

Bridging the Science and Practice of Clinical Supervision: Some Discoveries, Some Misconceptions

MICHAEL V. ELLIS

University at Albany, Albany, NY

This article attempts to bridge the science and practice of clinical supervision by summarizing 28 years of research and supervisory experiences. Seven myths about clinical supervision are debunked by empirical data and discoveries: Supervision theory is accurate, supervisees are anxious, recording sessions is in appropriate, supervisors do not need to monitor supervisees' in-session behavior, supervision is about using the right theory or techniques, supervisors are well trained, and supervisors protect supervisees and clients from harm. Suggestions are offered to build a stronger bridge between supervision research and practice. Some dos and don'ts are identified from my experience as a supervision practitioner and researcher.

KEYWORDS *clinical supervision, counselor supervision, counselor training, therapist supervision, therapist training*

INTRODUCTION

An alternative title to this article is "the most important things I have learned in clinical supervision." My intent is to summarize 28 years of experience both as a clinical supervision practitioner and as a clinical supervision researcher. In short, my applied supervision and research experiences are inextricably linked. Bridging the science and practice of clinical supervision

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Address correspondence to Michael V. Ellis, PhD, ED 220, Department of Educational and Counseling Psychology, University at Albany, 1400 Washington Avenue, Albany, NY 12222. E-mail: mvellis@albany.edu

is natural and ongoing. To provide some background and context for this presentation, I am a scientist-practitioner. I have an active research program with expertise in research methodology, statistics, and psychometrics theory. Clinical supervision and training is the other area of expertise as a researcher, teacher, and practitioner. I have been engaged in clinical supervision and supervisor training since receiving two years of formal training as a clinical supervisor during my doctoral training and pre-doctoral internship. This training included two courses with practica and a full year of supervised training in clinical supervision. (I was one of the lucky ones.) The training I received placed a heavy emphasis on multicultural and diversity issues. I also maintain a private practice where I see clients from early adolescents through the elderly, representing a diverse array of ethno-cultural backgrounds with a wide variety of presenting issues. Although my practice is a general one, I have expertise working with eating disorders, trauma, and medically related disorders.

For an overview of my basic orientation and perspective as a scientist-practitioner, I refer you to a few articles and chapters, as there is limited space here (Ellis, 1991b; Ellis, D'Luso, & Ladany, 2008; Ellis & Ladany, 1997; Ellis & Robbins, 1993). In brief, my scientist-practitioner approach is grounded in humanistic philosophy that is heavily dependent on developmental, systems, and interpersonal process perspectives along with cognitive, behavioral, and Gestalt orientations.

The second thing that is important for you to know about me are the lenses through which I view virtually everything I do as a professional—the lenses of diversity and multiculturalism (e.g., Ellis et al., 2008; Ellis & Robbins, 1993). My doctoral training was heavily focused on diversity issues—the “isms”: racism, sexism, homophobia, fatism, ableism, and so forth. For me, it is not a question of being racist or not. We live in a culture and society permeated by the *-isms*. The question is, where are you on the continuum of racism or sexism, and what are you doing about it? Sue and colleagues (2007), which I believe is a landmark article, provided a beneficial resource for conceptualizing the *-isms* as microaggressions and macroaggressions. I have found their model an invaluable tool for training supervisors and counselors, as well as in my own practice.

Third, a doctoral supervisor that I was training two years ago gave me a gift. She observed that I create structures. That deeply resonated with me and coalesced how I see myself as a researcher, supervisor, and trainer-instructor. I had not quite put it together that way. When I entered the field of supervision, back in the early 1980s, supervision was wide open. More was unknown than was known about clinical supervision. Very few researchers were working in the field. It was just starting to come into its own—recognized as a specialty distinct from teaching, counseling, and consultation (e.g., Leddick & Bernard, 1980). The advantage of this as a researcher was that supervision was a wide-open field; there was a lot of virgin territory

to investigate. The disadvantage, however, was that supervision was wide-open territory; nobody has done it before and you are at the cutting-edge in nearly everything you do. Where there is chaos and ambiguity, I create structure. I create ways to think about something in addition to concrete, down-to-earth, hands-on, pragmatic interventions and skills. That is something that I have been doing for close to 30 years.

As a place to start, a way of creating some structure in this article is to ensure that we are using the same terms. Of the available definitions of supervision, the one that I like the best is Bernard and Goodyear's (2009, p. 7):

Clinical supervision is an intervention that is provided by a senior member of a profession to a junior member or members of that same profession. This relationship is evaluative and hierarchical, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the junior member(s), monitoring the quality of professional services offered to the clients she, he, or they see(s), and serving as a gatekeeper for . . . the particular profession.

There are a couple of things that I agree and disagree with in this definition. Bernard and Goodyear (2009) talk about clinical supervision as "an intervention that is provided by a senior member of a profession to junior members of that same profession" (p. 7). The situation does not necessarily have to be between junior and senior people. Second, I do not believe that supervisors have to be from the same profession. In fact, some of the most important supervision that I received came from individuals outside of my profession; one was a stellar social worker and the other was a physician. Notice I did not say "psychiatrist"; he was a bariatric-internal medicine physician that I worked with in my private practice and we did peer supervision. He helped me with the medical aspects and I helped him with the relationship and mental health aspects of patients.

