Narratives of harmful clinical supervision: Synthesis and recommendations

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ABSTRACT
Scarce information exists that considers supervisees’ experiences of harmful supervision despite research that indicates occurrences at startling rates (e.g., Ellis, Creaner, Hutman, & Timulak, 2015). This Special Issue attempts to serve as a starting point for stimulating conversation, action, and change around harmful supervision practices across disciplines and internationally. Specifically, in this article we aim to synthesize the introductory, narrative, and reaction articles (Ammirati & Kaslow, 2017; Beddoe, 2017; Ellis, 2017; Ellis, Taylor, Corp, Hutman, & Kangos, 2017; Reiser & Milne, 2017). In addition, we offer implications and recommendations to minimize the occurrence of and redress harmful supervision.

KEYWORDS
Clinical supervision; counselor training; professional ethics; harmful supervision

Introduction
The authors of this Special Issue have endeavored to expose the unacknowledged truth of harmful clinical supervision, with the hope that raising awareness will provide the impetus for substantial changes across disciplines to protect supervisees and avoid harm. As demonstrated by these narratives and the previous literature (e.g., Anonymous, 1991; Ellis et al., 2014; Ladany, Friedlander, & Nelson, 2005), it seems clear that the experience of harmful clinical supervision is neither an isolated nor rare incident. We hope that emphasizing this phenomenon from the perspective of supervisees who have experienced harm will spark increased awareness internationally and across disciplines. Hence, our intent and goal for the Special Issue was to serve as a starting point for stimulating further conversation, action, and change. We provide an outlet for the narrative authors to have a voice and hopefully realize that they are not alone.

In writing the synthesis article, we presume that readers have read the other articles in the Special Issue (Ammirati & Kaslow, 2017; Beddoe, 2017; Ellis, 2017; Ellis, Taylor, Corp, Hutman, & Kangos, 2017; Reiser & Milne,
2017), as this article is predicated on the information and material presented therein. Limited information will be repeated. We would also like to emphasize that this Special Issue does not report empirical research, but rather it is a presentation of a collection of narratives (Ellis, 2017) with information about why and how these were obtained (Ellis et al., 2017); reactions to the collection of narratives (Ammirati & Kaslow, 2017; Beddoe, 2017; Reiser & Milne, 2017); and a synthesis of all of these in the current article.

The current authors recognize the bias inherent in exploring one person’s account of a supervision experience. Input from training program faculty, site and agency supervisors, and consideration of environmental factors were not included. Such information would certainly add nuance and further insight into each of the authors’ experiences. Unfortunately, the inescapable power differential and evaluative nature of the supervisory relationship (Falender & Shafranske, 2004) risks leaving supervisees without a voice, which was so clearly depicted in the narrative authors’ accounts.

Consistent with Ellis and colleagues (2017), we distinguish between a supervisor-protective stance (e.g., a legal context) and a supervisee-protective stance (e.g., a training context) where the thresholds for establishing proof differ substantially. Specifically, some professionals take a supervisor-protective, defensive stance (e.g., whereby they inappropriately apply legalistic standards and criteria that put the burden of proof on the supervisee). Unfortunately, the legalistic, supervisor-protective approach tends to further victimize the victim. In contrast, we take a supervisee-protective stance that provides supervisees the benefit of the doubt, and offers a venue where they are empowered to share their stories (see Ellis et al., 2017, for a more in-depth discussion of these issues).

**Recognitions**

The guest editors of the Special Issue would like to thank all of the narrative authors for sharing their stories. We understand that recalling and reflecting on the harmful experience(s) can be difficult. We are thankful for your fortitude and willingness to submit your narrative. We cannot overemphasize the importance of these stories, and we are sincerely grateful for your contributions. The guest editors would also like to thank the representatives from various disciplines who offered their commentaries; your contributions are greatly appreciated and have the potential to play an instrumental role in raising awareness of the phenomenon of harmful clinical supervision and promoting positive systemic change. Special acknowledgment goes out to the 100-plus initial people who were willing to share briefly their story by submitting the online questionnaire. Many factors were taken into consideration during the review process and, unfortunately, we were unable to select and publish narratives from all who expressed interest. Please know that your
individual stories are equally as important as those published in this Special Issue, and we hope that you are able to share your story with others in the future.

We found it difficult to read the harrowing stories of the 11 narrative authors (Ellis, 2017). Indeed, two of us have experienced harmful supervision that led to traumatic experiences, self-doubt, incredible stress, and painful moments. You are not alone, and your stories were vindicating. In reading your stories, all of us involved in the Special Issue felt angry for and protective of you; your courage only underscored the importance of this Special Issue. On behalf of the fields represented throughout this issue, we offer heartfelt apologies to those who have endured harmful supervision. A supervisor’s harmful behaviors are unacceptable. We regret that you had to survive such an experience.

There is much work to be done to improve clinical supervision. The 11 narratives offer a snapshot of the lived experiences of the large number of supervisees harmed in supervision (e.g., Ellis et al., 2014; Wong, Wong, & Ishiyama, 2013). For those who identify with any aspects of these narratives, we truly hope that reading about the harmful supervision experiences of others is cathartic and validating, albeit angering and heartbreaking.

