Clinical Supervision—Then and Now: The Professional Development of Social Workers

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This narrative is a reflection about the process of clinical supervision in the practice of psychotherapy. It traces the author's own experience in supervision over the course of his career, from the days as an MSW-student supervisee to post-master's entry-level practitioner to social work educator and trainer of other professionals about the process of clinical supervision.

This narrative grows out of my present work in teaching clinical supervisors how to supervise. Throughout my career, I have sought out supervision from more senior members of my profession to help me clarify my thinking about cases and to strengthen my professional use-of-self. Clinical supervision has been an important part of my life since my internship years, and the patience and skill of my supervisors has enabled me to become a much more confident and skillful social worker.

The current crop of students and new graduates (and even some professionals with considerable post-MSW experience), however, appear not to have had the same type of professional growth experience in supervision. Often, they appear to lack confidence in their knowledge and skill development and, perhaps, are less observant or reflective about themselves. In addition, many of these practitioners struggle to formulate ideas about clients' present and past development as well as about the change process—how their therapeutic interactions will help clients move from point A (the reason help was initially sought) to point B (the goal sought or change desired).

I am both saddened and angered about the present state of affairs and believe part of the problem lies in the poor quality of clinical supervision presently available. I realize that what I received in terms of preparation for this profession is not being offered today, and probably has not been offered for the past decade or more. The present narrative traces my own experience of supervision, from student days to my current work in teaching supervisors how to supervise. The unifying theme of these diverse experiences is the critical role supervision plays in the professional development of the worker.

My Experience of Supervision as a Student

Twenty-two years ago, I graduated with an MSW and was voted by my fellow students as "most likely not to stay in social work." This dubious designation was due not only to my age (at 23, I was the youngest in my class) but also to my ambivalence about social work. I was unsure if it was the correct pathway to the counseling work that I hoped to do.

Like many folks, I entered the profession knowing that I wanted to help others. While I was willing to learn, I had little idea about what learning in social work actually meant. My professors and field instructors, however, challenged me continually to think about *what* I was doing, *why* I was doing it, and *how* I could help my clients move from point A in their process to some undetermined point B. Looking back, I can smile (now) about my own struggle as a student—wanting to be good at something, yet at the same time feeling that I did not know anything.

I had two block field settings during my MSW training. The first was in a general hospital in a metropolitan area where I was assigned to the Family Practice Unit, working with clients usually over the age of 55 or under the age of 25—generally those people who did not have their own family physician. The department of social work had a strong and wonderful reputation. Over twenty social workers as well as interns from three different universities staffed it. My second internship was at a University Counseling Center in a small agricultural community 50 miles from a major metropolitan area. Ten professionals including three social workers, three psychologists, a psychiatrist, and two vocational counselors staffed the Counseling Center. The University was home to six thousand undergraduate and graduate students, mostly focused on liberal arts, agriculture, veterinary science, and home economics.

I remember preparing myself for supervision, one and one-half hours per week in those days. I had no idea that the major focus of supervision would be spent on looking at myself as a ***facilitator of change***. I was challenged to look at what I brought to the relationship with clients, how I felt about them and the presenting problems, and how I understood my role in facilitating change. In addition, I was expected to articulate options regarding how to work with clients to alleviate the presenting problems.