The Bernard and Goodyear (2009) definition provides structure (i.e., theory). For example, the last sentence of the definition provides structure in terms of what to do and helps us think about what it is that we are doing as supervisors. We serve as quality control agents. We ensure that supervisees are not harming clients and that clients receive adequate care, as well as that the counselors acquire and maintain sufficient clinical skills and develop professionally. In addition, for counselors who have problems, we are responsible to ensure that a remediation plan is enacted (Watkins, 1997). If they cannot remediate, then it is our job to say that perhaps they need to leave the profession (i.e., serve as a gatekeeper to the profession).

One of the keys to becoming an effective supervisor is learning to think like a supervisor (Borders, 1992). An important distinction, both in my practical work of training supervisors as well as my research work, is making the

shift from thinking about and seeing my supervisees and clients through the eyes of therapist to seeing through the supervisor's eyes of dual responsibility. We are responsible not just for the client's welfare, but also for the supervisee's professional development and welfare. That dual responsibility can be tricky for supervisors.

As we think about bridging the science and practice of supervision, take a moment and literally create an image of what you envision that bridge looking like right now. Imagine that bridge. Does your bridge look like a dilapidated, ancient cable bridge across a deep crevasse with a raging river below?—the type one might encounter while hiking through the Andes mountains, built a century or more ago, now with half of the planks missing and frayed, rusted cables? The kind of bridge that elicits pure terror? Let us use that image.

There are two cables coming from the practitioners' side going over to the scientist side. There are no boards on either side of the bridge for several yards out. So imagine that a practitioner wanted to journey over to the science side and find out what is going on in the science of supervision. The practitioner is over here straddling this side of the cable bridge. There are no handrails and she struggles to get out to the first plank. As she is about to get to the first plank and solid footing, a scientist on the other side takes a leap onto the bridge. The scientist's leap sends a shockwave down the bridge and the practitioner goes flying into the air. The irony is that when that practitioner is launched from the bridge, she is going to send a shockwave back to the other side, propelling the scientist into the air. Both end up in the drink and we end up with a bridge to nowhere.

Now envision a new, ultra-modern, double-deck, suspension bridge such as the Sunshine Skyway Bridge across Tampa Bay, Florida. This bridge welcomes if not invites safe, two-way traffic. Applying this metaphor, such a bridge facilitates open dialogue, communication, and is easily traveled between the science and practice of clinical supervision. The question is, how do we build a bridge such as this one?

MYTHS ABOUT CLINICAL SUPERVISION

I propose that theory (theorizing) is a way to bridge the science and practice of supervision. I am not referring to a major theory as in Freud's theory of personality. I am talking about theorizing—how we think about what we do as clinical supervisors, that which guides our practice. Theorizing guides the interventions, techniques, and strategies we choose in supervision, and guides what information we attend to and what information we ignore. If you are a supervisor practitioner, you are using theory, albeit perhaps an implicit one. One might wonder: How scientifically sound is the theorizing you use to guide your supervisory work? To answer this, let us examine some

discoveries and some misconceptions or myths about clinical supervision that I have encountered thus far as a practitioner-researcher in clinical supervision.

Myth: Theories Accurately Capture Clinical Supervision

The first myth that I encountered early in my career was that we have good theories of clinical supervision—our theories capture well what happens in supervision. The evidence suggests that our theories are partially accurate. I draw that conclusion from my investigations that tested several supervision theories including Bernard's (1979) Discrimination Model, Littrell, Lee-Borden, and Lorenz's (1979) Developmental Framework Model, Sansbury's (1982) modification of the Integrated Developmental Model (Loganbill, Hardy, & Delworth, 1982; Stoltenberg, McNeill, & Delworth, 1997), Bordin's (1983) theory of the supervisee working alliance, and Liddle's (1986) model of supervisee anxiety, to name a few. An in-depth presentation of each theory and how we tested them is beyond the scope of this manuscript. Only a brief description is provided here.

BERNARD'S (1979) DISCRIMINATION MODEL AND LITRELL ET AL.'S (1979) DEVELOPMENTAL MODEL

Beginning with Bernard's (1979) Discrimination Model, Janine tried to create a descriptive model for what was going on in supervision to help her when she was training supervisees. She suggested that supervision consisted of two dimensions: a dimension of supervisor roles (teacher, counselor, consultant), and a dimension of supervisor functions (process, conceptualization, and personalization). Process refers to the supervisee's behaviors or interventions used in supervision. Conceptualization taps how the supervisee thinks about clients as well as supervision. Personalization refers to the emotional aspect: biases, stereotypes, and emotional reactions to a client or supervisor. The combination of the two dimensions (roles and functions) creates a three-by-three matrix; an example of one cell (combination) is a teaching role with an intervention (process)—what the supervisee was doing in-session.