**Commonalities of harmful supervision experiences**

There are clear commonalities among supervisors, supervisees, and systems as a whole woven throughout the 11 narratives (Ellis, 2017) in combination with the reaction articles (Ammirati & Kaslow, 2017; Beddoe, 2017; Reiser & Milne, 2017). Consequently, behaviors described in the narratives align with some descriptors of harmful supervision within the taxonomy empirically tested by Ellis and colleagues (2014). Specifically, the narratives depicted situations in which the supervisors engaged in an abuse of their power; there existed discrimination based on age, race, gender, sex, and other cultural characteristics; and supervisees were publicly shamed, abused, or threatened. Given the data highlighting the startling prevalence rates of harmful supervision (e.g., Ellis et al., 2014; Ellis et al., 2015), it is reasonable to consider that these commonalities extend beyond the small sample of accounts within this Special Issue.

**Supervisee commonalities**

Many commonalities can be observed among the supervisees’ feelings represented in the collection of narratives. Overall, it appears that the supervisees felt intense, negative emotions throughout the harmful supervision experience. Many noted feeling depressed or anxious, and reported a sense of “dread” when they entered supervision or their clinical site. The experience
of harmful supervision was described as “traumatic” in several narratives, and frequently led to significant physical and psychological health problems, including fatigue, weight loss, headaches, and digestive issues. For example, Anonymous 8 (Ellis, 2017) reported feeling “powerless, angry, victimized, and helpless” (p. 68), which is consistent with the accounts of several of the narrative authors. In many cases, the experience impacted supervisees on a deep, emotional level due to the “destructive” feedback (Ammirati & Kaslow, 2017, p. 119) of supervisors, thereby creating an adversarial climate, which “pathologized” supervisees (Beddoe, 2017, p. 96). For example, Anonymous 5 (Ellis, 2017, p. 51) described her supervisor’s comments as a “brutal attack on who I was as a person” and Anonymous 4 (Ellis, 2017, p. 46) noted that the experience was “eating away into the core of my personality.” In fact, the emotional toll that harmful supervision can have on supervisees is so great that a few individuals declined the Special Issue editors’ invitation to submit a full narrative, citing that their experiences were so distressing that they could not commit to revisiting their trauma long enough to write a full draft.1 The physical and emotional consequences that the narrative authors reported offer clear evidence of the long-term damage that harmful clinical supervision can cause.

In every narrative, a common experience was the considerable personal and professional self-doubt that the harmful supervision instigated. Anonymous 1 (Ellis, 2017, p. 23) indicated that, at first, she did not recognize the behavior as harmful but as “indicative of my failure(s) as a student.” It is troubling to note that several of the authors had initially internalized the blame for their negative supervision experiences, consistent with the victim blaming or supervisor-protective approach described earlier. Although supervision is intended to facilitate supervisees’ self-reflection and growth (e.g., American Psychological Association [APA], 2014), many of the authors indicated that they experienced ridicule and condemnation from their supervisors. This process of denigration led the supervisees to, in the words of Anonymous 2 (Ellis, 2017, p. 34), “turn the oppression” on themselves. In the face of discouraging and dismissive comments from their supervisors, whom supervisees are socialized in their training programs to respect and trust, supervisees often questioned their own perceptions of their experiences. Although supervisees’ strengths should be fostered in clinical supervision, the rigidity of the harmful supervisors in the narratives inhibited their professional development and led several authors to instead reevaluate the extent to which they were adequate and suitable for the profession (Ammirati & Kaslow, 2017).

The self-blame present in many of the authors’ accounts seemed to intensify feeling isolated and silenced about the experience in both their personal and professional lives. It appears that by forcing unwanted disclosure from supervisees, supervisors paradoxically contributed to supervisees’
discomfort in speaking up about their negative experiences (Reiser & Milne, 2017). Such discomfort likely stemmed from the shame experienced by supervisees, which was only exacerbated as supervisees continued to remain silent about their harmful supervision experience (Ammirati & Kaslow, 2017). Supervisees’ silence also seemed to come from being fearful of the professional consequences that would follow their disclosure of negative feelings to their supervisor or to an outside party. The reaction authors all noted how clinical sites contributed to this problem by failing to set up a system of checks and balances that could protect the supervisees (Ammirati & Kaslow, 2017; Beddoe, 2017; Reiser & Milne, 2017). Such feelings appear to linger long after the harmful supervision experience ended; as Anonymous 2 (Ellis, 2017) noted, her experience was too painful to share with others, and she feared further judgment and blame. In fact, several potential narrative authors withdrew their participation from the Special Issue as they feared their supervisors might retaliate against them for sharing their story. Although the Special Issue editors took significant steps to protect the confidentiality and anonymity of narrative authors, some described their former supervisors as “litigious” and felt powerless to speak openly about their experiences. These experiences highlight how the desire to expose harmful supervision is challenged by real-world considerations, and that it is not enough to simply ask supervisees to “speak up” (e.g., Furr & Brown-Rice, 2016; Shen-Miller et al., 2015).

