. The supervisor's judgment at completion remains theirs.

PART FIVE

Individual and Group Supervision

The distinction between the two modalities, who may deliver each, and how each is credited toward the requirement.

13. Who May Deliver Which

13.1 Individual supervision

13.1.1 An individually registered supervisor may provide individual supervision only.

13.1.2 The supervisor sets their own fee. The Association does not set, review, or take any share of it.

13.1.3 A clinician in training may complete all fifty hours through individual supervision. Group supervision is capped at 24 hours; it is never required.

13.2 Group supervision

13.2.1 Group supervision may be delivered only by an IAPST-accredited program.

13.2.2 A group session counts in full. A clinician in training present for a two-hour group session logs two hours. Group supervision is a structured activity, and presenting one's own cases is only one part of it. The hour is not measured by how much of it the clinician in training spent talking about their own work.

13.2.3 Presenting is still required. Over the course of a group year a clinician in training presents their own work, and the program tracks who has presented and how often. A clinician in training who reaches the end of a group year having presented once has not been supervised in that group, and the program addresses it rather than the log absorbing it.

13.2.4 Partial attendance is counted under Section 1.3, like any other short session: actual time, rounded down to the nearest quarter hour, never rounded up into the standard band.

13.2.5 Everyone delivering supervision within a program must satisfy the conditions at Part Two in full.

13.2.6 Group size. Not more than six clinicians in training to one supervisor. A group larger than six is a seminar, and a clinician in training in it is attending rather than being supervised.

13.2.7 Presentation. A clinician in training presents their own clinical work not less than once each quarter of the group year. A program tracks this by clinician in training.

13.2.8 Partial quarters. A clinician in training who joins or leaves part-way through a quarter presents once in that quarter where they attended at least half its sessions. Where they attended fewer than half, no presentation is required for it.

13.2.9 The exemption concerns presentation only. Attendance hours in a partial quarter count under Section 1.3 in the ordinary way, whether or not a presentation was required.

13.2.10 Where a clinician in training has not presented in a quarter in which a presentation was required, the program schedules them in the next session and records that it did so. A clinician in training who has not presented in two consecutive quarters has not been supervised in that group, and the hours for the second quarter do not count. The two-quarter consequence applies only where a presentation was required in each quarter.

13.2.11 There is no separate group supervision agreement. Group hours are delivered by an accredited program under the terms on which that program enrolls its students, and no further instrument is signed with the Association. The individual supervision agreement covers individual supervision only and does not reach the group.

13.2.12 Group confidentiality. Every member of a group is bound by the same confidentiality terms, and the supervisor states them at the first session and enforces them thereafter. Material presented in group is de-identified.

13.2.13 Recordings in group. The consent at Section 3.3 is to review by a named supervisor. It does not extend to a group. Where recorded work is to be shown to a group, the patient consents to that specifically, is told that other clinicians will see it and in what setting, and may refuse without affecting their treatment. Where a patient does not so consent, the clinician in training presents the case without the recording.

13.2.14 Where a session records more than one person — a couple, a family, a therapy group — every person recorded consents, on the same terms.

13.2.15 Group hours are recorded by the program. The accredited program enters the clinician in training's group hours directly into their log in the Member Portal, stating the dates, the duration of each session, the supervisor who delivered it, and the dates on which the clinician in training presented. The individual supervisor does not sign for group hours they did not deliver, and the clinician in training does not submit anything for them at application.

13.3 What this means in practice

A clinician in training not enrolled in a program's supervision year has no route to group hours. That is permitted: all fifty may be individual, and the minimum of twenty-six individual hours is a floor rather than a target.

A clinician in training mixing the two pays for individual and group separately, and the individual supervisor remains responsible for the log, the recorded work, the fifteen topics, and the 150-hour review.

PART SIX

Interruption, Transfer, and Concerns

Suspension of the pathway, change of supervisor, and the procedure for raising a concern about supervision.

14. Interruption, Changing Supervisor, and Concerns

14.1 Interruption

14.1.1 Where a clinician in training is prevented from continuing by illness, parental leave, or another substantial interruption, they may apply to the Certification Board to suspend the two-year period, in writing, with the supervisor's support, before the period expires.

14.2 Where a supervisor dies or becomes unable to continue

14.2.1 The clinician in training notifies the Office of the Executive Officer, which determines how hours already delivered are evidenced and assists the clinician in training in continuing with another Registered Supervisor.