Littrell and colleagues' (1979) model applied a developmental framework to the role model approach to supervision (teacher, counselor, and consultant). That is, they suggested that clinical supervision should be tailored to the developmental level of the counselor supervisee. As counselors progress through the four stages of development, supervisors first need to establish a relationship with the supervisee, moving to a teacher/counselor role, then to a consultant role, with the last stage being self-supervision. The single underlying continuum is one of professional development. More specifically, the continuum pertains to who controls or structures what happens in the supervision session—going from the supervisor in charge,

initiating the relationship, to self-supervision where the supervisee is totally in control. There is a five-stage version of this model where the teacher and counselor roles are conceptualized as separate roles and stages—teacher role preceding the counselor role on the developmental continuum.

In a series of three studies (Ellis & Dell, 1986; Ellis, Dell, & Good, 1988), we tested the dimensionality (one or two dimensions) and structure of Bernard's (1979) and Littrell and colleagues' (1979) models; two previously untested models of clinical supervision. Specifically, we investigated how supervisors and supervisees think and make judgments about the role-function combinations. We found that neither model was reasonably accurate or complete. The models partially capture either supervisors' or supervisees' perceptions about clinical supervision roles and functions. Both models were simplistic. Rather than a two-dimensional model or a one-dimensional model, a three-dimensional model existed. Both models minimally attend to the supervisor relationship or to diversity issues. Littrell and colleagues (1979) acknowledge the need to establish the supervisory relationship; however, their four-sentence section provides little depth, and only indicates that the supervisor should initiate establishing the relationship.

Recently, a replication of Ellis and Dell's (1986) research was undertaken within a school counselor supervision context (Luke, Ellis, & Bernard, 2010). The results only partially replicated Ellis and Dell's findings for mental health supervisors. The results suggested that school counselor supervisors' perceptions of Bernard's (1979) role-functions differed from those of mental health counselor supervisors. Thus, Bernard's model may be in some measure appropriate for school counseling clinical supervision (see Luke & Bernard, 2006). Further investigation is warranted.

The limitations of Bernard's (1979) model notwithstanding, I have found it to be an excellent heuristic to teach supervisees how to take advantage of supervision. It provides a structure and a language for supervisees and supervisors to begin working together and building a solid working relationship. I have found it useful for novice supervisees, especially if they are working with novice supervisors.

THE INTEGRATED DEVELOPMENTAL MODEL (IDM) AND SANSBURY'S (1982) SKILLS PERSPECTIVE OF THE IDM

The second theory that I tested was a component of the Integrative Developmental Model (IDM) of supervision (Loganbill et al., 1982; Stoltenberg & McNeil, 2009; Stoltenberg et al., 1997) and Sansbury's (1982) modification of the IDM. According to the IDM, eight supervisory issues recur through each of the four stages of supervision. Sansbury (1982) proposed a developmental framework for the eight recurring issues as the counselor matures from neophyte to expert. Per Sansbury, the eight supervisory issues play out over the development of the supervisee in the following

order: Competence, Purpose and Direction, Identity, Emotional Awareness, Individual Differences, Autonomy, Professional Ethics, and Motivation. Rabinowitz, Heppner, and Roehlke (1986) found two additional issues not included in the IDM: Relationship Issues and Personal Issues.

Using a critical incidents methodology, I tested the two competing models of supervisory issues (IDM versus Sansbury) in both supervisor supervision and in clinical supervision (Ellis, 1991a). After each session of individual clinical supervision, and each session of group supervisor supervision, supervisees identified the critical incident(s) that occurred in that session. These were novice supervisors working with novice supervisees. It took three years to collect sufficient data to complete the study. Relationship issues were the most frequent critical issue identified in either supervision. In fact, the Relationship was identified greater than two times more frequently than its nearest competitor, which was Confidence. Ranked by frequency of occurrence, the issues were Relationship, Competence, Emotional Awareness, Purpose and Direction, Autonomy, Personal Issues, Individual Differences, Professional Ethics, Motivation, and Identity. Some of the latter issues (Autonomy through Identity) were rarely if ever observed, some occurring once or twice throughout the three years of the study. Other findings of interest pertained to parallel processes in terms of the issues that appeared in clinical supervision that would also appear in the supervisor's supervision. In short, we have evidence that our supervision models are not accurately depicting what is happening in supervision. The models also neglect paying attention to the relationship component of the supervisory process. At least nominally, individual differences issues may include multicultural and diversity issues.

Myth: Supervisees are Anxious—Monitoring/Recording Sessions Overwhelms Counselors and Clients and is Counter-Therapeutic

The next myth is common and still persists today: Supervisees are highly anxious. This myth permeates our theories. Some supervision theories portray supervisees as so anxious that it is detrimental to them and hinders their performance in sessions (e.g., Liddle, 1986; Loganbill et al., 1982; Stoltenberg et al., 1997). The corollary that goes with this myth is that monitoring and recording therapy sessions is debilitating to the supervisee therapist, as well as to the client. We encounter this myth in our internship and practicum placements where the site supervisors refuse to record client sessions. Even in terms of the Health Insurance Portability and Accountability Act (HIPPA), knowing that the recording does not leave the site/agency, site supervisors refuse to record or monitor sessions because they believe it is going to be too damaging to therapists, to clients, and the therapeutic process.