Supervisees reported engaging in several behaviors to “survive” their harmful supervision experience. For example, Anonymous 8 (Ellis, 2017, p. 67) stated that it “no longer felt safe to be vulnerable” with her supervisor, a feeling shared by other narrative authors. As a consequence, many authors described significant efforts to manage their emotional reactions at their clinical sites in general, and particularly in supervision. Anonymous 2 (Ellis, 2017) described acting as the “dutiful intern,” and Anonymous 9 detailed how she began to “shut down” and disengage from supervision sessions. Supervisees reported these types of self-regulating behaviors to be psychologically draining. Engaging in personal psychotherapy was cited several times as a way to cope with the distress of harmful supervision. Furthermore, supervisees remained hypervigilant about future harm long after the initial harmful experience. Anonymous 1 indicated that despite having positive relationships with her subsequent supervisors, she was “convinced” that she was destined to enter into another harmful supervisory relationship. Such fears led to discomfort and guardedness in supervision. Other narrative authors noted a significant distrust of future supervisors and others in positions of power. Thus, it is not surprising that many of the authors chose not to disclose their feelings to others both during and after their harmful supervision experiences.
It is important to note that some supervisees reported that the harmful clinical supervision experience became a source of growth for them despite it being traumatic. For example, Anonymous 2 (Ellis, 2017, p. 34) reported that “I have developed more resilience, better coping mechanisms, and have learned how to not let other people’s ‘stuff’ contaminate my well-being.” Although such growth does not justify or render less problematic the harmful clinical supervision experience, these accounts highlight that supervisees can become empowered through their work and about themselves following a traumatic supervision experience. The narrative authors displayed incredible resilience and did not allow their harmful supervision experiences to define them. Although these accounts highlight how future growth may be possible following harmful supervision, this is not experienced by all supervisees (Nelson & Friedlander, 2001; Unger, 1999), and does not justify the harm that is done to them in the process.

**Supervisor commonalities**

Sadly, it is challenging to tease out distinct harmful behaviors of supervisors, given that the behaviors seem to occur simultaneously or subsequent to another. For instance, Beddoe (2017) noted the racism that was woven throughout the narratives. Beddoe noted that Anonymous 1 (Ellis, 2017) was called a “mutt” by Supervisor X because of her cultural and racial heritage. Clearly this comment is discriminatory, but furthermore, because of the group context in which it occurred, it also involved publicly shaming this individual on the basis of her identity. In addition, Anonymous 8 (Ellis, 2017) described the sexist actions that took place as a result of her maternity leave. Specifically, this Supervisor X unjustly pointed to the supervisee’s role as a mother as compromising her abilities at work. Finally, Anonymous 11 noted that her Supervisor X used their age discrepancy as a way to assume authority, and further patronized the supervisee by suggesting the supervisor needed to act in a “motherly role.” Comments such as these not only cross boundaries, but also convey ageism. Moreover, Beddoe (2017) identified this scenario as an abuse of power. The aforementioned situations demonstrate that the harm taking place is complex and multifaceted.

The abuse of power on the part of clinical supervisors is another serious concern, given the uncomfortable and humiliating consequences for the supervisees, which was clearly represented in several narratives. Commentary from Beddoe (2017), Ammirati and Kaslow (2017), and Reiser and Milne (2017) also echoed the concerns regarding power differentials, and the pernicious impact on supervisory relationships when this power is unacknowledged, misused, or abused. In review of the narratives, whether intentionally or unintentionally, supervisors nevertheless inappropriately used their position of power over supervisees and crossed personal
and professional boundaries with impunity. In some accounts, supervisees’ personal information was used against them as evidence of clinical incompetence (e.g., Anonymous 11; Ellis, 2017). Supervisors used their power to coerce unwanted disclosure of personal information and, moreover, the trusting relationship, which was often already tenuous, was harmed when this information was used against supervisees. As Beddoe (2017) noted, “The best interests of supervisees are served by supervision in which boundaries are maintained, the relationship is respectful, and the focus is primarily on professional development” (p. 91). Unfortunately, Anonymous 9 (Ellis, 2017) described ways in which professional boundaries were consistently skewed and crossed by the supervisor’s disclosure of marital struggles and inappropriate sexual remarks. This supervisee was left with administrative duties beyond the scope of her role due to Supervisor X’s negligence or absence from work. Such negligent behavior (e.g., assigning responsibilities beyond the supervisee’s role and competencies without providing the requisite supervision and training) poses ethical concerns. Finally, for Anonymous 6, Supervisor X inappropriately required that the supervisee undergo neuropsychological testing as a condition of being on “probation,” despite the program training director’s disagreement. Nonetheless, Anonymous 6 felt immense pressure to comply. Subsequently, the results of the testing were disclosed to others. Obviously, this was both an abuse of power as well as an egregious ethical violation that resulted in humiliation and degradation for Anonymous 6. Unfortunately, the supervisees in these narratives often seemed to do as they were told out of fear for the potential impact on their professional advancement and/or academic standing, despite knowing that the supervisors’ behaviors were inappropriate (e.g., Furr & Brown-Rice, 2016; Shen-Miller et al., 2015). Clearly, the practicum and internship supervisors’ evaluations of their supervisees are key determinants in whether students move forward in their careers.