14.2.2 Hours properly accrued remain valid. The two-year period is suspended for the transition.

14.3 Where a supervisor's registration lapses

14.3.1 Hours delivered while a supervisor is not on the Register do not count toward certification, and that loss falls on the clinician in training.

14.3.2 A supervisor whose certification or registration lapses notifies the clinician in training the same day and tells them plainly what it costs them.

14.3.3 This is the single most important reason for a supervisor to keep renewal current, and for a clinician in training to verify registration before beginning and at each academic year.

14.4 What a clinician in training should be receiving

A clinician in training who has not been supervised before has no way of knowing what adequate supervision looks like. The following is what this standard requires, stated so that a clinician in training can tell when they are not getting it.

- The supervisor opens the log at the start of every session and checks it.
- The supervisor watches or listens to recorded sessions — a minimum of six, from at least three different treatment cases, across the relationship.
- The fifteen topics are covered against the clinician in training's own cases, and marked off in the log as they are covered.
- Three of those topics involve the supervisor reading something the clinician in training wrote.
- The supervisor conducts a written review at 150 clinical hours and gives it to the clinician in training.

- The supervisor is reachable between sessions, meaning they respond to ordinary contact within a reasonable time. Supervision is not an emergency or on-call service.
- The supervisor says what is not yet good enough while there is still time to act on it.

A clinician in training receiving none of the above is receiving case consultation. That may be valuable, but it is not supervision to this standard, and the hours may not support an application.

14.5 Changing supervisor

14.5.1 A clinician in training may change supervisor at any time and does not require the Association's permission to do so. Hours properly accrued with a previous supervisor remain valid.

14.5.2 A new supervision agreement is signed and filed with the Office of the Executive Officer before any session with the new supervisor other than their Agreement meeting. The two-year period continues to run from the original filing date.

14.5.3 The outgoing supervisor completes their entries to the date of ending, and the log is closed and signed in the Portal by that supervisor and the clinician in training at that point. Section 9.6 sets out how the logs work across a transfer. If requested, the outgoing supervisor also provides a transfer summary covering the period they supervised. It is not the final review and does not carry the final review's assessment or recommendation.

14.5.4 The continuity requirement at Section 1.1.5 is satisfied once and does not restart. A clinician in training who has already completed sixteen continuous individual hours with one supervisor carries that with them. A clinician in training who changes before reaching sixteen needs a continuous sixteen somewhere in the pathway, so they should plan for it with the next supervisor.

14.5.5 The Association assists the clinician in training in finding another Registered Supervisor through the Verification System.

Where the change is caused by the supervisor

Where a clinician in training changes supervisor because the previous one was not working to this standard, was found deficient at review, died or became unable to continue, or allowed their registration to lapse, the clinician in training is not penalized for it. The following apply to that case only. On an ordinary change of supervisor, the two-year period continues to run from the original filing date as Section 14.5.2 states.

14.5.6 The two-year period is suspended for the transition.

14.5.7 The Certification Board may vary the continuity requirement and extend or suspend the two-year period, so that the clinician in training is not required to repeat work because of a failure that was not theirs.

14.5.8 **What it cannot vary.** The Board cannot recognize hours delivered while the supervisor was unregistered, count supervision not supported by completed eligible clinical work, count clinical work performed before the agreement was filed, or count work performed while the clinician in training was not lawfully authorized or was uninsured. Those exclusions are absolute, and no provision of this standard reaches them.

14.5.9 Relief from the midpoint exclusion under Section 11.1.9 is separate from this power and is limited in the same way.

> **Why this provision exists**
>
> A clinician in training who believes that leaving a poor supervisor would cost them their hours will stay with the poor supervisor. That is the worst outcome available: the clinician in training wastes two years, the Association learns nothing, and the supervisor continues.
>
> A clinician in training should never be held in an inadequate supervisory relationship by the cost of leaving it.

14.6 Raising a concern about a supervisor

14.6.1 A clinician in training with a concern about how supervision is being conducted may raise it with the Office of the Executive Officer. This includes a supervisor who is not reviewing recorded work, not covering the required topics, not checking the log, or not otherwise working to this standard.

14.6.2 Where the concern is about conduct rather than standards, the Office refers it to the Ethics Committee.

14.6.3 Raising a concern does not affect the validity of hours already accrued.

That last provision is deliberate. A clinician in training weighing whether to report a problem should not have to weigh losing their hours against it, because a clinician in training who fears that cost will say nothing.