The research we have done suggests otherwise. Most supervisees are not overly anxious. Except for some clients diagnosed as paranoid schizophrenics

or those dealing with sexual orientation issues, recording is not an issue as long as they understand the purpose of the confidential recordings. If clients understand that the purpose of recording is to train the counselor and to improve the quality of treatment, they want it. The following summary is a compilation of 16 studies investigating supervisee anxiety in one way or another and conducted over approximately 20 years. I group this research into three sections: role induction for clinical supervision; the effects of monitoring and recording therapy sessions; and measuring supervisee anxiety (Liddle, 1986).

ROLE INDUCTION FOR CLINICAL SUPERVISION

First, we conducted two studies (Chapin & Ellis, 2002; Ellis, Chapin, Dennin, & Anderson-Hanley, 1996) to test the efficacy of a role induction procedure for therapists in individual clinical supervision. We used a replicated $N=1$ or single-subject design (see Ellis, 1999) because of the difficulty obtaining adequate sample sizes in supervision research (Ellis, Ladany, Krenzel, & Schult, 1996). The first study (Ellis, Chapin et al., 1996) randomly assigned four novice supervisees to a role induction or no treatment condition. The second study (Chapin & Ellis, 2002) randomly assigned four novice therapists and five pre-doctoral intern-level therapists to either a role induction or no-treatment condition. We tracked supervisee anxiety using multiple measures over the course of therapy with actual clients at an urban, fee-for-service training clinic. The two-hour role induction workshop educated supervisees about roles, expectations, goals, and processes of clinical supervision. The *supervisee bill of rights* as well as the *supervisee responsibilities* was developed for the workshop (available from the author). The role induction tended to reduce anxiety for novice supervisees. We did not, however, find high levels of anxiety. Nevertheless, a curious finding did emerge. Examining the Supervisory Working Alliance Inventory scores (Bahrck, 1990) from the supervisee-supervisor pairs in combination with the anxiety measures revealed a fairly consistent pattern: When there was a bad working relationship, anxiety was high; in a good working relationship, anxiety was low. In some ways, we probably learned more about the importance of the connection between the quality of the supervisory relationship and anxiety, than what we learned about role induction. The findings prompted us to begin thinking more about the supervisory relationship or working alliance.

MONITORING AND RECORDING THERAPY SESSIONS: *SELF-FOCUSED ATTENTION*

In short, the evidence from our research suggests that supervisees and therapists quickly adapt to recording or observation of their counseling sessions. Let me briefly summarize two studies (Ellis, Krenzel, & Beck, 2002) we did to test self-focused attention (SFA) or objective self-awareness theory (Carver & Scheier, 1982; Duval & Wicklund, 1972) applied to supervision. Space

limitations permit a brief presentation of the basic premise behind self-focused attention and objective self-awareness theory. In a self-focused attention state (also called objective self-awareness), a person is aware of and monitoring (paying attention to) oneself; the focus of attention is on oneself. Subjective self-awareness is where the focus is on somebody or something else; I am not an object of my own awareness (i.e., the client). SFA theory explained the ambiguous research findings in the literature. Some researchers found that taping therapy is incredibly anxiety producing and is detrimental both to the client and to the therapist, whereas others did not find any effects of taping sessions (see references cited in Ellis et al., 2002). We tested the effects of being videotaped and observed by a supervisor, seeing oneself in a mirror and audiotaping for self-review, and no observation or taping on counselor trainees' performance and anxiety.

We successfully manipulated the supervisee's self-awareness state. In one condition, the room was set up just like our training clinic; directly behind the client is a one-way mirror—therapists cannot escape from seeing a reflection of themselves as they are in-session with the client. Another condition manipulated a video camera mounted on the corner ceiling of the room. Before starting a session, the therapists watched as we focused and aimed the camera on them. Then, twice during the session, we moved the camera, which was clearly audible. The manipulations worked. They were keenly aware of the self-awareness manipulations (mirror, videotape, and audiotape) and were in a self-focused state, albeit briefly.

Audiotapes of all sessions were rated for speech disfluency and other measures of anxiety in addition to rating their empathic ability and connection with the client. We also used self-report measures of anxiety and performance. We found no deleterious effects of taping or monitoring on supervisees' performance or anxiety. In fact, even moderate levels of anxiety were not observed or reported. The counselors quickly adapted to self-focus manipulations and were swiftly able to focus on the client.

Some readers may be thinking that these "analog" studies do not have any connection to reality, to "real" therapy and supervision. We endeavored to ensure that the study was as realistic as possible. Every therapist supervisee believed that they were seeing a real client and would be seeing the client again. In fact, I had to come into a debriefing session with one counselor to assure him that the client was a confederate. Only after showing him the transcript of the angry client was he convinced that the client did not need to be referred for emergency care.

SELF-SUPERVISION

The second set of evidence regarding monitoring and recording therapy sessions came from two studies investigating self-supervision using a replicated N of 1 multiple baseline research design (see Ellis, 1999).

