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A CBT formulation of supervisees' narratives about unethical and harmful supervision

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ABSTRACT

There is growing evidence that clinical supervision may be experienced as harmful (Ellis et al., 2013). The 11 narrative accounts of supervision that form the focus of this Special Issue of *The Clinical Supervisor* corroborate this evidence, providing vivid and alarming accounts of supervisee experiences of unethical and harmful supervision. In order to treat these worrying reports of supervision with the seriousness that they deserve, we adopt a CBT formulation approach and apply it systematically to these narratives. First, we formulate the data contained in these narratives within a framework for judging unethical supervision. Then we develop proposed solutions to address the problems reported. Last, we describe practical implications for improvements in identifying and addressing unethical supervision and for minimizing harm to supervisees.

KEYWORDS

Harmful supervision; unethical supervision; CBT formulation; supervisor training

Negative experiences of clinical supervision have been recognized for many years, as reflected in reasons for disciplinary action: among psychologists, improper or inadequate supervision was the seventh most common reason for disciplinary action (American Psychological Association [APA], 2015). But it is only recently that the alarming extent of such negative experiences has become apparent. For example, a survey of 363 supervisees' experiences indicated that 35% had experienced harmful supervision (Ellis et al., 2013). The present article considers 11 first-hand accounts of harmful supervision, narratives that offer detailed illustrations of experiences that appear to reflect both incompetent and unethical supervision, and which have understandably been recounted as distressing and personally harmful. These reports suggest multiple and fundamental problems in the supervision provided to these supervisees, including lack of recognition of the importance of power, privilege, and cultural differences; poor supervisory boundaries; accounts of unresolved and unrecognized difficulties in the supervisory alliance; lack of consistent formative feedback; and inadequate, inconsistent documentation of problems in supervision. The profound and wide-ranging nature of

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apparent supervisory deficiencies in these accounts suggests an alarming prevalence of unethical practice and heightens our concerns as to reports of harmful supervision. We also note that the effects of such harmful supervision appear to have been pervasive, having reportedly generalized to many facets of the supervisees' functioning, including some persistent, severe, and long-term consequences. For instance, many of the narratives suggest that the authors are still struggling with lingering shame and doubts about their professional identity and competence, sometimes for years after the experience. Often these experiences are reported in terms that indicate that the events were highly traumatic, stigmatizing the supervisee within a cycle of social and professional isolation, shame, and self-doubt.

The overall picture presented by these narrative accounts graphically suggests the severe repercussions of unethical practice. Unfortunately, these reports are quite consistent with much earlier studies of harmful supervision (e.g., Ellis, 2001; Gray, Ladany, Walker & Ancis, 2001; Nelson & Friedlander, 2001). To illustrate, in a highly complementary review of 25 accounts of harmful supervision, Wong, Wong, and Ishiyama (2013) concluded,

> These negative themes reveal not only the causes and nature of negative incidents but also a wide range of negative experiences and feelings. Several participants suffered severe emotional pains related to their experience in supervision. Many had serious doubts whether they were in the right profession and seriously considered quitting the counseling program. (p. 9)

This is an alarming state of affairs and merits considered and systemic action. In this article, we set out our provisional understanding of the problem using a framework for judging the ethical status of supervision, together with some potential interventions to identify and address harmful supervision.

Our perspective

We are both clinical psychologists, with a total of more than 50 years' experience in clinical supervision, including directing clinical training programs, providing supervision within training settings, and conducting research on supervision (including developing guidelines for evidence-based supervision). At least 10 of these years were devoted to training and supervising supervisors within a university-based training program for clinical psychologists (DM), which entailed regular consideration of the acceptability of the supervision that was provided, linked to peer reviews concerning appropriate corrective action, involving the supervisees and other interested parties (e.g., clinical managers and university administrators). In short, we have long had to adopt a highly professional stance in relation to supervision, addressing concerns in an impartial manner,

consistent with best practices in both the clinical and the university contexts. This requires a quasi-legal emphasis on due process, including mechanisms to empower the supervisees involved. The perspective we developed due to this organizational context was impartial, transparent, objective, and constructive.

