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Article 45

The Necessity of a Philosophy of Clinical Supervision

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Introduction

Based on several years of field-based and university-based clinical supervision, we have analyzed our work and the work of our supervisees. Our analysis has prompted several observations about our work and their work and some challenges that arise from these observations. The agencies through which we have delivered clinical supervision have included the following: a crisis intervention center, a mental health center, a large private practice, a church, an adolescent sex offender treatment program, a university counseling center, a broad-based family/youth intervention program, a hospice, and others. Also, both of us have delivered clinical supervision in counselor education programs, including both CACREP and non-CACREP university programs.

From this history of clinical supervision, our belief is that a large source of failure in clinical supervision stems from the lack of clarity about the supervisor's philosophy of clinical supervision. From this observation, we have sought to define the necessary components of a philosophy of clinical supervision, along with a rationale for developing a philosophy of clinical supervision, regardless of the setting in which supervision is delivered.

A Philosophy of Clinical Supervision Defined

Clinical supervision is the process of training another clinician to function effectively. A philosophy of clinical supervision encapsulates the beliefs about supervision that a supervisor holds. These beliefs arise from the person of the supervisor, to be sure. But they also arise from the experience of delivering clinical services, receiving supervision of clinical supervision, and a careful and studied understanding of clinical supervision. The content of these beliefs encompasses the supervisor's beliefs about people, how people develop and change, how therapy works, and much more.

These beliefs are discussed later. As a whole, a philosophy of supervision serves to guide the work of clinical supervision and to inform supervisees about important aspects of supervision.

Unless the purported supervisor has delivered clinical services—our belief is that this should have been done for about 10 years—clinical supervision should not be attempted. However, an acceptable substitution for several years of delivering clinical services is training in clinical supervision, including a doctoral program in counselor education and supervision. Training in clinical supervision has been demonstrated to be effective in preparing competent clinical supervisors (McMahon & Simons, 2004). Clearly, the fact that counselor education programs sometimes include faculty who are not clinicians, but who supervise the clinical work of their students, makes this an emergent matter for many counselors and counselors in training. Clinically inexperienced faculty and non-licensed counselors should not be permitted to serve as clinical supervisors for counselors who anticipate being licensed as providers of mental health services.

A philosophy of clinical supervision emerges from experience as a clinician. However, if it is conducted well, clinical supervision emerges also from a thoughtful, studied, careful, and developmental philosophy of supervision. As such, it fulfills the often-cited dictum of Kurt Lewin from many years ago, "There is nothing so practical as a good theory" (Lewin, 1952). It reveals specific and practical actions of the supervisor.

Some Erroneous Beliefs About a Field-Based Philosophy of Clinical Supervision

Many supervisors seem to conclude that they are good clinical supervisors, because they are good counselors. Unfortunately, this is probably not correct. Despite many limitations of believing that being a good counselor is a sufficient basis for being a good supervisor, many supervisors believe this. While clinical service is a necessary prerequisite for supervision, it is not sufficient. Unfortunately, the belief that effective counseling is a sufficient basis for understanding and actualizing clinical supervision is supported by many states where training for post-degree clinical supervision is not required. In most states, no evidence of training in clinical supervision or even a letter that confirms interest in clinical supervision is required.

If they are most effective in their implementation, the beliefs that guide clinical supervision ought not to be a mere re-statement of beliefs about counseling and psychotherapy. This is to say that many clinical supervisors make the mistake of saying something like, "I am a person-centered therapist. This is my approach to clinical supervision." While this may appear to be sufficient from the point of view of the supervisor, it leaves too much unsaid and too many questions unanswered, particularly from the point of view of supervisees. Further, it omits, or even excuses, the weakness of attempting to clarify for one's self and supervisees how supervision works.