Across the collection of narratives, the extent to which the supervisors were intentionally harmful remains unknown. As Ammirati and Kaslow (2017) cogently argued, “we are all capable of harmful supervision” (p. 120). The narratives and the commonalities among them exemplify the need for supervisors to be mindful and self-reflective of their interactions with supervisees. Supervisors are encouraged to be cognizant of the power inherent in their role. When supervisors are sensitive to their positions of power, supervisees are well-positioned to grow professionally, learn, and pursue a career in the field because the supervisory relationship is more likely to be professional, collaborative, and evaluative (APA, 2015, p. 5). In light of the collection of narratives, we implore supervisors to be mindful that, although supervisees need to practice ethically and competently, they need not share the values, theoretical orientation, or background of the supervisor. Moreover, supervisors should refrain from inappropriately
disclosing personal information and working well beyond their own competencies, thereby modeling ethical and competent clinical practice.

**Systemic commonalities**

Some of these commonalities extend beyond the individual harmful acts of the supervisor. As demonstrated by the narratives, harmful clinical supervision does not exist in isolation. Common across the narratives were systemic features that seemed to permeate the agencies or institutions and, in some instances, contributed to and exacerbated the harmful experiences. In one account, a supervisee felt shamed by the agency and was told to consider the “professional consequences” of filing a complaint (Anonymous 7; Ellis, 2017). In another instance, the supervisee was afraid to speak out due to the hostile environment and fear of retaliation (Anonymous 2; Ellis, 2017). Throughout the narratives, there were several instances where programs or agencies were unresponsive when the supervisee decided to speak out and report the harmful supervision experience. Many supervisees felt silenced out of fear of professional consequences that extended beyond the specific training in which the harmful supervision occurred.

Moreover, there were instances in which the harmful supervisor held multiple roles (i.e., administrative/managerial and clinical supervisor), further complicating the professional relationship and contributing to the disempowerment of the supervisee. In Narrative 9 (Ellis, 2017), this Supervisor X held the highest administrative position at the agency, making it difficult for the supervisee to file a report or challenge this supervisor’s authority. Anonymous 9 often abided by the inappropriate requests from this supervisor for fear of being considered insubordinate. As noted by Ammirati and Kaslow (2017), multiple roles are not inherently negative, but can become problematic when the supervisor fails to prioritize the needs and training of the supervisee. It seems evident that the lack of protective agency policies left the supervisee in Narrative 9 feeling powerless.

Systemic racism and oppression are also apparent across some of the agencies described in the narratives. As noted by Beddoe (2017), instances of racial discrimination often went unaddressed throughout the narratives. In Narrative 1 (Ellis, 2017), the supervisee was unable to receive support from the organization when reporting that her advisor labeled her as a “mutt” in reference to her multiracial identity (Ellis, 2017). In Narrative 2 (Ellis, 2017), the supervisee experienced a culture of discrimination at the agency. This particular Supervisor X and staff engaged in microaggressions about individuals of identities different from their own. The site neglected to support the supervisee and ensure that the supervisee was not placed in a supervisory relationship with someone who had a history of making discriminatory remarks. Thus, the agency did not seem to consider the feelings and
experiences of the supervisee. In another instance, a supervisee was treated differently by her supervisor even though they had the same minority identity (Anonymous 8; Ellis, 2017). The supervisee noted that the supervisor treated her differently from her Caucasian colleagues. Upon discussing the discriminatory behavior of her supervisor with members of the licensing board, board members stated that they were familiar with her supervisor. She was told that she should not worry about her ability to become licensed. Although the credentialing board offered the supervisee some reassurance, it seems that the supervisor’s behavior largely went unaddressed. The aforementioned agency produced a training atmosphere of disenfranchisement and disempowerment.

Overall, institutional policies or the lack thereof left supervisees without a voice or an avenue to seek support or solutions to prevent and address their traumatic experiences. Recurrent across the narratives was a theme of feeling afraid that seeking help and speaking up about a harmful supervisor would have negative ramifications for their personal and professional lives. This fear seemed to stem from the supervisees’ positions in the overall power structures, and the lack of a chain of command to create an environment of accountability and support that would allow the supervisee and/or other professionals at these agencies to feel empowered to speak out.

Implications and recommendations

What are the implications of the narratives and reactions, and what recommendations follow? In subsequent paragraphs, implications are considered on a systemic level, as well as for supervisors, supervisees, and theory and research. The authors structured the following section according to where the authority and power resides within supervision practice (i.e., systemic implications, followed by implications for supervisors and for supervisees).