We sought to teach therapist supervisees how to self-supervise (Dennin & Ellis, 2003; Levitt, 2003; Levitt & Ellis, 2010). In my experience, the expectation is that supervisees are supposed to know magically how to review and learn from recorded counseling sessions. Were you taught how to review a recorded session? Few supervisees are. Nearly two decades ago, I created a framework to teach students the skills to review tapes, to provide feedback to others, and eventually to self-supervise. To the best of my knowledge, Morrissette (2001) is the only major resource on self-supervision. Two of my students set out to test if self-supervision worked for doctoral student counselors working with real clients at our training clinic. The therapists taped ongoing therapy sessions, and used self-supervision techniques to improve specific therapist skills (e.g., empathy, metaphor). The results suggested that through self-supervision techniques, therapists increased their level of empathy, and use of metaphor, interpretation, and therapeutic silence when it was appropriate. Self-supervision does work. It also was clear from the studies that for supervisees, being able to monitor and record their therapy sessions was not only helpful for them as a professional development tool, but also something they eagerly sought out.

MEASURING SUPERVISEE ANXIETY

The last set of studies we conducted because we kept trying to find supervisee anxiety but could not find it. We thought maybe the State-Trait Anxiety Inventory (Spielberger, 1977) might not capture anxiety in clinical supervision contexts. We set out to test Liddle's (1986) two-dimensional model of supervisee anxiety and to create a measure of supervisee anxiety. The first five studies we did over four years were attempts to develop a measure called the Supervisor Anxiety Scale (SAS) based on Liddle's model of performance anxiety and evaluation anxiety (Ellis, Dennin et al., 1993). The SAS did not work. Nor could we get it to work. We concluded that Liddle's model was untenable. Supervisee anxiety is not comprised of performance anxiety; it is not evaluation anxiety. Given the failure of Liddle's model, we sought a contemporary theory of anxiety.

David Barlow (2001), renown as an expert on anxiety, developed a new model of anxiety, which stated that all anxiety is anticipatory. Based on his theory, we adapted and reconceptualized the SAS to create and test the Anticipatory Supervisee Anxiety Scale (Ellis, Dennin et al., 1993; Ellis, Singh, Tosada, & Dennin, 2010; Singh, & Ellis, 2000; Tosada, 2004). For interested readers, the ASAS is available in Bernard and Goodyear (2009, pp. 331–332). The eight studies conducted to develop the SAS and ASAS found that supervisees were not anxious in general. Contrary to supervision theory (e.g., Liddle, 1986; Stoltenberg et al., 1997), neophyte supervisees did not report higher levels of anxiety than more experienced supervisees. About 15% of supervisees across all of these

studies reported or evidenced moderate or higher levels of supervisee anxiety. High levels of anxiety were relatively rare, even for the first supervision session following a videotaped role-played counseling session (pre-practicum).

We infer again that theories of supervision are not capturing well the phenomena that encompass clinical supervision. Alternatively, perhaps because the theories posit that anxiety is both pervasive and deleterious, we are just such wonderful supervisors that we have mitigated successfully these problems. Personally, I am not quite convinced of this conjecture. I suspect that it is not anxiety per se but rather something else. I am not sure exactly what "it" is; however, my educated guess is that it may be supervisee self-efficacy, competence, or a combination thereof.

Myth: Supervisors [or Supervisees] Do Not Need to Observe/ Monitor Supervisees' Sessions

The next myth is that, as supervisors, we get a sufficient understanding of what is happening with supervisees, that we do not need to monitor directly what goes on in their sessions. Perhaps we believe that monitoring in-session behaviors is irrelevant (i.e., "I have a good rapport with my supervisee; I know just what is happening with him or her and the client" or "I can trust the supervisee to portray accurately their sessions"). Unfortunately, the data suggest otherwise. In short, supervisees often miss or are unaware, misinterpret, or inaccurately recall that which transpires in the therapy session (Bernard & Goodyear, 2009). Consider for instance the well-documented actor-observer differences or other judgmental heuristics (e.g., Dumont, 1993; Ellis, Robbins, Schult, Ladany, & Banker, 1990)—recurring differences between supervisee self-report and observations made by the supervisor are to be expected. In addition, there exist a few studies (e.g., Reichelt & Skjerve, 2002) that found supervisees' perceptions (what they report, what they identify) do not reflect accurately that which transpires in a session. Parallel process (isomorphism; see Bernard & Goodyear, 2009), is another factor to consider. Parallel process occurs in supervision when supervisees are not aware that they are interpersonally engaging the supervisor in the same process that their clients engaged them in in therapy. Finally, it is unclear how supervisors can monitor potential racial microaggressions (Sue et al., 2007) without observing what takes place during sessions.

Supervisees can benefit from reviewing recordings of the session and from self-supervision, as previously discussed. From a more behavioral learning perspective, supervisees need to not only monitor their own in-session behaviors, but also receive detailed feedback from a supervisor to learn and refine the specific interventions and skills of being a practitioner. Taken in combination, these findings underscore the importance of monitoring in-session behaviors to increase the clinical skills of the supervisees (Dennin

& Ellis, 2003; Levitt & Ellis, 2010). That means supervisees need to record their sessions and both the supervisee and supervisor review those recordings. As a supervisor, we need to observe, monitor, or oversee and provide feedback on in-session behaviors and interactions.