The classic text on clinical supervision (Bernard & Goodyear, 2004) correctly distinguishes between supervision models that are grounded in psychotherapy theory and those that are grounded in a developmental model of supervision. However, while parsing concepts is a necessary and worthy pursuit, it falls short of fulfilling the obligations of clinical supervisors. A philosophy of clinical supervision may begin with parsing of concepts, but it should do more than this. Principally, clinical supervisors carry the

obligation of informing their supervisees about their personal-professional approach to clinical supervision. As only one indicator of this necessity, a psychodynamically oriented supervisor, for example, should be prepared to facilitate the professional development of a supervisee when the supervisee is a cognitively oriented counselor. In other words, a supervisor may identify closely with a theory of therapy, but should develop a philosophy of supervision that accounts for a broader range of thinking than a model that is grounded in psychotherapy alone generally allows. After all, effective clinical supervision requires solid experience in and understanding of therapy, but as a matter of practice is much more about effectively relating with professional colleagues than discharging the obligations of a therapist.

Characteristics of a Philosophy of Clinical Supervision

Our many years of serving in the role of clinical supervisors have prompted us to ask basic questions about a philosophy of supervision and attempt to answer them. These questions include ones that we believe every supervisor should attempt to answer. They include the following questions:

What do I believe about conducting therapy?
What do I believe about clinical supervision?
What is the role of the supervisor?
What is the role of the supervisee?
How do I define the good clinical supervisor?

Our answers to these questions may or may not be helpful for others. Instead, helping others to refine their questions may be more beneficial. The rest of this article is an attempt to do this.

What Do I Believe About Conducting Therapy?

Our accrued judgment, if not wisdom, is that a supervisor's beliefs about conducting therapy determine much of what is done in clinical supervision. Extending this, much of what is done in therapy and in clinical supervision stems from the supervisor's beliefs about people. With almost universal consistency among mental health care providers, answers to basic questions reveal these beliefs. Here are some of the questions: How do people change? What causes mental-emotional dysfunction? What basic assumptions do I make about the nature of being human? What characterizes a mentally healthy person?

Among others, Auger (2004) has emphasized the significance of raising these questions. In his article, "What We Don't Know CAN Hurt Us: Mental Health Counselor's Implicit Assumptions About Human Nature," he reminds us of what counselors know to be true. He confirms that, quite apart from commonly recognized and accepted theories of counseling, counselors and others hold views of themselves and other human beings that guide much of their behavior. He states, "Like all people, mental health counselors have basic assumptions about how humans behave and how change in human behavior occurs" (Auger, 2004). He goes further, though, in concluding that these assumptions "have an important influence on case conceptualization and intervention"

(pp. 13-24). What many counselors generally believe about Freud, Rogers, and Wolpe confirms that therapists may regard human beings in somewhat negative ways, somewhat positive ways, and somewhat neutral ways, among others, and that these ways of regarding human beings have specific and real outcomes in the conduct of therapy and, by extension, supervision.

A more challenging question to answer is "What is clinical thinking?" Or, "What is clinical judgment?" The answers to this question may take many different forms. The supervisor's answers, though, determine much of what happens in supervision. For example, is clinical thinking systematic and planned or is it serendipitous and open-ended or something else? Alternately, is the cognitive style of the supervisor compatible with the cognitive style of the supervisee?

A supervisor should have clear thoughts about how to define and, therefore, to recognize an effective therapist. Thus, another important question that supervisors should answer is "What are the characteristics of a good therapist?" Whether supervisors seek to integrate research findings in their answer to this question, they should consider their beliefs about the significance of professional actions and assets in conducting therapy. For example, what is the place of the supervisee's cognitive style, empathic understanding, curiosity, understanding of a therapist's power with clients, sensitivity to gender issues, tolerance for ambiguity, and flexibility? Beyond personal reflection on these issues, competent supervisors should seek to integrate research findings about effective therapists into the process of therapy.