Systemic implications and recommendations

Given the apparent preponderance of harmful clinical supervision that is occurring (e.g., Ellis, 2017; Ellis et al., 2014; Ellis et al., 2015; Goodyear, Bunch, & Claiborne, 2005), taking action to live up to our ethical code—do no harm—is sorely needed. In many ways, some of the most important implications from the Special Issue pertain to implementing changes at a systems level in terms of how we train supervisees and supervisors and conduct clinical supervision (i.e., intervening at the national and international levels as well as at the program and agency levels). We strongly endorse Castonguay, Boswell, Constantino, Goldfried, and Hill (2010, p. 35) as applied to clinical supervision: “we believe that one of the mandates of graduate training in [mental health fields] should be to raise awareness of
and to prevent, to the extent possible, predictable sources of harm in [clinical supervision].” In part, preventing harm entails creating a culture that acknowledges the potential for harm in clinical work and in supervision, while also working proactively to engage in harm minimization for clients and supervisees (Castonguay et al., 2010). Furthermore, embracing the paradigm shift to a competency-based approach, especially for supervisor training and supervision practice (e.g., Falender & Shafranske, 2004, 2014), seems particularly relevant, as doing so would redirect the focus to measurable supervision knowledge, skills, and attitudes. Moving forward, training programs, agencies, and professional organizations are urged to safeguard against the potential of harmful clinical supervision practice.

What systemic changes are needed?
Several potential systemic changes are salient. We advocate for changing the credentialing and accreditation standards implemented by national professional organizations, as well as the licensure laws and regulations, to protect supervisees from harm. In addition to creating a culture that explicitly acknowledges harm, implementing the current discipline and country appropriate guidelines and standards for clinical supervision is a clear first step (e.g., American Association for Marriage and Family Therapy [AAMFT], 2007; APA, 2015; Borders et al., 2014; National Association of Social Workers [NASW], 2003; New Zealand Psychologists Board [NZPB], 2010; Psychology Board of Australia, 2013; Roth & Pilling, 2009). Another mechanism in harm minimization is requiring the use of a written informed consent and contract for clinical supervision (e.g., Barrett & Molzon, 2014; Bernard & Goodyear, 2014; Borders et al., 2014; Falvey, 2002; Smith, Cornish, & Riva, 2014; Thomas, 2010).

Due to the marked discrepancy between the supervisees’ perceptions and the actual supervision they are receiving, it appears that supervisees are not likely to readily identify when they are receiving harmful or inadequate supervision (Ellis et al., 2014; Ellis et al., 2015). One of the striking findings of Ellis and colleagues (2014, 2015) was the simultaneous presence of beneficial and harmful supervision. Some supervisees self-identified the same supervisors as delivering both exceptional supervision and harmful supervision. Other supervisees identified their supervision as exceptional, yet they were classified as receiving harmful supervision. Thus, it appears that supervisors may offer supervision that promotes the professional development and competency of supervisees while at the same time engaging in harmful supervisory behaviors. As a result, it may be difficult for supervisees in these circumstances to recognize the harmful supervision, trust their ability to detect it, and feel comfortable reporting it. We recommend that legislative or regulatory bodies and accrediting organizations require that supervisees receive training in the content and process of clinical supervision (e.g., a role
induction; Bahrick, Russell, & Salmi, 1991; Ellis, Hutman, & Chapin, 2015). This training would include teaching supervisees how to recognize the criteria for inadequate and harmful supervision, and the detailed steps to be taken should they encounter such supervision. This training in supervision seems especially important inasmuch as some of the narrative authors believed that the harmful treatment they received was due to their performance (e.g., Narrative 1; Ellis, 2017), and did not initially perceive the actions of their supervisor as constituting harmful supervision.

Echoing Reiser and Milne (2017, p. 105), “clinical supervision systems often lack the essential checks and balances that might be provided by objective oversight, standardized training, and quality assurance processes.” Unfortunately, an in-depth discussion of these critically important issues is beyond the scope of this article. That being said, the use of measures, such as session-by-session ratings of therapy and supervision, collected by someone beyond the clinical supervisor (e.g., program or agency training director), would provide some systematic oversight. Thus, training programs and agencies are encouraged to gather formal and informal feedback from supervisees about their experiences with their supervisors and training sites to help ensure that supervision and training practices are appropriate.

At the agency and training program levels, a common component among the harmful supervision narratives was that the supervisor served in multiple roles. For example, multiple roles in clinical supervision exist when a supervisor holds both an administrative (e.g., manager, director, administrator) and clinical supervision position. Multiple roles in supervision may be a fairly common practice, with researchers finding that 36% (Kreider, 2014) to nearly 50% (Tromski-Klingshirn & Davis, 2007) of supervisors were in dual roles. When supervisors serve in both administrative and clinical supervisory roles, the power differential between supervisors and supervisees is amplified (Tromski-Klingshirn, 2006). As noted, multiple roles are not problematic in and of themselves; problems arise when the conflicting demands and responsibilities of the supervisor are not managed well and supervisees are intentionally or unintentionally exploited (Tromski-Klingshirn & Davis, 2007; Kreider, 2014). Unfortunately, data are limited and mixed in this area.