Myth: Supervision is All about Using the Right Theory and Techniques

The notion that supervision is all about the right techniques and using the right theory is a myth. Good supervision is about the relationship, not the specific theory or techniques used in supervision (Deihl & Ellis, 2009a,b; Ellis & Ladany, 1997; Ellis, Russin, & Deihl, 2003; Fama & Ellis, 2005). Ironically, the majority of supervision models attend minimally to the supervisory relationship. Perhaps the most well-known of the theories of the supervisory relationship (e.g., Holloway, 1992, 1995; Rigazio-Digilio, Daniels, & Ivey, 1997) is Bordin's (1983) model of the supervisory working alliance, which consists of three dimensions: Agreements on Tasks, Agreements on Goals, and the Emotional Bond. Like most supervision theory, these theories remain largely untested. Aggregating data from five studies (Ellis et al., 2003), we tested the dimensionality of the Supervisory Working Alliance Inventory (SWAI; Bahrck, 1990; Horvath & Greenberg, 1989). The results indicated that when applied to the clinical supervision context, the working alliance is one-dimensional. We do not know, however, the construct that underlies that dimension. We believe that it is more about the emotional bond than agreements on task and agreements on goals. Using the three separate scales is not wise (i.e., use the total SWAI scores). Once again, another supervision theory was found at least partially inadequate and inaccurate.

Other research evidence suggests that

1. the supervisory relationship (or aspects or components thereof) is directly related to supervisee outcome such as therapist's skills (Ellis & Ladany, 1997);
2. the supervision process may be more complex than previously postulated (Ellis & Ladany, 1997);
3. the supervisory working alliance mediates burnout and enhances vigor as well as mediates the effects of vicarious traumatization (Deihl & Ellis, 2009b; Fama & Ellis, 2005); and
4. the supervisory alliance is a major predictor of satisfaction in both United States and South Korea supervision (Ladany, Ellis, & Friedlander, 1999; Son, Ellis, & Yoo, 2007, 2009).

Even though increasing attention has been given to multicultural and cross-cultural supervision, little cross-cultural supervision research has been done (e.g., Bernard & Goodyear, 2009). Recently, colleagues from

South Korea and I completed research comparing clinical supervision in South Korea with the United States (Son et al., 2007, 2009). We found more similarities than differences between supervision in the two cultures. Although supervision in a collectivist culture (South Korea) tends to be more hierarchical than in an individualistic culture (United States), the supervisory working alliance was centrally important in both cultures.

Conceptually, I have struggled with Bordin's model because it is circumscribed. From my experience, the supervisory relationship encompasses much more than agreements on tasks, agreements on goals, and an emotional bond. We are currently in the process of developing and testing a new theory and measure of the supervisory relationship. We theorized the supervisory relationship to be comprised of 10 facets, like a 10-faceted jewel. Whether the 10-faceted model and the new measure hold up to empirical testing waits to be seen.

Myth: Clinical Supervisors Are Doing a Good Job, Protecting Clients and Supervisees From Harm

My interest in harmful and inadequate clinical supervision came from supervisees knocking on my door in tears as well as supervisors-in-training talking about their best and worst supervisory experiences. Unfortunately, the evidence suggests that many supervisors are providing inadequate supervision, some of which is harming clients, and that far too many supervisors are harming their supervisees. These data are both astounding and disconcerting. Like other topics that we do not address in therapist training and supervision (e.g., Pope, Sonne, & Green, 2006; Pope, Sonne, & Holroyd, 2000), it is time we confronted the "dark side" of our profession. Before presenting the results (Ellis, Berger et al., 2010; Ellis, Siembor, Swords, Morere, & Blanco, 2008; Ellis, Swords, Blanco, Morere et al., 2009), I begin with definitions. Based on a series of studies, we revised the earlier framework for and definitions of inadequate (bad) and harmful clinical supervision (Ellis, 2001).

Reconceptualizing Ellis's (2001) framework, inadequate clinical supervision subsumes harmful clinical supervision. That is, all harmful supervision is by definition inadequate supervision. Both inadequate and harmful supervision are established using two criteria—self-identified and de facto. *Self-identified* inadequate or harmful supervision occurs when a supervisee declares that he or she has received such supervision (i.e., after reading the respective definition). *De facto* harmful or inadequate supervision is defined more objectively, and pertains to the supervisor's actions, inactions, and effects thereof (called supervisor behaviors henceforth). Thus, for de facto inadequate or harmful supervision, supervisees do not have to identify or label their supervision as inadequate or harmful; the supervisor's behaviors become the criteria

for establishing if the supervision he or she delivered was harmful or inadequate. Both inadequate and harmful supervision can occur in individual or group clinical supervision or supervisor supervision, and with one or more supervisors.