Without trying to answer the question about the characteristics of a good therapist, the supervisor's work is likely to be weak. However, to give strength and credibility to the work, several useful resources are readily available. For example, one is the January 2005 issue of the *Journal of Mental Health Counseling*. This issue dedicates six articles to studies of "master therapists." Much of the information can help supervisors to create their own view of what good therapists are. In addition, there are numerous other reports about good therapists, including ones by Blatt, Sanislow, Zuroff, and Pilkonis (1996), Eells (1999), Huhra, Yamokoski-Maynhart, and Prieto (2008), Lafferty, Beutler, and Crago (1989), Ablon and Jones (1998), Goldfried, Raue, and Castonguay (1998), Jennings and Skovholt (1999), and Skovholt and Jennings (2004), among others.

What Do I Believe About Clinical Supervision?

A supervisor's approach to clinical supervision may be seen in answers to the following questions, among others:

- What is my definition of clinical supervision?
- What do I want to achieve through clinical supervision?
- What are my personal and professional assets that contribute to effective clinical supervision?
- What is my model of clinical supervision?
- What kind of relationship do I want to develop with supervisees?
- What are the ethically sensitive issues that I am likely to encounter in conducting clinical supervision?

Just as a counselor's view of therapy is significant in the conduct of therapy, a supervisor's view of supervision is significant in the conduct of supervision. Our conclusion is that most supervisors have answers to these questions, but that they have not sought to make them clear and explicit. Making them clear and explicit is an important and necessary task for effective supervisors. When they successfully complete this task, supervisors very likely gain important insights into their individual ways of delivering clinical supervision and an elevated way of communicating their view of supervision to others.

What Is the Role of the Supervisor?

One of the most important considerations for a supervisor is how the supervisory role is conceived. Unless the supervisor has given expansive thought and study to this area, the supervisor may do little more than emulate the style of a favored clinical supervisor from the past. In actuality, a supervisor faces multiple options in defining the supervisory role (Bernard & Goodyear, 2004). Generally, the many possible roles of supervisors include being a model as a therapist, a teacher, a consultant, a supporter, and an evaluator. Supervisors need to be alert to the many options of roles and attempt to be clear about the particular role that should be taken in meeting the supervisee's clinical or learning goals. Just as supervisees develop and continually redefine their roles as counselors, supervisors need to give attention to a plan for professional development so that their supervisory work may be refined. To define and/or refine the supervisory role, a prospective supervisor should, at least, work through Campbell's workbook on clinical supervision (Campbell, 2000). Her workbook is an excellent and readily available resource that can assist prospective supervisors in their training for supervision. Another of Campbell's books, *Essentials of Clinical Supervision*, is also an excellent resource for helping supervisors to understand their role (Campbell, 2006).

Here are some questions that a supervisor may want to answer, in trying to understand the supervisory role: Is a good supervisor one who answers all the questions for the supervisee or provides options for the supervisee to "try on" in his or her clinical situation? Does the supervisor see self as the "expert" or a "fellow traveler" on the counseling journey with the supervisee? How does the supervisor maintain availability for the supervisee? Does the supervisor want to be approachable, dialogical, and disclosing or prefer not to disclose self to the supervisee? Does the supervisor want the supervisee to be disclosing of personal issues or protect the supervisee from a fear of rejection or ridicule?

Generally, supervisors must draw on their own experience and sense of self to reach thoughtful conclusions about their way of conceptualizing the supervisory role. However, this needs to be done in a manner that is more transformative than summative, more integrative than conclusive, and more growth-oriented than status-affirming.

What Is the Role of the Supervisee?

The supervisee will come to supervision with his or her own ideas about supervision. This will help to define the role of the supervisor. Still, the role of the supervisor and the supervisee should be largely defined by the supervisor, while making the role of the supervisee as much as a mutual discovery as possible. The risk of the supervisor taking appropriate authority as a senior member of the profession is that

supervisees may take on the role that they feel has been "assigned" by the supervisor, instead of believing that they can discover their own role in the supervision process. Again, while supervisees must define their own respective roles, the conception the supervisor holds of the supervisory process will substantially contribute to supervisees' definition of and selection of their preferred roles.