Also relevant to our reaction to these narratives is the fact that we both share a cognitive behavioral therapy (CBT) orientation to clinical and professional issues, with a strong preference for the methods and findings of applied science (e.g., evidence-based practice). That is, we reflected on these narratives as career-long scientist-practitioners, clinicians who regard this perspective as highly appropriate and relevant to the study of supervision itself. The CBT stance places these methods ahead of the quality of the relationship, so please bear in mind that in the present reaction piece we will appropriately be prizing rational problem-solving ahead of providing reassurance or facilitating emotional processing (Leahy, 2008). Unfortunately, this may seem slightly invalidating or even somewhat dismissive to the supervisees or others involved. This is not our intention at all: we wish to firmly acknowledge that unethical supervision is completely unacceptable, especially when the power differential is so great. Consistent with the way that CBT therapists work with those who have experienced trauma, we seek to validate, collaborate, and strengthen how supervisees respond in the future (Leahy, 2008).

Given this background, we will adopt a CBT formulation-based approach to the narratives, regarding them as data that offer information on how the supervisees perceived the events that they reported. We will also contextualize these narratives within our understanding of supervision competencies and standards for professional practice (especially concerning unethical supervision). Specifically, we propose to illustrate our CBT-informed reaction to these narratives by following the initial procedure for addressing ethical concerns described by Knapp and VandeCreek (2006): scrutinizing the problem (taking the context into account; problem assessment), hypothesizing what happened (formulation), appraising intervention options, and ultimately evaluating the outcomes of our intervention. In so doing, we intend to react to the narratives as we would to a patient receiving CBT: in a compassionate but professional fashion, validating the experiences recounted, through according them a thorough and systematic analysis, taking into account the full contextual considerations, and seeking mutually beneficial solutions. This may seem cold and calculating, but we believe that this approach is entirely consistent with CBT, and that it represents the best possible service that we can offer. Whereas those with a humanistic orientation should properly react with empathy and engage in an "opening up," experiential process, the relationship stance that suits CBT is primarily educational, and includes offering constructive feedback (Watkins, 2014).

We should note another important feature of our CBT perspective, which concerns the reliance on self-report data, including these narratives. By contrast, a CBT approach would normally rely on multiple perspectives (e.g., supervisors' perspectives on the same events), combined with multiple methods of data collection (e.g., direct observation, such as tapes of problematic supervision interactions; permanent products, such as feedback forms and correspondence). This is consistent with applied science, as self-report is known to introduce particularly marked bias. Therefore, the convention is to supplement self-report data with more impartial or objective data in order to substantiate self-report. When critical decisions are being made that will affect professional careers, we would be loath to form a view or take punitive action solely on the basis of one individual's unsubstantiated concerns. Further data collection would be indicated. We point out this lack of objective data and evidence not as a criticism of the trainees who wrote the narratives, but as a general observation regarding a systemic weakness within training and supervision systems, which have unfortunately tended to eschew direct observation of supervision as an integral part of the training and quality assurance process for supervisors. In this sense, the supervisees who wrote the narratives appear to have been disempowered by their training programs (compared to programs in which observation is conducted routinely by supervisors and supervisees). We have to recognize that clinical supervision systems often lack the essential checks and balances that might be provided by objective oversight, standardized training, and quality assurance processes (e.g., supervision-of-supervision; direct observation of supervisors). This is a great shame, as these are the kind of mechanisms that might "level the playing field" and protect vulnerable trainees.