14.7 Fee disputes

14.7.1 The log is the clinician in training's and the supervisor has access to it. Neither party can withhold it.

14.7.2 The supervisor records hours actually delivered regardless of any outstanding fee. A fee dispute is a commercial matter between the parties and is not resolved through the certification record.

14.7.3 A supervisor does not withhold signature over a fee. Signature attests to hours delivered and work reviewed. It is not a receipt, and refusing it to enforce payment is a matter for the Ethics Committee. Where a supervisor will not sign, the clinician in training writes to the Office of the Executive Officer, which determines how the hours are evidenced.

PART SEVEN

General Provisions

Language, jurisdiction, fees, amendment, and the documents issued under this standard.

15. General Provisions

15.1 Language

15.1.1 Supervision may be conducted in any language the supervisor and clinician in training share.

15.1.2 Documents submitted to the Association are in English. This includes the supervision agreement, the log, the 150-hour review, the final review, and the statement. Where a document was produced in another language, the party submitting it supplies an English version and is responsible for its accuracy.

15.1.3 Section 7.1 states the language competence requirement.

15.2 Records

15.2.1 Both parties retain their records of the supervisory relationship for five years from the date supervision ends — the agreement, the 150-hour review, correspondence, and the dates of recorded work reviewed. The Association may request them.

15.2.2 Recordings are not retained. The five-year rule does not apply to clinical recordings, which are destroyed under Section 3.4 within ninety days of review. Nothing in this section authorizes keeping one.

15.2.3 The prohibition at Section 9.1.3 is on keeping a second certification log. It does not prevent a supervisor from keeping their own professional notes, the records required above, or a record of a concern they raised and when.

15.3 Jurisdiction

15.3.1 This is supervision toward a professional certification. It is not licensure supervision, and hours completed do not count toward any licensure or registration requirement in any jurisdiction unless that jurisdiction independently recognizes them.

15.3.2 The clinician in training is already licensed, registered, or otherwise legally authorized to practice in a clinical mental health profession, and holds that authorization independently of supervision.

15.3.3 All clinical work is conducted under the clinician in training's own authorization. The clinician in training is the treating clinician of record and is solely responsible for the care of their patients and for compliance with the law where they practice.

15.3.4 The supervisor assumes no clinical or legal responsibility for the clinician in training's patients and has no emergency or on-call duty. Supervision does not itself create an

employment relationship; any relationship that already exists between the parties is subject to the prohibitions and the disclosure requirement at Section 6.6.1.

15.3.5 Supervisor and clinician in training may practice in different countries. Each is responsible for compliance with the requirements applying to them, including any restriction their own regulator places on receiving or providing supervision across borders, and any data-protection obligation arising from transmitting clinical material between jurisdictions.

15.3.6 A supervisor conducts supervision in accordance with the professional and regulatory standards applying to them in their own jurisdiction. The Association is not responsible for the conduct of supervision by an individual supervisor.

15.3.7 The clinician in training maintains their own professional liability insurance throughout and is not covered by the supervisor's policy.

15.3.8 Change of authorization. Where a clinician in training's license or registration is suspended, restricted, or conditioned, or their liability insurance ends, they notify their supervisor and the Office of the Executive Officer within five working days.

15.3.9 Clinical work performed while a clinician in training is not lawfully authorized to practice, or is uninsured, does not count toward certification. Work performed under a restriction counts only where the restriction does not bear on psychosexual practice, and the Certification Board determines that question. A routine requirement to practice under supervision, attached to an otherwise qualifying provisional, associate, or limited authorization, is not such a restriction, and work performed under it counts.

15.3.10 Before countable work resumes, the clinician in training provides written evidence that the authorization and the insurance are restored, or that the restriction bearing on psychosexual practice has been lifted or varied so that it no longer bears on that practice.

15.3.11 The same applies to a supervisor. Where a supervisor's own license or registration is suspended or restricted, they notify the Office of the Executive Officer and their clinicians in training within five working days. The Office determines whether registration continues. A supervisor may not supervise toward a credential in a field they are no longer authorized to practice in.

15.3.12 While the Office decides. Supervision may continue, and hours delivered count, only where the supervisor remains professionally authorized to provide it and meets the other applicable requirements. This paragraph does not permit supervision prohibited by Section 15.3.11.