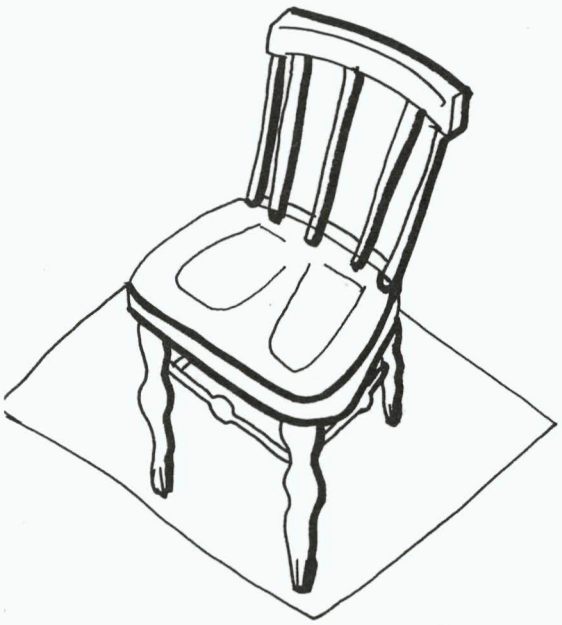
Two memorable cases from my student days come to mind. During my first placement, I worked with a 55-year-old immigrant widow who was on disability leave because of a severe back problem. Her medical course of treatment involved lots of bed rest, medication, and home-based physiotherapy. The client was referred to the Family Practice Unit for help because of symptoms of depression. Her back problem resulted in her first extended absence from work, and she began to experience a profound sense of aloneness and significant dependency needs. She appeared depressed and isolated, having no family or friends except for those from work whom she would not be able to see until she recovered.

My inner gut reaction in this case was fear. I dreaded being exposed as an imposter—someone who had nothing to offer to clients in distress. I remember coming face to face with my own anxiety and how uncomfortable I felt with "not knowing" what I was talking about. I recognized that I had been masking the fear with humor, mostly of the self-deprecating type, in order to hide the discomfort at being asked a question that I did not have an answer to, nor could even imagine where to begin to come up with an answer.

As I presented my work with this client in supervision, my supervisor questioned me about my understanding of depression. What was its etiology? What did I know about the course of depression in people's lives? What were my own experiences and exposures to depression and loss issues? Did I think depression was different in female clients or with clients from differing age groups? In struggling to answer these questions I often felt inept. (My supervisors

in both first and second year placements were seasoned professional women, fifteen years my senior, who made it look *so easy*!) Yet, slowly and surely, a process was occurring in which I began to trust my supervisor to help me find my own way into becoming the professional I would grow to be. I was forced to look at the concept of aloneness and fears of being alone. My supervisor focused in on *my empathy* and its place in relation to this client. She carefully balanced an inquiry into my own personal issues (i.e., times in my life when I had felt alone and past experiences I'd had helping others deal with their aloneness) with explorations of my own current beliefs and theoretical conceptualizations about how therapists help clients deal with the issue of aloneness. She encouraged me to read, to ask questions of others, and to remember back to moments in time where others I had known or worked with had dealt with their own sense of aloneness. She helped me to examine the process of aloneness and loss as a developmental issue that occurs throughout the life cycle.

In my second year placement, a 19-year-old male client came into the University Counseling Center seeking help in his struggle to develop and maintain relationships. I noticed that the client was wearing an obvious full toupee, which is unusual in one so young. While I was understandably curious about it, sensing that it was a significant issue in the client's life, I found I could not ask the client directly about it. My supervisor, being bright and sensitive, helped me explore my hunches about the reasons for the toupee and encouraged me to reflect on the reasons I was having difficulty asking the obvious question: "Why the toupee?" Her prompting helped me get in touch with strong internalized values from my family of origin that kept popping into the back of my mind: "Don't ask something to someone if you have nothing nice to say," and "Don't stare at things that are different."



Session after session, I knew I had to ask about it, but session after session, my family's words kept popping in my head, handcuffing me. Finally after many weeks, with the encouragement of my supervisor and her ability and patience to explore my family's values, I awkwardly and in a roundabout way asked the client about his toupee. To my relief, he did not have cancer (which was one of the hunches I had to rule out) but, in fact, had a benign explanation to what I thought was an embarrassing topic. Once I was finally able to ask the question (the theme music from the movie *Rocky* playing in my head), I was relieved and jubilant. I spent several more supervisory hours processing with my supervisor this struggle, coming to understand the dilemma I experienced more fully and developing a greater ability to confront uncomfortable things that popped up during the course of clinical work with clients. Although that process was not necessarily a smooth one, I was surprised at my own willingness to take risks about my learning. I began to ask questions and owned up to what I didn't know.

As the above examples illustrate, the infrastructure of the profession was set up to accommodate and help new workers learn. I received support and further challenges from both of my field placement supervisors. They believed that I did know, or if nothing else, at least could offer an opinion. In those days, MSW students were prepared to do an assessment, formulate a diagnosis, and create a treatment plan. The actual learning of treatment would take place in internships and, more often than not, in the worker's first job.