This, then, is our first and most general "reaction": *don't react* to expressions of harmful supervision on the basis of incomplete and intrinsically biased information, even when there seems to be a need for swift action. Instead, we would counsel responding thoughtfully by following due process. Due process (natural justice) is an aspect of "fidelity," one of four fundamental principles of ethical practice (see Figure 1). It concerns acting in a correct and proper manner (e.g., by being fair, just, and consistent). Reacting on the basis of the narratives alone would violate due process, as for instance the supervisors' need to be informed and have the opportunity to respond (e.g., by determining the facts and by presenting evidence). Our experience, allied to expert advice on addressing ethical issues within supervision (e.g., Knapp &VandeCreek, 2006; Thomas, 2014), has taught us to proceed with great care in these matters. This is true whether it is a supervisee or a supervisor who raises a concern. This is because we need to ensure that due process occurs in a balanced fashion, and that it is seen to occur fairly. Otherwise, we risk compounding what appears to be the supervisors' unethical conduct with our own, in reacting prematurely.

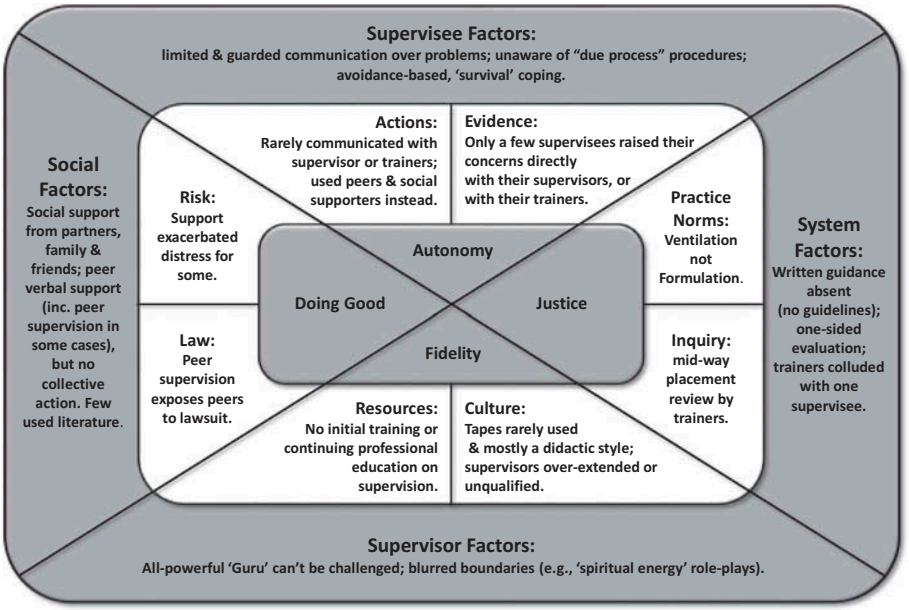

Figure 1. A formulation of the major factors influencing the unethical supervision described in the supervisees' narratives.

Addressing harmful supervision: A CBT formulation-based approach

Formulate the problem

Following our perspective and the CBT model, before intervening we should first define and formulate the problem, which in this case means examining the narratives for relevant clues as to the individual and system-contextual factors that have contributed to the problems. Within the CBT approach, case formulation is an essential task, as it collates contextual information, organizing the available objective assessment data and the more subjective associated reactions and emotions into a concise formulation of an individual patient's distress, guided by CBT theory. This formulation should suggest what the precise problems are, what might be maintaining the problems, and what approaches might be most likely to help (Kuyken, Padesky, & Dudley, 2009). As we only have subjective reactions to go on (the narratives), in this article we must make many assumptions (e.g., that all supervision and all harm were in some sense similar), and so can only attempt here to illustrate the formulation approach in a general way. Specifically, we provisionally define two problems: unethical supervision and the consequent harm to the supervisees (as summarized already and elaborated later).

Taking a CBT approach requires us to place these problems in context, as problem statements only make sense when we understand the situation or circumstances that surround them. We assume that behavior such as harmful

supervision is a function of individuals in interaction with their environment (Lewin, 1951). A recent, supervision-specific illustration of the importance and nature of the context can be found in Milne and Reiser (2016), who argued for a broader systems-contextual view of supervision, including training for supervisors, allied to supportive administrative and organizational systems. In the present instance, this formula translates as harmful supervision being assumed to be a result of the supervisees' interactions with their supervisors, alongside any other relevant environmental factors (e.g., inadequate and unsupportive training systems, hierarchical power imbalances, lack of oversight). That is, under optimal conditions we assume that both supervisees and supervisors have complementary responsibilities for the success of supervision, and for this and other reasons we also assume that supervision is collaborative and "co-constructed," an assumption that is not unique to CBT (Falender & Shafranske, 2012). This assumption does not mean that we believe that supervisees have as much power as their supervisors, but rather that they have a role to play that is appropriate for their status.