The supervisor carries several specific responsibilities in the process of helping supervisees to define their respective roles. One of these is ensuring informed consent by the supervisee. Inexperienced supervisors may ask, "Informed consent? About what?" An answer is that, just as informed consent in counseling seeks to make sure that a client understands everything about the treatment process, informed consent in supervision seeks the same kind of goal. In the supervision process, informed consent orients supervisees to the supervision process, aids in creating mutual understanding with the supervisor, and explains the expectations and tasks of the supervision process.

Another important responsibility is to complete a contract with supervisees. A clear and thorough contract is a method that contributes structure and important rules for the process of supervision. What should be in the contract? In short, everything that defines the supervisory relationship should be in the contract. However, more specifically than this, a good supervision contract includes the following items:

- Detailed information about the supervisor
- Supervisor's understanding of and philosophy of supervision
- Information about the supervision process
- Days and times of meeting, number of meetings for each week/month
- How to contact each other in case of emergency
- Paperwork to be kept and by whom, and payment issues, if a paid process
- Discussion of ethical issues and the ethical code that will govern the supervisory process
- Purpose and goals of supervision
- Specific areas of responsibility for the supervisor and the supervisee
- How the supervisory process will be evaluated
- Signature page to formally adopt the process.

A supervisory contract offers clear boundaries about the supervision process. An important by-product of clarifying boundaries is that both the supervisor and the supervisee create safety for themselves. Also, by knowing the boundaries within the supervisory relationship, the supervisee feels empowered, knows what to expect, and more likely commits self to the experience of receiving clinical supervision.

Ultimately, the role of the supervisee is discovered through the process of supervision. Unlike the supervisor's role, the supervisee's role cannot be known in advance of receiving supervision. Knowing this should enable a supervisor to facilitate the supervisee's discovery of his/her role.

How Do I Define the Good Clinical Supervisor?

As field-based and university-based supervisors, our experience has required us to define "the good clinical supervisor." In our attempt to do this, we have created several statements from which we have benefited, insofar as they offer specific and practical

guidelines for our work as clinical supervisors. Our reason for citing them here is that they may be useful to others who wish to define their view of the good supervisor for themselves. We encourage others to borrow and modify these statements for themselves, as needed. Here are our statements that define the good clinical supervisor:

- Good supervisors understand and practice good therapy, because they have practiced good therapy.
- Good supervisors understand and affirm the power differential between themselves and their supervisees.
- Good supervisors unambiguously support their supervisees in forming clear goals for their supervision so that they gain self-awareness and skill in progress toward being effective practitioners.
- Good supervisors should be willing to demonstrate their clinical skill for their supervisees. (The assumption here is that master therapists ought to be able to demonstrate their clinical prowess, as needed, for their supervisees.)
- Good supervisors know that their supervision exists in the real world where human lives are seriously impacted by their supervision, instead of contemplating their supervisory role as an only academic or intellectual exercise. While supervision may have academic components and times for intellectual exploration, it is essentially a clinical process. As such, among many other things, it requires supervisors to confront substandard clinical work, on the experiential base of knowing what good clinical work is.
- Good supervisors ask good questions of those whom they supervise and help the supervisee to experience the worth of the struggle to serve clients in a positive fashion. They help supervisees to discover that therapy is more a way of being than a way of doing.
- Good supervisors empower supervisees to confidently conduct clinical work, by confronting supervisee's inadequacies, but, moreover, by affirming their struggle to succeed and their consequent successes. They stay alert to opportunities for helping supervisees to improve their clinical judgment.
- Good supervisors respect the boundary between clinical supervision and the supervisee's possible need for personal therapy.
- Good supervisors understand that their way of responding to clinical situations is likely one among many clinically appropriate ways of responding.
- Good supervisors seek to nurture counseling identity in their supervisees.
- Good supervisors know that clients' needs take precedence over supervisors' and supervisees' needs.
- Good supervisors remain cognizant of advancing the profession of counseling, along with nurturing supervisees' development.
- Good supervisors understand that supervision is a process, not an event or a technique. As such, the process involves a quest for meaning, satisfaction, and personal fulfillment as a supervisor. Similarly, the process is perpetual, ever dependent on the need of supervisors and supervisees to improve the delivery of clinical services.
- Good supervisors commit to spontaneity, experimentation, inventiveness, and other existential necessities, knowing that their self-discipline is indeed

disciplined and well informed. This means that good supervisors are accountable for the process of growth for themselves and their supervisees and, paradoxically, subordinate to it.