Post-MSW Supervision

In each of my first three post-MSW jobs (each lasting three years), I had individual supervision for one hour a week and weekly group supervision (six to eight workers with a supervisor) for one and one-half hours per week. My first job was in a regional Children's Hospital, organized around a multi-disciplinary team approach focusing on specific diseases or illnesses. I was the social worker to three teams working with children having juvenile

arthritis, asthma, and developmental delays. My second job was in a community mental health center in a small community. I worked on the day treatment team where clients were seen in a group therapy format from 9:00 AM-3:00 PM daily over the course of four months. The work was done in front of a one-way mirror and videotaped. The team was also responsible for the community-based aftercare program involving over one hundred clients suffering from severe and persistent mental illness. The multi-disciplinary team consisted of the social worker (me), a psychologist, two psychiatric nurses, a psychiatrist, and a support staff member. The third post-master's position was at the same hospital setting as my first field practicum, this time working in the outpatient psychiatry department.

Throughout these three jobs, the focus of supervision continued to be on my professional use-of-self and on my development as a clinical social worker. The discussion in supervision focused less on the management or disposition of the case and more on conceptualizations of how I would approach this client. In both individual and group supervision, I had the opportunity to explore in depth how I understood clients' presenting problems, their strengths and supports, and their relationships to the environment (both micro and macro). Furthermore, I explored what I could do to facilitate change, alleviate symptoms, achieve growth, and build on the supports and networks the clients already had established. The entire focus was on my professional development in terms of understanding what I brought to the situation that could help or hinder the therapeutic process and what theories were informing my clinical thinking and judgment.

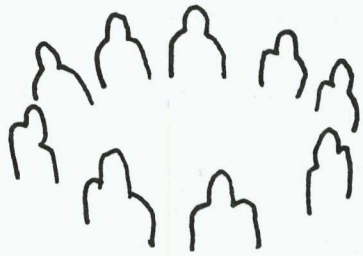
My Current Work in Training Clinical Supervisors

Currently in my private practice, I function as a consultant and clinical supervisor to several agencies and teams at mental health centers, social service agencies, gerontology centers, and an outdoor wilderness training school for difficult adolescents. In contrast to my own rich experience of professional growth through supervision with an experienced senior clinician, many professionals in today's

rapid paced practice settings tell me that, more often than not, they are being supervised by someone with little more experience than they have—at best, just two to five years more. Often, the supervisors are people whose job description and demanding administrative duties have not allowed time for them to develop good clinical supervision skills. As a result, the supervisor's primary interest centers on the movement of the worker's cases from intake to discharge in as short as possible a time frame, rather than focusing on the professional development of the worker. Little, if any, focus is on teaching the skills of treatment. Workers' abilities to articulate what they are observing in their interaction with clients are never addressed nor even asked about directly. Many workers (and supervisors) appear to have never moved from their graduation status in terms of the development of their understanding of the process of psychotherapy. While the supervisors may have multiple years of post-MSW experience, in actuality, they appear to be simply repeating their first year experience over and over again.

The workers' frustrations are evident. They acknowledge openly that they don't know what they *don't* know, and (sometimes, it seems) have difficulty articulating what they *do* know. For example, when I asked a team of social workers in a social service agency to discuss what I thought was a reasonable, straightforward question—what were their standards for returning a child who has been in placement back into a family of origin—"deer-in-the-headlight" looks were everywhere.

Today, it seems, there is little individual time and resources available for "growing" new workers into seasoned professionals. Unfortunately, many senior clinicians and experienced supervisors have left the profession, some out of attrition, some due to managed care constraints, others because of retirement, lack of fulfillment, or struggles with organizations that have become more bureaucratic and impersonal. I leave to future historians the task of tracing what happened to the practice of psychotherapy over the past 15-20 years. I am aware daily of how lucky I was to have received the clinical education and training that I did, yet how "old" I feel in comparison to the many workers that I meet. In contrast to my own experience, in the current age, little or no feedback is given to young therapists about their work nor typically are they exposed to more senior clinicians' work.