Given the assumed co-construction of supervisory events, we should properly consider the role of the supervisees in relation to their reported problems. But we recognize that the supervisee is only one of the actors on a larger professional stage, and is normally the least powerful actor. This applies especially to pre-licensure trainees who are especially vulnerable and dependent on their supervisors, and who may have very limited institutional recourse when problems arise in supervision. We also recognize that supervisors play a far more powerful and influential role and can have problematic dual roles in some instances (faculty and clinical supervisor), whereas social supporters and the organizational systems function in rather different but potentially complementary ways. These factors are assumed to interact, influencing one another, as we have tried to depict in Figure 1, our diagrammatic formulation of harmful supervision.[1] These four factors associated with the supervisee, the supervisor, the social support system, and the organization-system are illustrated around the outside of Figure 1, and they are regarded as providing a context for one another. As can also be seen, Figure 1 gives weight to both trainee and supervisor factors (e.g., Did the supervisee gather any evidence, or discuss the problem with the supervisor? Did the supervisor document problems and provide ongoing formative feedback?). The figure also encourages us to consider larger cultural and administrative factors (e.g., How well were policies and procedures implemented? Was there a clear system for resolving complaints and grievances?).

In turn, within Figure 1 all four contextual factors are associated with particular considerations that should be related to judging the ethical practice of supervision, as they provide important circumstantial evidence, remediation ideas, or possibly mitigating circumstances. To be concrete, in Figure 1

the supervisee factor is linked to any "actions" taken and to any available "evidence." For example, a supervisee who has taken appropriate independent action (e.g., raising concerns over supervision firstly with the supervisor, as early and constructively as possible), and who has also furnished useful evidence (e.g., a record of that discussion, including agreed actions), has acted in accordance with the ethical principle of autonomy. Although this type of response represents a highly desirable course of action in initial efforts to resolve conflicts within supervision, we recognize that it sets a high bar for exemplary behavior, especially for a vulnerable trainee who is also coping with the hierarchical power structure within supervision. Trainees are not "responsible" for the quality of supervision they receive, as this is a professional responsibility falling on the supervisors (in conjunction with their employing and training institutions).

As a second example, under "system factors" in Figure 1 we should note that a critical aspect of the professional and service context is that supervision is now rightfully regarded as a professional specialization (APA, 2015; Falender et al., 2004). Hence, supervisors and supervisees need to be trained in supervision, which is part of the administrative responsibilities of the clinical service and/or training system within which supervision occurs. Without such training, supervisees may not know what is expected of supervisors, or may not understand their role in terms of following due process regarding their concerns (e.g., Are there supervision guidelines or standards?). Furthermore, as a best practice standard for supervision, these expectations as to roles and rules within the supervisory system (including description of a due process procedure for resolving disputes) should be embedded within an initial supervision contract that is reviewed at the beginning of the period of the supervised experience. The presence or absence of such supportive documentation and procedures is likely to shape the perspectives, concerns, and actions of both trainee and supervisor. There are further considerations that arise from the mental health service and training program contexts. For example, the system must ensure that initial training in supervision is offered at a high educational standard, and is followed by regular refresher seminars (alongside ensuring regular feedback to supervisors from supervisees and from the system). But we know from personal experience that more often than not the system fails to support and develop supervisors (Milne & Reiser, 2016). While unethical supervision is never justified, this lack of support for supervisors potentially alters one's perspective accordingly, at least providing the possibility of some mitigating or extenuating circumstances for the supervisors' misconduct (e.g., locating some of the responsibility within the broader administrative context).

