An exploration of trainee high-intensity therapist's views of self-disclosure in clinical supervision using q-methodology and semi-structured interviews.

Joseph Kreft

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Declaration

This work is original and has not been submitted in relation to any other degree or qualification

Name: Joseph Kreft

Signature: 

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Abstract

Self-disclosure is an important component of clinical supervision within psychotherapy, however despite research into different disciplines little is known about its function within cognitive behavioural therapy. Fifteen trainee high-intensity CBT therapist's views on acceptability, experiences, and barriers were explored using both Q-methodology and semi-structured interviews, analysed using inductive Thematic Analysis. Within the Q-method data, one consensus factor was extracted with a second specificity factor also identified. These two factors were highly intercorrelated and indicated current, continued moral and ethical importance of self-disclosure and the role it has on individual professional practice, personal wellbeing and the supervisory relationship. An inductive thematic analysis of interview data was used to examine and identify common themes associated within the participants. Four key themes were identified from the analysis these where named; *Function & purpose of clinical supervision, experiences of self-disclosure, supervisee self-disclosure and supervisor self-disclosure*. Results provided suggestions to encourage and promote the use of self-disclosure in education and primary care settings.

Introduction

Clinical Supervision: Setting the Scene

Clinical Supervision is considered to be a core professional competency within mental health practice (Milne, Sheikh, Pattison & Wilkinson, 2011) and is also identified as a standardised proficiency with practitioner psychologists (Heath & Care Professions Council, 2015) and a key conduct, performance and ethical requirement for Cognitive Behavioural Therapists (British Association for Behavioural & Cognitive Psychotherapies, 2017). Despite its significance within therapeutic practice its definition has been deliberated across psychotherapy research for many years (Bernard & Goodyear, 2014; Roth & Pilling, 2007) due to its content and application differing widely across professional grouping, therapeutic approach and clinical context. It can be most appropriately be defined as "The formal provision, by approved supervisors, of a relationship-based education and training that is work-focused and which manages, supports, develops and evaluates the work of colleagues" (Milne, 2007 p. 439).

Clinical supervision in the context of Cognitive Behavioural Therapy (CBT), involves regular confidential meetings between a therapist (trainee or qualified) and a typically more advanced or experienced colleague to review client cases, discuss concerns, develop competence, personal difficulties and wellbeing but also other factors that could affect the therapist's ability to perform their professional role and responsibilities. The format can also vary between individual and group based meetings. In 2006, Pretorius noted that CBT and its supervision share the same characteristics in that they are based on mutual trust, openness, practice, experience, enable change, consolidate and develop individuals' strengths, build conceptualisation skills, allow application of new skills in therapy, empower people to change and actively elicit and enable individuals to respond to feedback.

Current empirical research on clinical supervision has identified that it serves a number of important functions including improving client outcomes in therapy (Bambling, King, Raue, Schwetzer, & Lambert, 2006), improving therapist wellbeing and development (Falender & Shafranske, 2014). Research has recognised the function that supervision serves both to the client, supervisee, supervisor and organisation it sits within Inskipp and Proctor (1993) For example, identified three functions of clinical supervision; normative; in which supervision provides quality assurance encompassing moral, ethical and professional considerations, formative, referring to skills development, knowledge and other core competence of the supervisee; and restorative, encouraging emotional processing and supporting the supervisee's wellbeing.

The role of the supervisory relationship has also been highlighted as particularly important for trainee therapist's experience and a main influence on their individual practice (Wilson, Davies and Weatherhead, 2016; Ramos-Sanchez et al 2002).

However, despite the importance of supervision the current evidence base has demonstrated inconsistencies in the application across different professional disciplines. A possible explanation for this could be related recent body of evidence identifying inadequate support and guidance being given to supervisors. Riser and Milne (2016) completed a survey of 110 BABCP accredited clinical supervisors to establish the current level of practice of CBT clinical supervision in the United Kingdom. The results showed supervisors had a general level of satisfaction with their role, but indicated a need for further development of resources and competence instruments to provide guidance and support.

Within the UK a small but significant body of research has attempted to address this these inconsistencies, by presenting a case for an evidenced based approach to clinical supervision in order to increase its consistency and quality. Milne and Riser (2016) argue that

the clinical supervision of CBT is a professional specialism that is that remains neglected despite its relative importance to clinical practice. They also stress the need for organisational systems to support, guide and develop clinical supervisors and constructed an evidenced based supervisor support model integrating Kolb (1984) experiential learning cycle and the previous work of Inskipp and Proctor (1998) they present an interesting case for a multilevel evidenced- based approach in combining supervision training methods and existing competencies frameworks (Falender et al, 2004; Roth & Pilling, 2007: Olds & Hawkins, 2014) in a modern healthcare setting which reflects similar models already present in other professional specialisms and organisations such as the National Health Service (NHS).