In the past two years, I have shared my own experiences in seminars and presentations throughout my state, and pushed heavily to go back to a day when one of the major focuses of agencies was the development of their staff to become seasoned professionals. In that process, I have worked with several agencies on an ongoing basis in the development of ***supervision groups for clinical supervisors***. Meeting weekly with up to eight participants, the focus of this work has been helping them to become better clinical supervisors. The task is challenging since many of the supervisors have not had great experiences themselves when they were being supervised. Typically, these groups meet weekly for six months, focusing on the supervisors' work, their own past experiences with supervision, developing ways in which they imagine supervision to be, and helping them define the roles, boundaries, and teaching styles

involved in clinical supervision. We set a firm boundary around our time in order to focus exclusively on clinical supervision issues, leaving administrative and management concerns for other forums of discussion. Each supervisor is in charge of bringing in topics for discussion on a rotating basis, and half the session's time is devoted to current issues he or she is dealing with.

In one mental health center agency, a second phase of this group supervision—a train-the-trainer model—is now in place. The original eight supervisors now work with their own group of eight other clinical supervisors in their development (64 people in total, working in groups of eight). I continue to meet with the original eight on an ongoing basis to continue helping them to become better clinical supervisors and teachers.

In these groups, I spend a lot of time going back to what I learned clinical supervision to be and how they can translate that into their current systems. With support from their administrations and commitment of time, we are making headway, one small step at a time. The supervision groups focus on teaching the knowledge, skills, and attitudes necessary for the performance of the clinical tasks. This is done through a ***detailed analysis*** of the worker-client interactions. Supervision is directed to the needs of a particular worker, carrying a particular caseload, encountering particular client problems, and needing some individualized support in his or her professional growth and development. Supervisors, in turn, learn to help their workers make transitions from *knowing* to *doing*.

In the narrative vignettes below, I have tried to share the experiences, learning, and teaching moments in these supervision groups. (To preserve confidentiality, the names of the supervisors and workers have been changed.)

Working with "passive" practitioners.

Ellen supervises a number of practitioners working with adults in residential treatment. In the supervisors' meeting, she shared her ongoing struggles with one particular practitioner, Mary, who was reluctant to set goals for supervision and acted in what seemed to be a relatively passive manner—at least in relationship to the process of supervision. Other members of the group immediately responded to this topic, and it became clear that many supervisors had encountered similar difficulties.

Ellen brought up the issue following a particularly frustrating supervision session with Mary. After she vented her frustration, I asked the group to share with each other their own experiences with passivity and whatever meanings they might attach to it. The supervisors were challenged to think about reasons for a worker's reluctance to engage, to set goals, and to be part of the learning process. Collectively, we looked back at times in our own lives in which we encountered passive behaviors, trying to understand the meanings it had and the frustrations which we may have felt. We then focused on the ways a supervisor could intercede, focus, support, confront, and deal with the current issue in Mary's work performance and use of supervision. It was particularly helpful to have the group talk about their experiences of being in Mary's situation as "the supervisee."

I then posed the question as to what supervisors should do to help workers like Mary become unstuck, emphasizing that the process of supervision is one in which the supervisee's experiences of self and other is examined in the presence of a teacher. The experience of focusing and recalling aspects of the client-worker relationship, the manner in which it is remembered, the meaning given to those recollections, and how those meanings are arrived at are the

core of clinical supervision. Going through the exercise, although difficult, proved helpful, as it generated different scenarios, ideas, and suggestions not only for Ellen, but also for all members of the group.

At the next meeting, Ellen brought back to the group her follow-up supervision session with Mary. She had first focused on Mary's strengths and then posed the question to her as to why, in the area of setting supervision goals, she appeared reluctant and passive. Mary was able to respond positively to Ellen's empathy and support and opened up to a direct discussion about the struggle she had with setting goals. Mary began to recognize how she was repeating a non-adaptive pattern from her past with the supervisor and subsequently felt good that the issue had come out.

Enlarging workers' capacity for observation.