In addition to fidelity and autonomy, the other core ethical principles are "beneficence" ("doing good"; actions should promote human welfare and do no harm) and "justice" (treat all people equally and fairly). These four

principles are at the heart of Figure 1. Thus far we have been providing hypothetical examples, but the material summarized within Figure 1 and placed alongside these ethical principles is based on our reading of the narratives, and represents our initial formulation of what is described in these narratives. As per our hypothetical examples, the narratives-based examples in Figure 1 suggest that there are problems at every level of this analysis. We will turn to formulation shortly, but having considered the context, a CBT approach next requires us to consider the task of assessing the problems presented in these narratives.

Identifying harmful supervision

Assessment and formulation

Within CBT supervision, problems would normally be identified through longitudinal assessment, by means of such complementary methods as interviews, paper-and-pencil instruments (e.g., satisfaction questionnaires and competence rating scales), and primarily through direct observation (e.g., based on tapes or co-therapy). For instance, in our own research we have utilized an observational instrument to rate the supervisor's competence, and satisfaction ratings to monitor the ongoing supervision-of-supervision (Milne, Reiser, & Cliffe, 2013). Our instrument for evaluating supervision, SAGE, specifically evaluates four factors related to establishing and maintaining the supervisory alliance: "Relating," "Collaborating," "Managing," and "Facilitating" in supervision (akin to the concept of "common factors" in psychotherapy). In the present article, given the dearth of more objective data and reports, we will need to adapt our usual assessment methods and rely solely on analyzing the narratives in relation to possible indicators of unethical or harmful practice.

One of the major themes that is recorded in these narratives is difficulties within the supervision alliance. In CBT, this alliance can be defined as having the following key elements: establishing an explicit learning agreement, developing a collaborative bond (mutual engagement in tasks), providing a role model (e.g., reflective practice), and using formative feedback (Milne & Reiser, in press). This expands on the traditional definition, sharing a recognition of the alliance as a collaborative, co-constructed supervision relationship (Bordin, 1983). Ladany, Mori, and Mehr (2013), in a survey of 128 supervisees, identified that the management of the supervisory alliance was one of the key behaviors of effective supervisors, and this is reflected in multiple competence frameworks (e.g., APA, 2015; Rodolfa et al., 2005; Roth & Pilling, 2008).

As to more specific problems within the supervisory alliance, in these vignettes we see consistent themes of blurred supervisory boundaries (e.g.,

supervision becoming psychotherapy), with a sense of forcing unwanted disclosures from supervisees. For example:

> Supervisor X informed my supervision group that she was a leader within her spiritual community. She then proceeded to lead us through activities aimed at changing our "spiritual energy." Supervisor X asked permission to place her hands on my colleague's head in order to draw out the "bad energy" that was causing his headache. (Narrative 5; Ellis, 2017, p. 50)
>
> Throughout the semester, my supervisor demonstrated little respect for personal boundaries as she repeatedly asked unwanted questions about my personal life. (Narrative 11; Ellis, 2017, p. 83)

Second, we see consistent themes related to neglect of the innate power differential, often associated with a lack of cultural competence in the handling of differences. This ability to recognize and manage the power differential within supervision is a key supervisory competence (APA, 2015; Falender et al., 2004; Roth & Pilling, 2008). Examples include the following: "When I shared my ethnicity, Supervisor X interrupted abruptly and stated, 'Yeah, we get it. You're a mutt'" (Narrative 1; Ellis, 2017, p. 23); "Given the cultural connotation attached to my supervisor being my guru, challenging his authority and decisions was not an option" (Narrative 4; Ellis, 2017, p. 47).

Related to the key themes just noted, we see a corresponding lack of ability to reflect in supervision within these narratives, another core aspect of managing the supervisory alliance: "Supervisor X was unable to recognize the impact of his technique of supervision upon my sense of self" (Narrative 4; Ellis, 2017, p. 46); "I am going to share plebeian, small ruptures in a relationship coerced by circumstance, where neither party had full awareness, but one party, in my opinion, was negligent in lacking that awareness and the other an unwilling victim" (Narrative 10; Ellis, 2017, p. 77).