Concerns about supervisors serving in multiple roles were present among the 11 narratives (e.g., Anonymous 9; Ellis, 2017). Hence, whenever fiscally possible, training programs and agencies are encouraged to avoid using supervisors who are in multiple roles. When supervisors must take on multiple roles, training programs and agencies need to (a) ensure that policies and procedures for conflict resolution, grievances, and due process exist (Reiser & Milne, 2017); and (b) educate supervisees about these policies as well as their rights (e.g., via a supervision informed consent and contract; Barrett & Molzon, 2014; Falvey, 2002; Smith et al., 2014; Thomas, 2010).
Regardless of the stipulations set forth by regulatory and accrediting organizations, Reiser and Milne (2017) urged training programs and agencies to take the initiative to educate their students on what is expected and not expected in supervision prior to or at the initiation of practicum, internships, and post-degree training (e.g., a written informed consent and contract for supervision; APA, 2015; Borders et al., 2014; Roth & Pilling, 2009). As indicated earlier, students, faculty, and agency staff would benefit from becoming familiar with and employing the relevant supervision guidelines (e.g., AAMFT, 2007; APA, 2015; Borders et al., 2014; NASW, 2003; NZPB, 2010; Psychology Board of Australia, 2013; Roth & Pilling, 2009).

In situations where harmful supervision practices are reported, training program and agency administrators are urged to take the supervisees’ assertions seriously, seek confirming and disconfirming evidence of the supervisor’s unethical and harmful behavior, investigate the situation systematically, and, as necessary, take appropriate action to remedy the situation (Reiser & Milne, 2017). Many of the narrative authors who attempted to voice their concerns were blamed for the circumstances, disregarded, and left feeling trapped and helpless. Anonymous 8 (Ellis, 2017) described multiple failed attempts at reporting her concerns. Supervisees are in a vulnerable position and need systemic support. Training programs and agencies are urged to consider developing their own policies and procedures to address issues between supervisors and supervisees such that supervisees are not expected to navigate such issues alone. As mentioned previously, supervisees who advocate for themselves often risk retaliation as well as potentially delaying or preventing professional advancement (e.g., licensure).

Training programs and agencies are urged to empower supervisees and provide them with options. If harmful situations do not resolve quickly, supervisees should be reassigned, supervisors should be removed from their supervisory role, and, if necessary, formal complaints can be filed. We would advise the person in authority to seek legal counsel as to how to proceed to minimize risk on the part of the agency or training program. (A discussion of pursuing legal or formal ethical allegations against the unethical and harmful supervisor, however, exceeds the purposes of this article.) Judging from the 11 narratives, as well as the literature (Ellis et al., 2014; Ellis et al., 2015; Nelson & Friedlander, 2001; Unger, 1999), no site or supervisor is so indispensable that programs or agencies should risk the well-being of their supervisees.

**How do we train supervisors?**

As has been advocated for regarding harmful psychotherapy (Castonguay et al., 2010), we strongly endorse the position that clinical supervisors should be explicitly educated about minimally adequate, inadequate, and harmful supervisory practices (e.g., Ellis et al., 2014), especially in the context of a
A competency-based approach to clinical supervision and professional development (e.g., Falender & Shafranske, 2004, 2014). Equally essential, supervisor training ought to include practice in implementing strategies to avoid and minimize the potential for harmful supervision (Ammirati & Kaslow, 2017; Pettifor, Sinclair, & Falender, 2014). Although considerably more could be delineated here, in essence, it distills down to training supervisors, including supervised supervisor training, to understand and implement the current standards of care and competencies as delineated by the various guidelines for clinical supervision across disciplines and countries (e.g., AAMFT, 2007; APA, 2014, 2015; ASP, 2003; Borders et al., 2014; Canadian Psychological Association, 2009; Davys & Beddoe, 2010; NASW, 2003; Roth & Pilling, 2009).

**Implications and recommendations for supervisors**

A plethora of potential implications for clinical supervisors seem evident; however, our intent is to introduce those that appear most salient. As suggested by Ammirati and Kaslow (2017), all supervisors are capable of delivering harmful supervision, and may have, in fact, harmed a supervisee at some point in their career; this is a disquieting and sobering fact. Consistent with the harmful effects of psychotherapy (e.g., Barlow, 2010; Dimidjian & Hollon, 2010), harmful supervision may be difficult to identify for multiple reasons. For supervisors, it seems essential to first accept the possibility that they unknowingly could be harming supervisees. Paralleling the psychotherapy literature (Castonguay et al., 2010), and as suggested by Reiser and Milne (2017), to minimize the risk of harming supervisees, supervisors need to monitor the process of supervision, how they are reacting to supervisees and their own countertransference (especially anger), and how supervisees are reacting and responding to supervision and the supervisor. It is essential for supervisors to routinely solicit and be responsive to supervisee feedback, using both ongoing open discussions as well as formal evaluations of supervisors at multiple points during the clinical experience.

**How do I assess whether or not I am doing something harmful?**

In addition to the strategies and suggestions previously proposed, several options seem appropriate. Per the definition of harmful supervision (Ellis et al., 2014), all harmful supervision is unethical; comport and hold yourself to the highest ethical standards. As a colleague suggested to us, if you need to ask someone if an action is unethical, do not do it. Be attentive to your cultural identities, areas of privilege, and experiences of oppression, as well as how these diversity issues intersect with those of your supervisees and your supervisees’ clients. If you have not done so already, negotiate a signed informed consent and contract for clinical supervision (for examples, see
Bernard & Goodyear, 2014; Borders & Brown, 2005; Thomas, 2010). Doing so will facilitate clarification and discussions of expectations, roles, responsibilities, and confidentiality. Moreover, contracts can generate conversations around goals, competencies, corresponding evaluation criteria, and policies and procedures regarding grievances. On a regular basis, ask supervisees about their supervision experience, the extent to which their professional and developmental needs are being met, and improvements that could make supervision more effective. If you have not addressed inadequate and harmful supervision, take the time to do so. As suggested earlier, create a culture where harmful supervision can be openly discussed (e.g., Barlow, 2010; Castonguay et al., 2010). Working to establish and maintain a supervisory relationship grounded in safety, trust, and humility, where you seek to empower supervisees to be active collaborators in supervision, will go a long way in preventing harmful supervisory actions.