Who is told what, and by when:

Who	What happened	Who is told, and by when
Clinician in training	License or registration suspended, restricted, or conditioned, or liability insurance ends	Their supervisor and the Office of the Executive Officer, within five working days
Supervisor	Own license or registration suspended or restricted	The Office of the Executive Officer and their clinicians in training, within five working days
Supervisor	Own IAPST certification or registration lapses	Their clinicians in training, the same day, under Section 14.3.2
Certified Member	Authorization to practice revoked or suspended	The Certification Board, within thirty days, under the Bylaws

15.3.13 **A supervisor carries both sets of duties.** A Registered Supervisor is also a Certified Member, so the prompt notifications in this Section apply to them in addition to the duty every Certified Member owes the Certification Board. Satisfying one does not satisfy the other.

15.3.14 Where that prohibition applies, supervision stops on the date the supervisor's authorization was suspended or restricted, not on the date the Office decides. Hours delivered before that date stand; hours delivered after it do not count, and no route in this standard recovers them.

15.3.15 Where the prohibition does not apply and the supervisor continues, the Office states the date from which any later decision takes effect, and hours delivered before that date stand.

15.3.16 A supervisor may pause rather than continue while the question is open. Where they do, the two-year period is suspended for their clinicians in training for the duration of the pause.

15.4 Terminology

15.4.1 The Association's term for this activity is supervision, and the designation is IAPST Registered Supervisor. Nothing prevents either party from describing the activity as clinical case consultation in their own professional materials.

15.4.2 The Association uses the term patient rather than client, in this standard and in the documents produced under it.

15.5 Fees

Supervisor's registration	USD 300 per year, or USD 150 at Tier II, paid by the supervisor

Supervision sessions	Set by the supervisor; the Association takes no share
The 150-hour review	No fee
Certification application	USD 300, or USD 150 at Tier II, paid by the clinician in training

Association fees are set by the Executive Board and published in the Association's fee schedule. The supervisor's own fee is not among them and is a matter between supervisor and clinician in training.

15.6 Related documents

This standard is the authoritative statement of the requirement. The following implement it and are read alongside it:

- The IAPST Supervision Agreement — the contract between supervisor and clinician in training
- The IAPST Supervision Log — held in the Member Portal, kept by the clinician in training, signed in the Portal by both parties
- The IAPST 150-Hour Review — the midpoint assessment, completed by the supervisor on the Association's form and filed with the Association
- The IAPST Supervision Final Review — the supervisor's assessment at the close, filed in the Portal and read with the application
- The IAPST Supervisor's Handbook — issued to Registered Supervisors, on how the work is done
- The IAPST Standards of Accreditation — for programs delivering supervision
- The IAPST Code of Ethics

Where any of those and this standard differ on a requirement of supervision, this standard governs.

The Code of Ethics is not subordinate to this standard. It governs conduct, this standard governs the requirements of the supervision pathway, and where a course of action permitted here would breach the Code, the Code prevails. A supervisor is never required by this standard to do something the Code forbids.

15.7 Amendment

15.7.1 This standard is maintained by the Certification Board and adopted by the Executive Board.

15.7.2 A clinician in training is held to the edition in force at the date their first supervision agreement was filed. A change of supervisor does not change the edition that governs.

15.7.3 Electing a later edition. Where a later edition is more favorable to them, the clinician in training may elect to be assessed under it instead. The election is made in writing at application, and it is of one edition in its entirety rather than of provisions drawn from several.

15.7.4 The election covers both standards together. An election made under the Standards of Certification applies to these Standards as well, so that the supervision requirement and the certification requirement are assessed under editions in force at the same date. A clinician in training does not elect one edition of one standard and a different edition of the other.

15.7.5 Each edition carries an edition number, an adoption date, and an effective date, so that the applicable version can be identified from the filing date alone.

Edition	____
Adopted	1 November 2026
Effective	____
Supersedes	____

APPENDIX

The Fifteen Required Topics

The scope of each topic and the evidence required before it may be recorded as covered.

Each topic is covered against the clinician in training's own clinical material and recorded in the log with the date and the supervisor who covered it. Completion requires all fifteen to reach Evidenced. This does not prevent signature of an accurate incomplete record; Section 9.5 states the difference.