Self-Disclosure in Therapy

Self-disclosure (SD) as a therapeutic concept has long been surrounded in theoretical debate across psychotherapy research, informally and in the context of therapy it can be thought of as a therapist telling a client something about themselves or their experience which can be related to the therapeutic interaction or personally relevant to the problem area. This debate has viewed SD as a controversial practice especially from psychodynamic approach in that therapists should be present as a ‘blank screen’ to support and not inhibit a client’s transference reaction. The humanistic person-centred approach on the opposite advocates therapists to attune and empathise with their client’s experiences by using their own experience to help reflect with them (Farber et al, 1996) SD in CBT research has also sparked debate around its acceptability and appropriateness. In 2003, Goldfried, Burckell and Eubanks-Carter, take the stance that in CBT the emphasis of treatment is on inter-session change and, that anything that enhances such change can be integrated into the therapeutic interaction. Therefore, the therapist by proxy becomes a model for non-problematic behaviours they report that through sharing similar experience, challenges and successes can

influence positive behaviour change in the client. With this SD can also serve many purposes including; providing feedback on the interpersonal impact made by the client on the therapist, enhancing positive expectations and motivation, strengthening the therapeutic bond, normalising the client's reaction, reducing the client's fears and modelling an effective way of functioning. Ambiguity in the research has also been characterised by a lack of agreement in terms between researchers Henretty and Levitt (2009) for example identified many problems with the definition of SD in a review of the research. They found multiple authors definitions involved breaking it down into specific disclosure categories such as high and low intimacy (Carter & Motta, 1998) and positive and negative information (Hoffman-Graff, 1977). Despite this they discovered a general agreement across authors as SD being as of the external (e.g., relationship dynamics, emotional response to client) and of the internal e.g., sharing personal experience (Farber, 2006; Knox et al,1997; McCarthy,1979).

For the purposes of this review, the definition of SD will be distanced from the general understanding presented above into the specific context of clinical supervision. Therefore, Self-disclosure will be defined as the process of sharing information about the self with another that they would be unlikely to know otherwise (Spence, Fox, Golding & Diaches, 2014).

Supervisee Self-Disclosure

We being by defining supervisee SD according to Spence et al. (2014) as:*"...Supervisees revealing information to their supervisors about their past/present experiences and/or their mental processes. This can be related to their clinical practice or can be entirely personal in nature" (p.188).* Examples of supervisee SD can be if a therapist told a supervisor that a client made them feel hopeless, or angry, or sad, or if a therapist told a supervisor that the issues that a client had discussed resonated personally with them because

they had a similar experience. Also, a supervisee telling a supervisor that they felt overworked, or overwhelmed etc.

Although available literature on the use of supervisee SD in therapeutic professions has provided useful insights into the reason for and against its use. It has primarily focused on what tends not be disclosed thus far. Hess et al. (2008) for example investigated fourteen pre-doctoral counselling psychology interns use of 'wilful withholding' in supervision. From this they combined interview data and self-report measures and identified that intern's disclosure would be affected but not mediated by the quality and satisfaction they had in the supervisory relationship. Concerns about evaluation, negative feelings, power dynamics in the relationship, inhibiting cultural or demographic variables and the supervisor's theoretical orientation where all cited as reasons for why they did not disclose to supervisors. Another study, Mehr, Ladany & Caskie (2010) investigated 204 trainee' psychotherapists nondisclosures in a single supervision session using qualitative and quantitative self-report questionnaires, following analysis of the data they discovered that 84.3% of them withheld information from their supervisors and also tending not to disclosure around issues directly related to the supervisory relationship when compared with clinical issues (making mistakes etc). Also, that trainee's worried about supervisor's perceptions of them in both professional and personal contexts. Other studies have used similar methodological approaches included Ladany, Hill, Corbett & Nutt 1996 ;Yourman, 2003; Yourman & Farber, 1996; Webb & Wheeler, 1998) and contributed to the understanding of the reasons and overall experience of nondisclosure in the supervisory relationship (Knox, 2015). However, the research shows an absence of understanding in the experience of the what, where, why and how of trainee's use self-disclosure in clinical supervision.

More recent research has attempted to look at the factors that influence the likelihood of supervisee SD occurring, for example, Gunn and Pistole (2012) identified that clinical/counselling trainee's disclosure would increase by facilitating attachment security with the supervisor and Kreider (2014) who found that supervisors have a prime role in the encouragement of supervisee's SD and discovered that the perception of comfort and authenticity with the supervisor rather than his or her training role positively influences the likelihood of SD occurring. Also, Spence et al. (2014) explored how qualified clinical psychologists used voluntary SD in clinical supervision and provided useful insight into how supervisees conceptualise of the process of SD within supervision. As they considered it to be a valid intervention if it related to their ability to perform their professional duties. In the study a constructivist grounded theory method was used to explore and understand this processes and also found that the quality of the supervisory relationship was directly associated with the level of supervisee disclosure, in that the better the relationship, the more likely it would be to occur. Limitations of the study however only highlighted clinical psychologist perspective on the process with no rigorous analysis of individual practitioner's viewpoints of it.