Lucia is a clinical supervisor in a specialty mental health unit focusing on Latino issues. She brought to the supervisors group her concerns about the apparent reluctance of workers to describe their clinical observations about clients. Other group members shared her concerns, stating that the issue is not only the workers' ability to describe clients, but also their ability to observe themselves. The group brainstormed as to how supervisors could help workers better understand the clients' concerns, conflicts, and responses to the helping process. The focus of the discussion centered on the role of clinical supervisors in enlarging workers' ability to observe others as well as themselves, and on how supervisors can encourage workers to examine and reflect on the meaning and value they give to those observations. The group discussion focused on not only how to get supervision to focus in this direction, but also validated the supervisors' belief in its importance.

I asked the group to focus on their own first experiences of perceiving a "threat" or "risk" when asked to share client observations. I raised the question of whether anyone else ever had experienced difficulty in not only trusting their own observations but also trusting whether colleagues or supervisors would listen in a supportive, helpful manner. Out of this discussion ideas and suggestions flowed, as the group spent considerable time identifying other potential barriers or restrictions in their workers' capacities to think or feel about clinical material. For example, supervisors were able to acknowledge that workers might struggle with "how to proceed" with particular clients and that this sometimes can be an impediment because workers might feel ashamed or embarrassed at "not knowing." In addition, the group recognized that workers might have certain issues they did not want to discuss.

Dealing with power, authority, and shame.

Jeannie supervises workers whose practice primarily is with child clients. In group, she brought up several workers in whom issues of shame, especially those related to power issues between themselves and parents, kept coming up. Jeannie described her workers' difficulties in confronting issues head on and their reluctance to take an authoritative role or stance with parents. Many appeared to feel ashamed when having to make clinical judgments about parents' harmful child-rearing practices in a crucial and timely manner.

I asked the supervisors group to share their ideas about Jeannie's perceptions of the relationship between power and shame in workers. The group supported Jeannie in reflecting upon her own experiences, particularly the emergence of her own sense

of power and how she learned to become comfortable in exercising it. Other group members shared their own struggles with these issues, bringing out a full range of emotions about power. Gender, cultural, and socialization issues were highlighted and

we began to see power, like most other issues, as ***developmental in nature***. We spent time talking philosophically and then moving to our actual experiences with power, both on the side of having power and also on the experiences of not having power. The stories which most helped supervisors gain perspective and empathy with their workers' difficulties concerned recalling their own struggles to avoid being like someone negative in their past. For example, this might have been a hostile parent or adult authority figure who had confronted them in harsh or unhelpful ways and whom they had taken great pains to avoid becoming similar to. Drawing on these recollections, supervisors were able to help their workers learn ways in which they could be direct or even confrontational, when necessary, while still maintaining a caring and empathic helping relationship.

Creating a safe environment in supervision.

Thea supervises clinicians working with clients suffering from severe and persistent mental illness. In one session, she encouraged the group to look at issues of safety in the relationship between the practitioner and the supervisor. She stated her belief that whether in individual or group settings, clinical supervision, at its best, creates an environment that allows for great learning. Yet often this leads to disturbances in the workers' sense of self. As Thea went on to describe her efforts to create a safe environment in supervision, she identified her own dilemma of creating safety vs. allowing the workers to struggle alone.

The subsequent group discussion highlighted the fact that clinical supervision is clearly a multi-level process. Both the practitioner and the supervisor are ***learning together*** about the client, about one another, and about themselves. The group brainstormed about how supervisors could create conditions allowing workers to learn safely—an atmosphere in which meaningful dialogue can take place. All the supervisors felt strongly that having tact, sensibility, sensitivity, and, most importantly, knowledge of the boundaries of supervision were the real challenges for supervisors to develop and display.