Inadequate clinical supervision occurs when the supervisor is unable or unwilling to enhance the professional functioning of the supervisee, monitor the quality of the professional services offered to the supervisee's clients, or serve as a gatekeeper to the profession (Bernard & Goodyear, 2009). That is, inadequate supervision is the supervisor's failure to adhere to the minimal standards of supervisory practice. Inadequate supervision can be self-identified or *de facto*. *De facto* inadequate supervision is defined as the supervisor's failure to provide the minimal level of supervisory care as established by his or her discipline or profession, or by law (Giddings, Cleveland, & Smith, 2007; Greer, 2002; Saccuzzo, 2002); or when the supervisor clearly violates accepted ethical standards (e.g., Dye & Borders, 1990; Ladany et al., 1999). Inadequate supervision has the potential to be harmful to supervisees and their clients. Usually, inadequate supervision refers to an ongoing supervisory situation or relationship; however, it may encompass one truly inadequate supervision session or incident.

We defined *harmful clinical supervision* as supervisory practices that result in psychological, emotional, and/or physical harm or trauma to the supervisee. The two essential components of harmful supervision are: (a) that the supervisee was genuinely harmed in some way by the supervisor's behaviors, or (b) the supervisor's behavior is known to cause harm, even though the supervisee may not identify the actions as harmful. Thus, harmful supervision may result from the supervisor acting inappropriately or with malice, or supervisor negligence. Harmful supervision behaviors may harm clients as well. Harmful supervision can consist of one or more incidents, or can be an ongoing supervisory situation.

Consistent with Ellis (2001), harmful supervision should be distinguished from those instances where a supervisee struggled with painful issues in supervision, or when a supervisor gave painful-to-hear, emotionally upsetting feedback about the supervisee's professional inadequacies that was necessary for the supervisee's professional growth. We are attempting to differentiate between the supervisor's behaviors that focused on the supervisee's professional growth and development—and respectful of the supervisee's boundaries—within the context of a positive supervisory relationship from those instances where the supervisee's best interests were not primary (Ellis, 2001). A potentially harmful impasse between the supervisee and supervisor that is successfully resolved in supervision would not be considered harmful supervision. (Ellis, Swords et al., in press, Table 3)

A sample of 363 supervisees from multiple disciplines participated in a study of inadequate and harmful clinical supervision (Ellis, Siembor et al., 2008; Ellis, Swords et al., 2010). On the positive side, roughly 65% of the

supervisees indicated that their supervisors were trained in supervision. That may or may not be true, but at least they thought that their supervisors were trained. The other good news is that when asked about exceptional supervision, having a “wow” experience in their current supervision, 57% of the supervisees said yes. Thus, more than half of the supervisors were providing outstanding supervision. Also positive, supervisors identified by their supervisees as trained in clinical supervision were providing significantly less inadequate clinical supervision than untrained supervisors were. Supervisor training did decrease the occurrence of harmful clinical supervision. Supervisor training matters somewhat.

After reading the harmful supervision definition and then asked, “have you been harmed in supervision?”, 12.4% of the supervisees indicated that their current supervision relationship was harmful. When asked if another supervisor had harmed them, 27.4% said yes. Thirty percent of the supervisees (30.3%) were currently receiving de facto harmful supervision. Considering de facto and self-identified together, a shocking 36% of this sample of supervisees were currently receiving harmful supervision. Even more disquieting, fully 51.5% of the supervisees received harmful in supervision at some point in their training.

In terms of inadequate supervision, 25% indicated that they were currently receiving inadequate supervision. Just under half (49%) reported that they had received inadequate supervision by another supervisor. Of the individuals who said that they were currently receiving inadequate supervision, one-third of them (32.7%) reported that the inadequate supervision was moderately to totally harmful to their clients. Let’s repeat that: One-third of the supervisees receiving inadequate clinical supervision said their clients were harmed. In terms of de facto inadequate supervision, 42.3% were experiencing inadequate supervision with their current supervisor. When combined with self-identified inadequate supervision, 49.7% of the supervisees were currently receiving inadequate clinical supervision. Fully three-quarters (75.2%) of the supervisees had experienced inadequate supervision at some point in their career.

I encourage you to reread these data and to consider their profound implications. I find these data keenly disconcerting and intolerable. No matter the discipline, the principle underlying all ethics consists of three words: do no harm. Yet, some supervisors are harming supervisees and harming clients. I hope that the data truly speak for themselves and serve as a wakeup call to the profession. The implications just in terms of legal liability are staggering—not to mention the toll on human suffering. One of the questions these data raise is, What are we going to do about this state of affairs (and when)?

We Need a Plan

Let us return to the two bridges between clinical supervision research and practice (the rickety and ultra-modern bridges). What is our status? I would

say it is a bridge under construction. How do we get to the modern, safe, and reliable bridge? What do we need to do? I suggest several possibilities.