Although scant evidence exists, it seems reasonable to assume that interventions that are beneficial for most supervisees may be harmful to a few (e.g., constructive feedback appropriate for advanced supervisees may be devastating for novice supervisees). Thus, it may be important for supervisors to consider an array of factors, including the unique characteristics of the supervisee (e.g., areas of competence and deficiencies, relational skills, defensiveness); characteristics of the supervisor (e.g., limits of competencies and expertise, skill level); and how supervisory interventions are implemented (e.g., incompetent implementation of constructive feedback). We suspect it may also be more about how an intervention is delivered than what the intervention is per se (e.g., overwhelming constructive feedback with little or no positive feedback or support, or using an angry versus more neutral tone of voice and demeanor).

When receiving feedback from supervisees, actively listen, and check that you heard what the supervisee said in the way that it was intended. Strive to be non-defensive and welcome the feedback, even though it might be difficult to hear. If necessary, manage your reactions such that you are intentional rather than reactive, especially if the feedback is constructive. Anger is a normal part of any relationship. In the context of a hierarchical supervisory relationship, supervisors’ anger toward supervisees can have considerably greater impact than intended. In general, we caution supervisors to be especially careful about expressing anger toward supervisees, which may also be framed as empathic failures (Mordecai, 1991). In such cases, consulting with other supervisors is recommended. How supervisors receive supervisee feedback can be an opportunity to role-model professional behavior for supervisees as they receive client feedback. Furthermore, to the extent that supervisors are able to receive feedback and demonstrate a commitment to improving the supervision experience, the relationship has the potential to become even stronger (Safran & Muran, 2000).
Alternatively, you may not be participating in harmful supervision, but identify harmful supervision behaviors in a fellow supervisor. One of the ethical responsibilities of professionals is to serve as a gatekeeper to the profession for those already in the profession (APA, 2010). Thus, it may be helpful to consult with the person in the training program or agency who has the authority to address such issues before personally attempting to express your concerns and observations with the supervisor.

**If I am doing harm, what can I do?**

Impasses in supervisory relationships are common (Mueller & Kell, 1972). Some harm can be resolved and the likelihood of a successful resolution will depend on how the supervisor chooses to address the issue(s). As suggested by Mueller and Kell, demonstrating a commitment to the supervisee’s well-being and to the supervisory relationship is central. Taking responsibility for the harmful actions, coupled with a genuine apology and humility about what happened, can go a long way toward healing the breach in the relationship and mitigating any harm that may have been done.

**Implications and recommendations for supervisees**

The guest editors of this Special Issue hope that all the supervisees who may be reading this and have experienced or are experiencing harmful supervision walk away from reading this knowing that you are not alone. Although the occurrence of harmful supervision is all too common (Ellis et al., 2014), it can often feel isolating and lonely. Due to the hierarchical nature of supervision and supervisees’ reliance on supervisors for letters of recommendation and passing practicum/internship experiences, supervisees often feel stuck and left without options. Even though this experience is undoubtedly overwhelming, there are always options available to you, which are delineated in the ensuing sections.

**How do I know if my supervisor is being harmful?**

When beginning supervision, supervisees typically do not know what to expect (for more information on supervisees’ rights and responsibilities, see Supervisees’ Bill of Rights; Ellis, Hutman, et al., 2015). Most supervisees assume that their supervisor is competent, has their best interest in mind, and is behaving as he or she is supposed to. It is important to trust your instincts; when something does not feel right, or something feels “off,” we encourage you to first discuss your situation with someone with whom you feel most comfortable in order to obtain another perspective on your experience. This consultant should be a professional whom you trust (e.g., an advisor, a mentor, your training director, or a former supervisor).
Just as supervisors are advised to familiarize themselves with the literature and guidelines for clinical supervision (e.g., Borders et al., 2014), it is to your benefit to have this knowledge as well. Knowing your rights and responsibilities as a supervisee will enable you to recognize when a harmful situation might be occurring in supervision. We also urge you to reflect on the narratives in this Special Issue (Ellis, 2017) and assess whether similar experiences are occurring, or at risk for occurring, in your supervision sessions.

**What do I do if my supervisor is being harmful?**

Supervisees would benefit from documenting every experience with their supervisor, including their attempts to resolve and manage the conflict (Greer, 2003). In cases where supervision is not egregiously harmful, it is ideal to attempt to discuss any concerns with your supervisor and advocate for yourself and your professional needs. When discussing concerns with your supervisor does not feel safe or feasible, seek support from other professionals you trust (e.g., your training director or agency director). Consultation with a person in a position of authority may also protect your professional advancement and career. Again, documentation is an imperative step in this process. Although it may be difficult to do so, we want to encourage you to continue to act in a professional manner, even if your supervisor is not maintaining professional behavior. Your demeanor can further your credibility and show your commitment to professional and ethical practice.