I asked the group to discuss ways in which they could help supervisees learn to tolerate the disruption in their own sense of self, which learning requires, while still living with feelings of ambiguity and vulnerability that often accompany new knowledge. In response, supervisors began to recall their own experiences with learning something that was a difficult hurdle for them, how they came out the other side of the learning experience and were then able to "look back," and what it took for them to have gone through those experiences. The group discussed how supervisees learn to marshal their own capacity for confronting new information about both the client and themselves, and how the supervisors learn to respect the difference between supervision and therapy. Group members shared their own experiences of being in "the supervisory moment"—those times when issues arose that forced them to look at something from their past that was interfer-

ing with their work in the present. Most often, the experience involved dealing with client issues similar to ones that they have yet to sort out in their own lives. This realization helped supervisors appreciate that for most workers, the risk of exposing this type of information to supervisors is a challenge. Sorting out the professional from the personal is a difficult but essential moment in the development of the clinician.

Developing person-centered language.

Stacie supervises clinicians working with clients who have been dual diagnosed with a mental health disorder and with substance abuse, and who often are experiencing other problems as well, such as homelessness. She brought to the group her struggle to develop a language for both supervisor and supervisee that fits both of them. This is an issue close to my own heart. One of Stacie's workers tended to talk about her clients by their diagnostic labels (e.g., "the borderline" or "my bipolar client"). For Stacie, an important facet of her teaching, therefore, was using clinical language which respects clients as human beings and not as disorders.

I asked the group to consider the possibility that workers who persist in describing clients by their diagnostic labels may be doing so to create ***an illusion of professionalism*** so as to obscure their lack of knowledge or deficiency in ethics and values. The group responded by discussing their own experiences at learning diagnostic nomenclature, putting jargon to work, and how understanding the language made them initially feel "professional"—that is, like they belonged. Issues of the degree of empathy and respect for the clients and their conditions then entered the discussion. Finally, the group focused its attention on the supervisors' efforts to facilitate workers' understanding of their own issues of authority and to develop their own theories of how clinical language is used. This discussion led to clearer ideas about how clinical supervision can provide workers the opportunity to discuss the "how-tos" and "shoulds" of diagnostic nomenclature.

Identifying the worker's style of learning and dealing with defensiveness.

Wendy supervises student interns in their clinical placements. She brought to the group the issue of how to identify her interns' learning style. While aware that clinical supervision involves many skills, processes, empathy, and teaching abilities, focusing on the inner thinking of the supervisor—particularly identifying how their workers learn—was a challenging discussion for the group. For many, this was a new, perhaps even foreign, concept. It was helpful to recognize, for example, that many supervisees are visual learners—they need to see something in action first before they can practice it and organize it into their own style. Whatever the supervisee's learning style, however, supervisors must learn how to adjust their role to fit the needs of the individual worker in terms of what the worker wants or doesn't want and what pushes his or her buttons.

I encouraged group members to ask the practitioners they supervise what kind of social worker they want to become, to gauge their openness to differing ideas, and to assess the present stage of their professional identity. This led to an extended and difficult discussion about how to deliver criticism, especially when workers have a history of reacting defensively. I asked the group to consider the question of how *they* preferred to hear criticism in their own professional life. Surprisingly, many of the group members had never been asked how they wanted to hear criticism. As the discussion unfolded, some members shared that they would want to hear feedback as soon as an issue arises, preferably in

private, so that they would have a chance to think about what had been brought up. After this, they felt they would be able to come back to a supervisor and talk about it directly. Half jokingly, others said did not want to hear any criticism at all, and appeared wounded at the thought that something they did might not sit well with a supervisor. The discussion ensued about how supervisors learned to assess and judge their workers' receptivity to constructive criticism. The concept appeared both new and worthwhile.

Subsequently, assessments of workers' capacities in others areas—intuition, empathy, associations, leaps of imagination, and reasoning processes—came up in the discussion. To the group's surprise, they were all struck by the number of supervisees with whom they had worked who were, for the most part, generally caring and empathic clinicians, yet, in specific situations (e.g., when their buttons have been pushed), they responded in defensive, cold, and non-empathic ways. Assessing workers' empathy and ability to care seemed obvious to everyone, yet in discussion the group members were aware of how often empathy and caring were the first things to go in their workers' discussion involving a case. I asked the group to consider that when caring, empathic workers lose their empathy and begin sounding like they don't care, then supervision has arrived at the "teachable moment." Loss of empathy should be a first clue to the supervisors that something has occurred in the clinical process that needs both the supervisor's and therapist's attention.