A final related theme was the rarity of direct observation and effective formative feedback: "Even though Supervisor X had not, at that time, viewed a tape of my therapy sessions and had no way of measuring my therapeutic skills" (Narrative 5; Ellis, 2017, p. 51); "This was the first indication Supervisor X had given me that anything was wrong with my performance in my practicum training" (p. 51).

Addressing harmful supervision with implications for all professional groups

Intervention

Many implied actions follow from our formulation in Figure 1, including the vital role of preparing supervisees for supervision (e.g., being aware of due process). Falender and Shafranske (2012) provided a rare resource aimed at

inducting supervisees into their role. Additional actions include the provision of supervision standards and guidelines by training programs, audits of supervision by clinical service providers, and the replacement of peer supervision with supervision by a properly qualified practitioner. For space reasons, here we only focus on the training of supervisors in order to address the identified boundary violations, alliance ruptures, and unethical conduct. There are very likely also basic supervision competence issues to be addressed as well. One of the sad and disturbing truths that emerges from these narratives is that supervisors are also often unprepared for their roles, and not surprisingly fail even the most basic tests of competence. For instance, the ability to reflect on one's behavior, experience, and cultural assumptions is a fundamental competency for supervisors, reflected in multiple frameworks (APA, 2015; Falender et al., 2004; Milne & Reiser, in press; Roth & Pilling, 2008). Students rightfully expect competence in their supervisors:

> We assume that our supervisors are going to be competent, professional, and supportive (in a similar way that our clients most likely assume their therapists will be) yet the reality is that this is not always the case. (Narrative 3; Ellis, 2017, p. 43)
>
> At the core, he was an incompetent clinical supervisor although, admittedly, I did not realize this at first. He lacked knowledge regarding best practices associated with clinical supervision, maintained unclear clinical and supervisory approaches, and did not maintain an interest in my professional development as his supervisee. (Narrative 9; Ellis, 2017, p. 70)

As a further example of additional problems arising within the system, supervisor training and orientation still appear to be relatively neglected (Watkins & Wang, 2014), although it is pleasing to note that some professions (e.g., counseling in the United States and clinical psychology in Australia) do now require supervisor training. There is also growing evidence available to structure effective supervisor training (Milne et al., 2011b), and, at least as far as CBT supervisors are concerned, there is a training manual, with guidelines, instruments, and demonstrations of competent practice (Milne & Reiser, in press). For psychologists in general, there are additional guidelines available (APA, 2015).

Evaluation

The role of ongoing evaluation of supervision appears to have been relatively neglected within these narrative reports. Consistent with utilizing clinical outcome monitoring for providing critical guidance for therapists, we believe that training should be followed by ongoing evaluation and regular feedback to the supervisor. Any intervention will need to be evaluated in a systemic, ongoing way to test its effectiveness. This should be as valid as possible, as in

the example of rating tapes of supervision in terms of the supervisor's competence (Milne et al., 2012). As already mentioned, in order to provide a more reliable, objective measure of supervision, we have designed an instrument, SAGE, to profile, evaluate, and enhance supervisor and supervisee competence. These aims are achieved by providing very specific feedback about the observed key behaviors, processes, and mini-outcomes within supervision (Milne et al., 2011a). SAGE is closely linked to the Roth and Pilling (2008) supervision competency framework, as well as being closely aligned with Kolb's (1984) experiential learning model. In these ways, SAGE can be used both as a training tool (and this is the single most highly recommended use), as a part of initial and ongoing training, and additionally may be considered as a way of auditing services that provide supervision (e.g., identifying strengths or deficiencies; indicating improvements).

But if tapes and coding instruments are not an option, then at a minimum there should be formal written feedback from the supervisee to the supervisor, at least partly tied to the expected standards of supervision (thus empowering the supervisees and enhancing the relevance of feedback). Because of the power imbalance, at least the key feedback from supervisees should be encouraged by trainers or service managers, and then it should be made as confidential as possible (e.g., feedback from multiple supervisees can be provided as average or general information, used as part of an audit cycle). Practical examples from a clinical psychology program are presented in Milne (2008). As this feedback point indicates, in addressing problems it is vital to ensure that a systemic approach is adopted, with all parties given a full opportunity to discharge their responsibilities and contribute to improvements.