- Good supervisors know that their conjoint and occasional incapacity to help clients provides opportunities for growth. Further, a great deal may be learned from the experience failure.
- Good supervisors understand that a professional working alliance with supervisees is necessary and mutual.
- Good supervisors increase supervisees' awareness of transference and counter-transference issues in therapy, but also in supervision.
- Good supervisors establish plans for their own professional development.
- Good supervisors remain cognizant of the potential threats that sometime attend growth toward healthy and effective therapeutic functioning by their supervisees. This is to say that good therapy sometimes upsets individuals and the institutional political systems in which they function.
- Good supervisors know that confrontation—along with its consequent stress—is necessary in the conduct of clinical supervision, but that tenderness and support are necessary, too.
- Good supervisors appreciate empirical research in counseling and psychotherapy and self-consciously integrate findings into the process of supervision.

Application and Conclusion

Just as good therapy comes from a heightened understanding of the several processes of therapy, good supervision comes from a heightened understanding or the several processes of supervision. A useful, productive, and developmental future of clinical services depends on the acquisition and utilization of this understanding and of a supervisor's ability to articulate a well-developed philosophy of supervision that incorporates this understanding. Because of the importance of a philosophy of clinical supervision, we would like to offer assistance to those who may pursue the development of one.

Therefore, to assist you in developing your philosophy of clinical supervision, we would like to offer some suggestions. There are six of them.

- Write your philosophy of supervision
- Start a workbook
- Create a reflection tool
- Consult with other supervisors
- Review your experience as a supervisee
- Ask your supervisees and former supervisees

We could offer a longer list of suggestions than we offer. To no one's surprise, these suggestions express the view that growth as a supervisor involves self-examination, along with the belief that shared self-examination enhances the process of growth. We hope that they are useful for you.

Write Your Philosophy of Supervision

Because it is useful toward clarifying many activities and goals of supervision, having a clearly articulated philosophy of supervision is important. One way to achieve a clearly articulated philosophy is to write one. While this may appear to be a daunting thought, it may be better regarded as an ongoing process of development than a completed task. Just as supervisors expect their supervisees to demonstrate a commitment to growth, supervisors need to demonstrate this commitment, too. Writing a philosophy of supervision is one way to demonstrate this commitment.

To begin the process of clarifying your philosophy of supervision, you may want to write your responses to the questions that we raise, above, and repeat here.

- What do I believe about conducting therapy?
- What do I believe about clinical supervision?
- What is the role of the clinical supervisor?
- What is the role of the supervisee?
- How do I define good clinical supervision?

To take increased advantage of what you write, you may want to encourage a colleague or two to write their responses to these questions. Then, you may want to compare your responses to theirs so that all of you may gain insight from one another and develop your skills with them.

Start a Workbook

Create your own workbook through which you develop your philosophy of clinical supervision. While many more questions could be raised, here are some of the questions that you may want to answer, as ways to focus your thinking about clinical supervision:

- How do I define good clinical supervision?
- What is my preferred role as a supervisor?
- What resources—books, mentors, records of your supervision, articles—do I or may I utilize, to help me clarify my approach to clinical supervision?
- What should I tell my supervisees about my approach to supervision?
- How do I measure the effectiveness of my clinical supervision?
- To which, if any, professional ethical issues am I vulnerable in my approach to supervision?
- To which client problems am I drawn? To what degree does this lead to good clinical supervision or inhibit good clinical supervision?
- To which client populations am I drawn? To what degree does this lead to good clinical supervision or inhibit good clinical supervision?
- How do I handle clinical weakness in my supervisees?
- How do I handle clinical strength in my supervisees?