At a glance

#	Topic	Best covered	Method
THE WORK OVER TIME			
1	The arc of treatment	Months 4–12	A case tracked forward across several sessions
2	Rupture and repair	When one occurs	Recording
3	Termination and discharge	Final third	Live case, discharge criteria drafted
4	Non-response and stuck cases	When one occurs	Case discussion to a decision
THE INTERVIEW			
5	Conducting a sexual history	Months 1–4	Recording of a first or second session
6	Language in the room	Months 1–6	Recording
7	Delivering psychosexual education ✱	Months 2–8	Written, 200 words, reviewed
THE APPARATUS			
8	Documentation of sexual material ✱	Months 1–4	Written note, de-identified, reviewed
9	The frame in practice	At the first frame test	Case discussion
10	Interprofessional communication ✱	Months 3–10	Drafted letter, reviewed
11	Building a referral network	Months 4–10	Referral map produced between sessions
THE CLINICIAN			
12	Scope of practice in real time	When a case nears the edge	Case discussion
13	Values, discomfort, countertransference	Recurring	Sign when a reaction is named and traced
14	Using supervision well	Month 1	Direct instruction, early and deliberate
15	Sustainability	Final third	Planning discussion

The timing column is guidance rather than requirement. Four topics are best covered when a particular event occurs and cannot be scheduled; the rest can be planned, and a supervisor who plans them will not arrive at month eleven with six outstanding.

Three of the fifteen require the supervisor to read something the clinician in training produced

Topic 7 requires written psychosexual education. Topic 8 requires an actual clinical note. Topic 10 requires a drafted letter. A conversation about any of the three does not reveal what the clinician in training actually writes, and these are the topics most often signed off on the strength of a discussion.

The rubric

Each topic sits at one of three levels. Only Evidenced may be marked off in the log, and a topic at Developing is not a partial credit — it is a topic not yet covered, with the work named.

Not yet evidenced	The topic has not been covered against the clinician in training's own material, or has been discussed in the abstract. Cannot be marked off.
Developing	The work has been done but falls short of the standard. The supervisor gives feedback and the clinician in training does it again. Cannot be marked off.
Evidenced	The standard is met. The supervisor marks the topic off in the log, and the Portal records the date and the supervisor.

A clinician in training is entitled to know which level each of their topics sits at, and to be told what would move a topic from Developing to Evidenced. A supervisor who marks a topic Developing without saying what is missing has not used the rubric.

Three topics cannot reach Evidenced through conversation

Topics 7, 8 and 10 require the supervisor to have read something the clinician in training produced — written psychosexual education, an actual clinical note, and a drafted referral letter.

Where nothing has been read, the topic is Not yet evidenced however much has been discussed. This is the most common place a pathway is found deficient on review.

1. The arc of treatment

Not yet evidenced	Discussed in general terms, or a case sampled once. No treatment has been tracked forward across supervision sessions.
Developing	A case has been tracked, but the clinician in training describes what happened rather than where the treatment is. They cannot say what would signal readiness to move on, or the answer is generic.
Evidenced	The clinician in training can name the phase a live treatment is in, say what they expected by now, account for the gap between expectation and reality, and state what would indicate readiness to move.

2. Rupture and repair

Not yet evidenced	Rupture discussed conceptually. The clinician in training has not identified one in their own work.
Developing	A rupture has been identified — usually by the supervisor, on a recording — but the clinician in training attributes it to the patient, or describes repairing it without being able to say what they actually did.
Evidenced	The clinician in training has identified a rupture in their own work, named their own part in it, described what they did next, and can say what they would do differently.

3. Termination and discharge

Not yet evidenced	Not addressed against a live case, or addressed only as “when the patient is better.”
Developing	Discharge criteria drafted but vague, or the clinician in training can state criteria and has not thought about how the conversation opens.
Evidenced	The clinician in training has articulated discharge criteria for a named live case, drafted the conversation, and can say what would make them extend instead.

4. Non-response and stuck cases

Not yet evidenced	No non-responding case brought, or brought as a complaint about the patient rather than a question about the work.
Developing	A stuck case has been worked, but the clinician in training defers the decision to the supervisor, or holds the same course without being able to say why.
Evidenced	The clinician in training has worked a non-responding case to a decision — change course, refer, or continue deliberately — committed to an answer before hearing the supervisor’s, and can say what evidence would change it.