Words of encouragement to supervisees who have been harmed in supervision

We firstly wish to applaud the competent ways in which the supervisees have coped with distressing situations, and commend their coping strategies to other supervisees. Many of these narratives revealed the professionalism of the authors, including using reflection to reappraise painful thoughts and feelings, altering painful negative self-appraisals, attempting to formulate what happened, utilizing social support, and also taking reparative actions in their own work as supervisors:

> As a result of my harmful supervision experience, I took my work consulting with practicum students very seriously because I was acutely aware of the potential of harm of my words and actions. (Narrative 5; Ellis, 2017, p. 53)
>
> Despite the pain I had during my internship, I have found ways to grow. Professionally, I have a newfound respect for those people who experience oppression each day, approach those I supervise with a deeper level of care, and regularly

> check in with them about the experience I am providing to them. I also provide students with other paths to provide me feedback. For example, if they feel more comfortable giving feedback about me to my supervisor or a different person in the organization I allow that. (Narrative 2; Ellis, 2017, p. 34)
>
> My observations of this person have made me more intentional in my own work as a supervisor. I now understand the incredible importance of maintaining boundaries within a supervisory relationship as not to burden the supervisee. I also understand how critical a supervisory contract is in protecting all parties involved in the supervisory relationship. I also understand the importance of adhering to a particular supervisory model, as this serves as a guidepost for the entire supervisory process. (Narrative 9; Ellis, 2017, p. 75)

Finally, we were saddened by what appears to have been very limited administrative support, such as the seeming absence of mentoring systems, internship advisors, faculty advisors, or ombudspersons. Consequently, these trainees were largely left to seek social support and validation from their coworkers, peers, friends, and family: "I reflect and see my strength in reaching out to others for support, in acting professionally when inside I felt like I was crumbling" (Narrative 3; Ellis, 2017, p. 43); "I had sought the help of a supportive therapist, as an outside supervisor, someone who knew me and my work. It was a place to be heard, to sort out the craziness, to strategize about getting through the supervision" (Narrative 10; Ellis, 2017, p. 80).

Conclusion

As is the case with other instances of trauma, the consequent isolation, self-doubt, shame, and guilt associated with unethical and harmful supervision can produce a vicious cycle that makes it difficult to gain perspective. In this scenario, as elsewhere, the supervisee is entitled to expect support and guidance from senior colleagues. We believe that our contribution has offered an independent perspective, founded on years of relevant experience in ensuring that unethical supervision is addressed through the proper due process. Through following the CBT approach, our contribution has also been relatively distinct, leading to a formulation that we believe highlights how all parties may have a role to play. We recognize that this represents a practical, problem-solving emphasis that supervisees may perceive as unsupportive. It is more to the point that our approach seeks to make an objective assessment that can be misunderstood as uncaring (just as a CBT therapist may be regarded by a client as cold and detached). But we are actually very supportive of their narratives as efforts to highlight supervisors' unacceptable professional conduct.

In this present case, we applaud the supervisees for their willingness to share these narratives, as they can serve to spur long-overdue changes in supervision and in the organizational systems that should support and guide supervisors. Within these narratives are powerful warnings as to the dangers of incompetent and harmful supervisors, testaments to the resilience of trainees who have come

forward to tell their story, and suggestions of faulty or negligent training systems. There must be so many more stories that remain untold, given Ellis and colleagues' (2013) analysis of the prevalence of harmful supervision. These narratives serve as a clarion call for properly orchestrated supervision systems, including support and guidance for supervisors, and the greater efforts to prevent harm to vulnerable supervisees (Milne & Reiser, 2016).

Note

1. The original formulation figure was developed in 2008 by a project team within The Group of Trainers in Clinical Psychology, a UK group, but was (to our knowledge) never published.

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