- How do I track progress in supervisees? How do I affirm progress in my supervisees? How do I express clear and comprehensive evaluations of my supervisees?
- In what ways may I try to ensure that my supervision provides a reasonably good match with my supervisees needs?

Create—or Borrow—a Reflection Tool

Here is one that you may adopt and alter in any way that you wish:

Question	Disagree									Agree
I enjoy delivering clinical supervision.	1	2	3	4	5	6	7	8	9	10
I have a clearly articulated approach to counseling/therapy.	1	2	3	4	5	6	7	8	9	10
I utilize an informed consent form with supervisees.	1	2	3	4	5	6	7	8	9	10
I consult with others about my supervisions.	1	2	3	4	5	6	7	8	9	10
I have grown as a clinical supervisor.	1	2	3	4	5	6	7	8	9	10
I have a clearly articulated philosophy of supervision.	1	2	3	4	5	6	7	8	9	10
I have recently reviewed the ethics of supervision.	1	2	3	4	5	6	7	8	9	10
I have written my philosophy of supervision.	1	2	3	4	5	6	7	8	9	10
I have plans for my professional development.	1	2	3	4	5	6	7	8	9	10
I have clearly defined good clinical supervision.	1	2	3	4	5	6	7	8	9	10
I help supervisees to understand the goals of supervision.	1	2	3	4	5	6	7	8	9	10
I bring sufficient clinical experience to supervising.	1	2	3	4	5	6	7	8	9	10
I utilize research in my supervision.	1	2	3	4	5	6	7	8	9	10
I maintain appropriate boundaries in supervision.	1	2	3	4	5	6	7	8	9	10
I advance the counseling profession through supervision.	1	2	3	4	5	6	7	8	9	10
I respect the power differential in supervision.	1	2	3	4	5	6	7	8	9	10
I demonstrate clinical skill in supervision.	1	2	3	4	5	6	7	8	9	10
I engage my supervisees in positive struggles.	1	2	3	4	5	6	7	8	9	10
I raise questions about ethics and law with supervisees.	1	2	3	4	5	6	7	8	9	10
I have a well-developed plan for supervision emergencies.	1	2	3	4	5	6	7	8	9	10

The value of a reflection tool is that it assists supervisors in their ongoing reflection on their work as supervisors. After you complete the ratings, above, you may want to consider adding features of your supervision that are not represented in the list. Also, if you complete the reflection tool, you may want to invite a colleague to complete it, too, and discuss your results with your colleague.

Consult With Other Supervisors

Experienced counselors and supervisors understand that much of what they do is necessarily done in a cone of privacy. Because of this, supervisors often find themselves in the position of "having to view the picture from the frame." They are close enough to the experience of supervision that they know the limits of their objectivity and self-evaluation. Usually, they conduct supervision alone, as the only supervisor in the room. Understandably, they may need others to help them to view their work as supervisors.

Clinical supervisors need other supervisors as sources of assistance in the process of refining skills and insights. Still, in contemplating action on this need, they need to affirm that they usually take considerable, already acquired, skills and insights to consultations with other supervisors.

Each consultative relationship should set its own way of working and its own goals. We recommend, though, that the consultation give attention to self-identified needs for professional development. The expression of these needs may be seen in questions, such as "I need to figure out what is happening with a particular supervisee, because there is a disconnect in our relationship. May we talk about this?" Or, "When I offer feedback, I can sometimes see fear in the eyes of those who hear it. I'm very good at creating safety for my supervisees, but something is happening here. What is it?"

Review Your Experience as a Supervisee

Take time to review your experience as a supervisee. This may take a while—especially, if you need to locate attendance records and evaluations that you received—but may be a valuable process through which you clarify your philosophy of clinical supervision, insofar as first experiences with clinical supervision are almost always powerful ones.