One thing we have been doing well and need to continue are conferences, such as the International Interdisciplinary Conference on Clinical Supervision (IICCS), which seek to bridge the practice and science of clinical supervision. On the other hand, maybe we have been trying to build the wrong kind of bridges. Maybe we have not been encouraging and including dialogue among the supervisor practitioners, the management-business-administrator side of supervision, and the science-research side of supervision. Another possibility is probably more important: We need more resources devoted to clinical supervision, to both the research and practice of supervision; and to conferences such as the IICCS. Think about the number of people generating supervision research—there are not many of us, especially those engaged in long-term programmatic research. We also may need to be more politically and socially active, in terms of advocating for supervision. We may need to sell the importance and benefits of clinical supervision to constituents and authorities. Finally, we need to continue to build and stand on the broad shoulders of those who came before us and on the work they have done. To this end, here are some dos and don'ts from my experience as a researcher and practitioner of clinical supervision.

DON'TS OF CLINICAL SUPERVISION

In terms of the don'ts, do not neglect diversity issues and the "-isms." Unfortunately, diversity and multicultural issues are all too often overlooked. Diversity and the -isms are often viewed as background instead of foreground as supervisors work with supervisees and those supervisees' work with clients. Second, one of the major issues confronting novice supervisors in particular is coming to terms with the evaluative-gatekeeper role and attendant issues of legitimate authority, responsibility, and power (Ellis & Douce, 1994; Ellis & Robbins, 1993). Do not avoid confronting fears and anxieties about being a man or woman in a position of authority, power, and privilege—what this means, and the discomfort and anxiety these issues elicit (e.g., confront through self-reflection and through dialogue with a supervisor). My own experience has been that those people who are least aware of their true power bases are the ones who are most likely to abuse their power.

In group supervision, do not neglect basic group therapy theory, group process and dynamics, group development, and therapeutic factors (e.g., Yalom & Leszcz, 2005). For example, group cohesion and safety are essential for effective supervision outcomes. One trap of group supervision for supervisors is to remain in the expert-leader role as the group develops, which is essentially individual supervision in a group format. Let go of control; let the group members work and interact among themselves. You will be amazed at

how much they know and how much work they can do with minimal guidance from the supervisor.

Do not provide inadequate or harmful clinical supervision. Equally important, do not let somebody else continue to provide inadequate supervision or to harm their supervisees.

DOS OF CLINICAL SUPERVISION

Do work to establish and maintain a solid working supervisory relationship. Do use basic communication skills and active listening. Do provide empathy and support. Do strive to empower the supervisee. Do actively foster the professional development of the supervisees. Do respect and maintain interpersonal boundaries.

Do use an informed consent and contract for clinical supervision. The legal standard of care in clinical supervision is to use an informed consent and contract (Bernard & Goodyear, 2009). The data suggested that less than 19% of supervisors used an informed consent and only 41% used a supervision contract (Ellis, Swords et al., 2010). We need to do both. The supervision informed consent and contract set the stage for creating the positive atmosphere and strong working relationship desired in supervision.

Do monitor-observe in-session behaviors and give feedback to the supervisee. Do attend systematically to the -isms and other forms of microaggressions (Sue et al., 2007) at all levels (therapy, clinical supervision, and supervisor supervision). Do focus on supervisee competencies versus impairment (Ellis, D'Luso et al., 2008; Falender & Shafronske, 2004). Do focus on supervisees attaining minimal-level competencies. Do document what transpires in supervision, problems encountered and resolved, intervention and skill competencies and deficiencies, and so forth. From a legal point of view, you have done nothing if you cannot prove that you have done it via documentation. Hence, if a supervisee is having problems, and/or is not responsive to supervision, talk to him or her and document it. Do ensure that a letter or memo goes to the supervisee and to their file: Document the problem and the remediation plan.

Do what you know is right (e.g., gate-keeping, evaluation). In my experience, doing the right thing is almost always doing the hard thing. This includes confronting a colleague who is providing inadequate clinical supervision or who has harmed supervisees. Do seek out supervision and consultation. We do not have to do supervision in isolation.

Do work to bridge the science and practice of clinical supervision. Do read the clinical supervision literature (e.g., Bernard & Goodyear, 2009; Falender & Shafronske, 2004). Do learn and use supervisory skills (e.g., Ellis, 1988; Ellis & Deihl, 2005). Do participate in research. Take the time to complete questionnaires and research materials. For researchers to help supervisor practitioners, practitioners need to help researchers.

Researchers: Do consult with and seek input from supervisor practitioners when conceptualizing and designing research projects.

Two of the most important lessons that I have learned in the past 28 years are trust and having the courage to do the right thing. For me it keeps coming back to trusting myself, trusting the supervisee, trusting the process of therapy, and trusting the process of supervision. Most important of all of these, however, is trusting myself. Going with what I know at a gut level is right at that time. And, taking the risk to act on what is right, and maybe the harder, more difficult and uncomfortable path. These are two of the toughest things to train supervisors to do, especially when they are new.

Finally, I have learned the importance of humility and maintaining perspective. As I am often fond of saying, I know just enough about clinical supervision to be extremely dangerous. I am keenly aware of the little I do know and the enormous amount that I do not know. My hope is that the information shared herein may stimulate you to think more deeply or clearly about clinical supervision, or perhaps spark new ideas about bridging the science and practice of clinical supervision.

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