In cases where the supervisor is being egregiously harmful (e.g., physical or sexual abuse or harassment), it is not your responsibility to try to defuse or resolve the situation. We encourage you to consult with someone in a position of authority so that protective action may be taken on your behalf. Contacting professional organizations and state licensing boards is an option if the appropriate protective action is not being taken. We encourage you to do extensive consultation with a trusted professional before taking this route, so that you understand fully the potential implications of formal complaints (e.g., potential for retaliation or ramifications from supervisors, sites, or programs).

**Theory and research**

Ellis and colleagues (2014) developed a taxonomy of inadequate and harmful clinical supervision that purportedly was international and interdisciplinary. In the process of preparing the Special Issue, we found it important to further refine their conceptualization of harmful clinical supervision. Specifically, when considered globally, it became apparent that two contexts existed in which clinical supervision occurs internationally: pre-licensure or equivalent
(i.e., qualified, certified, registered, and so forth; pre-licensure henceforth) versus post-licensure clinical supervision (e.g., ongoing supervision that is required to maintain one’s professional license; NZPB, 2010). The distinction of pre-licensure and post-licensure supervision contexts has profound theoretical/conceptual and practical implications for understanding harmful supervision.

Pre-licensed supervisees, such as those in the majority of the collection of narratives (Ellis, 2017), are in a much more vulnerable situation wherein harmful clinical supervisors hold supervisees’ careers and futures in their hands—the supervisor has all of the authority and nearly all of the power over the supervisees and their futures. There are considerable risks associated with supervisees attempting to advocate for themselves when encountering harmful supervision in this context. Other than raising their concerns with the harmful supervisor, they lack the authority and power to address effectively the harm they are experiencing, as the authority largely lies with the training program or agency. Given the power differential in the supervisory relationship, a pre-licensed supervisee is neither free to leave the supervisory relationship nor quit the clinical placement per se. They would have to risk being put on a remediation plan or dismissal, or leave the program or profession, which are hardly viable options for most supervisees.

In contrast, in post-licensure supervision, supervisees have the ability to more easily and readily identify, attempt to rectify, and ultimately extricate themselves from the harmful situation without profound adverse impact; they have more authority and power to take corrective action to protect themselves (and not necessarily filing formal charges or complaints against the harmful supervisor, as doing so inevitably entails professional risks). Thus, it boils down to the relative level of inherent authority and power in a hierarchical relationship. Pre-licensure supervisees are particularly vulnerable and systematically disempowered relative to their supervisors, as illustrated by the pre-licensure supervisees in the collection of narratives. Hence, we propose that Ellis and colleagues’ (2014, 2015) taxonomy be refined to differentiate pre-licensure supervision from post-licensure supervision when conceptualizing the context in which supervision occurs and assessing the level of risk for and impact of harm for supervisees. Although under-investigated (Bernard & Goodyear, 2014; Falender & Shafranske, 2004), the two contexts for clinical supervision, especially comparative studies thereof, warrant empirical investigation. Paralleling the research and discourse on harmful psychotherapy (e.g., Barlow, 2010; Castonguay et al., 2010; Dimidjian & Hollon, 2010), investigations around the causes and effects of harmful supervisory practices are encouraged. More specifically, research on the topics and commonalities discussed throughout the narratives (e.g., racial dynamics, multiple roles) is needed to assess what may be effective in supervision and what is ultimately harmful. We hope that
these narratives have inspired scholars to investigate empirically harmful clinical supervision as a mechanism for enacting change.

**Conclusion**

The narratives in this Special Issue provide a glimpse into the alarming phenomenon that is harmful clinical supervision. As editors of the Special Issue, we hope that these narratives have been eye-opening, and also have ignited a commitment across disciplines to effect change at multiple levels. In addition, we hope that this Special Issue has served as an outlet for the narrative writers to have a voice. Furthermore, these narratives may inspire others to share their story and further spread awareness of the occurrence of harmful clinical supervision.

What is next? What can we do as a profession to protect supervisees? For the well-being of supervisees, clients, and the profession, there seems to be a dire need to reform policies and ensure that there is a system in place for supervisees to feel supported, empowered, and respected. Given the inherent hierarchical nature of clinical supervision, the onus to engender change does not rest with the supervisee; rather, it rests with the system and those who have the power and capabilities to spearhead change, including supervisors themselves. It is our hope that some of the ideas and suggestions presented in this synthesis will provide the foundation for developing systemic change to redress harmful supervision. It is time that we recognize the unacknowledged truth. The pervasiveness, consequences, and impact of harmful clinical supervision cannot be ignored. Please see the Clinical Supervision Contract & Consent Statement and Supervisee Rights and Responsibilities example included at the end of the issue.

**Note**

1. All respondents who indicated interest in writing a narrative about their harmful supervision experience were provided supportive resources.

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**References**


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