Here are some suggestions about how to proceed. Beginning with your first clinical supervisor, write comments in response to the following items:

1. The name of the supervisor.
2. The manner in which he/she provided clinical supervision.
3. What made clinical supervision with this person memorable?
4. How did your work with this person change or challenge your self-perception as a counselor?
5. What are the positive and negative things you remember from this supervision experience?

After you have recorded your responses, take time to consider each one and begin a process of synthesis. How does your past experience inform the present manner in which you offer clinical supervision? Have you created your own "style" of supervision or are you "mirroring" a past experience that you found "comfortable?" How much is your current supervision is challenged by your experience as a supervisee? Or, how much of your current supervision a fulfillment of the supervision that you received? What are the really good and useful things that you learned from those who supervised you? What aspects of your work as a supervisee did you find unhelpful and of little use to you as a counselor and now as a supervisor? Are you "re-treading" these same issues with your supervisees?

After taking the time to review former clinical supervision and comparing the past with your present supervision style, ask the question, "Am I doing the same things in supervision now that I received back then?" And, "Am I mostly repeating my supervisee experience? Clinical supervisors, like everyone else, get "stuck" in the familiar and that which is "easy." Have you taken the style of supervision that your clinical supervisor(s) used with you because it is comfortable for you? Do you seriously reflect on the manner in which you deliver clinical supervision? Are your actions with supervisees continually

"acting" in thoughtful ways based in the present or are you "reacting" to your past supervision with your current supervisees?

After undertaking this review of how the past has influenced your present manner of supervision, what areas of growth may need to be addressed? Hopefully, you will have discovered places for possible growth as a clinical supervisor. What is your plan of action for addressing your identified areas of growth as a supervisor? If you discovered parts of your present supervision style that are "baggage" from past supervision, what may you do to relieve your burden? How do you plan to refresh your skills, attitudes, and supervisory relationships? As you see positive change in your supervisees, can you describe the "gifts" from the supervisors who supervised you and that may be an affirmation of them and you? Are these "gifts" that you may pass to others? Are these "gifts" that you may continue to improve?

Another way to reflect on your experience as a supervisee and the influence of the experience on your current supervision is to list the resources that you consult or to which you usually refer. For many who do this, the list may be as good as it is bad, because observations about the list are likely to be both affirming and challenging. For example, consider asking, "When did I last read or research clinical supervision?" Or, "What are the dates of the books to which I usually refer, when I need information about clinical supervision?" In other words, reflecting on your experience as a supervisee and the resources to which you refer may indicate that you need to develop plans for updating and refreshing your views about clinical supervision. If you find that your resources are dated, you will likely find that your philosophy of clinical supervision is dated, too. If you suspect that your views of clinical supervision are dated, you may want to pursue the challenge of re-conceptualizing and refreshing your views. Just as clients and supervisees gain from new information, supervisors usually gain from new information and insights about supervision. New information and insights have ways of challenging an old philosophy and prompting new ways to conceptualize a fresh philosophy.

Ask Your Supervisees and Former Supervisees

Clinical supervisors should always be open to and seeking to solicit feedback from supervisees. Do those whom we supervise find meaning, worth, and clinical assistance from what we offer? Could it be that supervisees are merely "sitting" through the process with us because they must? If someone that we supervise is not finding growth from our work with them, is it a reflection of faulty conclusions from our philosophy of clinical supervision?

There are ways to guard against the possibility of ineffectual or stale supervision. One of these is that, at various points in time during the supervision process, you can make yourself vulnerable to your supervisees and ask for their feedback. Here are some questions, for your consideration: Is the process of supervision useful to you? In what ways am I being helpful to you as a clinical supervisor? What, if anything, have I missed that you find important, but are uncomfortable to address with me? Are your clients being helped because of the work that we are doing together? What would you like for us to do differently?

The value of a philosophy of clinical supervision is seen in its translation into the practice of clinical supervision. Surely, those whom we supervise may be in the best position to help us understand how our philosophy translates into positive help and practice.

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