Working with metaphors and symbols.

Corey, a supervisor on an adolescent team, brought to the group her workers' struggles in deciphering and appropriately responding to clients' symbolic communications. As the discussion unfolded, several supervisors commented that many clinicians, although bright and knowledgeable, nonetheless struggle with client analogies, metaphors, and unconscious communications. She brought up her experience with Anne, a clinician who had difficulty recognizing and conceptualizing a countertransference response to a client—a reaction not usually characteristic of her. Anne had difficulty seeing that the client, with whom she obviously enjoyed working, was communicating indirectly his attraction to her through seductive analogies, symbols, posture, etc. Eventually, this indirect communication needed to be pointed out to Anne in supervision.

The group discussed way in which they learned these concepts—in school, in supervision, through seminars and case conferences, etc. This discussion brought back visual images for many of their own struggle to figure out countertransference issues and to translate theoretical abstractions into the real world of client-therapist interactions occurring in psychotherapy practice. Going back and remembering, then figuring out ways in which one can help a worker deal with these issues and learn about them, proved helpful to the group. I asked group members to talk about their role in helping workers articulate what they know. We then discussed how to match the practice or intuitive wisdom of workers to human behavior theories and diagnostic categories and how to help them formulate clinical hypotheses and inferences.

Understanding emotional reactions to clients.

Georgia supervises mental health workers who liaison with the local county department of social services. She brought to the group's attention her difficulty in getting workers to reflect upon their own emotional reactions to clients, and the related difficulty of controlling their affect.

Many workers struggle with their own feelings about their clients, ranging from looking forward to seeing them to, at the other end of the continuum, feelings of never wanting to see them again. In both instances, supervisors shared their efforts to help workers identify their own affective response to their clients and to examine what things get in the way of their work.

I shared with the group my own observations that it is not uncommon for many new professionals who work with children and families initially to have strong feelings of wanting to rescue a child from "bad," uncaring parents. Good supervision—and ongoing practice—can help workers begin to see parents as individuals in their own right, with strengths and capacities, not just problems or deficits. By facilitating workers' self-reflection, supervisors can help practitioners get in touch with the positive and negative feeling about parents and to sort out which feelings are reality based from those stemming from countertransference. This discussion helped group members figure out additional ways to aid their workers.

Conclusion

Hardest among the many things in supervision is helping workers to develop an ability to look at the supervisor's questions as a ***method of inquiry*** rather than an attack. It was important to help the supervisors understand the threats to workers' own self-esteem and to assess their ability to tolerate shame and exposure. Our discussion focused on our own difficulties in hearing criticism and times in our life in which we felt left hung out to dry. We talked about helping the supervisee develop and articulate his or her channel of thought: "Why am I going in a certain direction?" The supervisor needs to know what their supervisees understand about the individuals with whom they are working. Often, new workers may focus exclusively on the diagnostic component of the client, rather than seeing the totality of the person. We agreed that the supervisor's job was to help the worker talk about the personhood of the client rather than the diagnostic label. The most important aspect from this discussion was supervisors learning ways to help workers understand that diagnostic labels have limited value in and of themselves. It is only as the diagnosis is connected with specific intervention and change plans that it becomes clinically relevant.

Now six months later, the group of clinical supervisors program is progressing well. Supervisors are more confident in their work, are consulting each other about their workers, and feel strongly in their commitment to developing worker skills and knowledge. The process has allowed a renewed investment in supervision that, in turn, will have an impact on workers' growth and development. It is hoped that this process will encourage workers to stay in agencies rather than leave in frustration. Clinicians being supervised, in turn, report perceiving a positive change in commitment from the agency, corresponding to their own commitment to the development of their professional identity.

Maybe there is hope that we can reverse the dearth of quality clinical supervision. In the present era, "supervision" too often has been reduced solely to attention to administrative tasks. In contrast, the effort of this clinical supervision group has been to restore an understanding of supervision as a mutual process whereby strong clinical supervisors teach clinical knowledge and skills to their workers and foster their professional development.