5. Conducting a sexual history

Not yet evidenced	The supervisor has not reviewed the clinician in training conducting a sexual history — by recording, live observation, or transcript.
Developing	Reviewed. The history runs as a checklist, stops at the first sign of patient discomfort, or collects facts without forming hypotheses.
Evidenced	The supervisor has reviewed the clinician in training conducting a sexual history, the clinician in training can say why each line of inquiry was opened and when, and they can account for how they handled the patient's discomfort, whether by staying with a question, pacing it differently, or deferring it and saying why.

6. Language in the room

Not yet evidenced	Not examined against recorded work or a permitted equivalent.
Developing	Euphemism, avoidance, or clinical distancing is evident in the reviewed material and the clinician in training has not noticed it, or notices only once it is pointed out.
Evidenced	The clinician in training can account for their vocabulary choices with a particular patient, has noticed at least one word that landed badly, and adjusts deliberately rather than by habit.

7. Delivering psychosexual education ✻

Not yet evidenced	Discussed only. The supervisor has not read anything the clinician in training wrote.
Developing	A written piece has been read. It is inaccurate, pitched wrong for the patient, over-long, or reads as a lecture rather than something this patient could use.
Evidenced	The supervisor has read written psychosexual education the clinician in training produced for a named patient. It is accurate, it is usable by that patient, and the clinician in training can say what they left out and why.

8. Documentation of sexual material ✻

Not yet evidenced	The topic has been discussed but the supervisor has not read a note the clinician in training wrote.
Developing	A note has been read. It is clinically thin, uses euphemism where it should be specific, or would not stand up to outside scrutiny. Feedback given; the clinician in training writes another.
Evidenced	The supervisor has read a note the clinician in training wrote about a real session. It records sexual material accurately, in clinical language, at a level of detail that would serve a colleague picking up the case, and the clinician in training can say why they included what they did.

9. The frame in practice

Not yet evidenced	The frame discussed in principle. No test has arisen, or none has been brought.
Developing	A frame test has been brought, but the clinician in training either conceded without noticing, or held the line without understanding what was being asked of them.
Evidenced	The clinician in training has managed a frame test in a live case, reviewed it with the supervisor, and can say what the test was about clinically rather than only administratively.

10. Interprofessional communication ⁕

Not yet evidenced	No letter has been read.
Developing	A letter has been read. It apologizes for existing, directs the physician's treatment, over-discloses, or omits what the recipient actually needs.
Evidenced	The supervisor has read a referral or medication-review letter the clinician in training wrote. It states the clinical question, gives the recipient what they need and no more, and is written as one professional to another.

11. Building a referral network

Not yet evidenced	Not attempted, or produced as a list of disciplines rather than of people.
Developing	A map has been produced but is generic — no named practitioners, or no account of where the gaps are.
Evidenced	The clinician in training has produced a referral map for their own practice setting, with named practitioners across the disciplines they actually need, and can say where the gaps are and what they will do about them.

12. Scope of practice in real time

Not yet evidenced	Scope discussed in the abstract.
Developing	The clinician in training can state their limits but has not recognized one in a live case, or recognized it only after the supervisor raised it.
Evidenced	The clinician in training has identified a limit of their competence in a live case, acted on it — referred, sought consultation, or acquired the competence — and can say how they knew.

13. Values, discomfort, countertransference

Not yet evidenced	Not raised, or raised only as an assurance that the clinician in training has no reactions to the material.
Developing	A reaction has been named, but not traced to what it did in the room — or it was the supervisor who traced it.
Evidenced	The clinician in training has identified a reaction of their own, traced its effect on a specific session, and changed something as a result.

14. Using supervision well

Not yet evidenced	The clinician in training arrives unprepared, or arrives with everything and no question.
Developing	Prepared, but presents to be reassured rather than examined, or deflects rather than considers what is said.
Evidenced	The clinician in training prepares, arrives with a question, brings work they are not proud of, and takes in feedback and works with it. Reasoned disagreement is part of using supervision well; refusing to consider what is said is not.

15. Sustainability

Not yet evidenced	Not addressed.
Developing	Addressed as an intention — the clinician in training says they will arrange consultation — without a plan.
Evidenced	The clinician in training has a named plan for consultation after the pathway, has thought about caseload composition and its effect on them, and can say what their own early warning signs are.

✻ Requires the supervisor to have read something the clinician in training produced.

Standing items

Not part of the fifteen, and present in every session regardless of what else is covered.

- The clinician in training's own reactions to the material and the patient
- Case formulation — not what happened, but why
- Risk
- Whatever is urgent for the clinician in training this week

Questions about this standard: info@iapst.org