Supervisor Self-Disclosure

Supervisor SD can best be defined by Ladney and Walker (2003) as an intervention based upon personal statements made by a supervisor existing in five different categories; the firs *Personal materials* refers to disclosures related to a supervisor's personal life that are indirectly linked to what a trainee brings to supervision. The second; *Therapy experiences* are when the supervisor shares information regarding their own therapeutic work to provide a model to guide a trainee in their own practice. The third category; *Professional Experiences* refers to supervisor disclosing accounts of non-therapy events (e.g. administration /

organisational tasks etc). The fourth category; *Reactions to the Trainee's clients* involves the supervisor self-disclosing their own impressions or preferred approach to working with a trainee's client. The final category; *Supervision Experiences* pertains to self-disclosures around the role and experience associated with being a supervisor. From this general working definition, a model was then presented to determine the effectiveness of using supervisor SD. It found that it has a positive and significant impact on supervision outcome, especially related to meaningful supervisory alliances, improved trainee self-disclosure and trainee edification. This mirrors a similar point proposed by Farber (2006) who suggested that along with the need for supervisee self-disclosure, disclosure on the part of the supervisor is a crucial component of clinical supervision

Existing research on supervisor SD has primarily focused on categorising self-disclosure and its outcome on trainee development. From this a quantitative survey methodological approach has been favoured (e.g. Ladany, Hill, Corbett, & Nutt, 1996; Ladany & Melincoff, 1999; Ladany & Walker, 2003; Ladany, Walker, & Melincoff, 2001; Lehrman-Waterman, 1999; Norcross & Halgin, 1997; Walsh, Gillespie, Greer, & Eanes, 2003; Worthen & McNeill, 1996 & Yourman, 2003) taking this approach has come with its own limitations, primarily in the rigidity associated with using surveys as a data collection tool and the potential validity concerns of responses to standardised questions.

Recent studies into the importance of supervisor SD have adopted a consensual qualitative approach in order provide further exploration and insight into its impact and effectiveness on trainees. Knox et al. (2011) concluded that supervisor SD was positively experienced by trainee's and resulted from a good supervisory relationship; responsiveness to supervisees' needs or concerns; and appropriate with clear intentions or purpose. Kozlowski et al. (2014) explored the benefits of Positive Boundary Crossing such as using SD by supervisors in clinical supervision and found it had a positive effect on trainees by

strengthening the supervision relationship and enhanced their perception of training. Other studies demonstrated similar findings (Davidson, 2011; Knox, Burkhard, Edwards, Smith, & Schlosser, 2008, Knox, Edwards, Hill, & Hess, 2011; Reichelt, 2009) which could be interpreted as positive modelling according to Social learning theory (Bandura, 1970).

Self-Disclosure in Supervision

Qualitative research completed in the area of the use of self-disclosure in clinical supervision currently shows some specific limitations. The main emphasis has been on the role of SD from a supervisor's perspective and experience rather than a multipurpose activity used by both parties of the supervisory relationship. In turn, it has neglected the investigation of supervisee's own views of SD within the supervisory context. Also methodologically, the use of consensual qualitative approach, as with all qualitative research, demonstrates that some limitations exist around the generalisability of the findings, and the possible influence of researcher influences on analysis. (Hill et al, 2005). Lastly, the empirical research has been situated predominantly in the United States with participants from differing professional fields (e.g. counsellors, clinical psychologists, psychotherapists).

Current Study

Whilst this review of the literature has highlighted a number of qualitative and quantitative studies exploring the role of self-disclosure within the supervisory relationship, a number of limitations of this research has also been identified. Furthermore, as yet, no research has examined the role of self-disclosure in supervision within the United Kingdom, within high intensity cognitive behaviour therapists. High-intensity therapists hold a key position in the delivery of modern evidenced-based psychological therapies services within the NHS as part of the national IAPT. Since its inception primary care has seen an

exponential rise in workforce with a total of 2,629 high-intensity cognitive behaviour therapist currently (NHS England, 2016) providing CBT interventions to patients across the UK.

Given these recent changes and by the nature of CBT, SD in therapeutic practise is less straightforward than in other therapeutic modalities as discussed earlier in this review. Although some discussion around the benefits of SD in CBT is present in the empirical research (Goldfried et al, 2003) there is a lack of specific guidance around the use of SD in CBT supervision. Due to this reason and the exponential increase in the amount of psychotherapists within modern services delivering and receiving supervision on regular basis, it would seem further investigation is required to explore these individual's views of SD in clinical supervision.

In order to address some of the methodological limitations in the current evidence base the study will use q-methodology approach. Q-method allows for explorations of subjective viewpoints in a reliable, experimental and quantifiable manner (Watts & Stenner, 2012) and is being increasingly used in healthcare research to explore both staff and patient's opinions of interventions and approaches (Absalom-Hornby et al, 2012; Evans, Wittkowski, Butler, Hedderly & Bunton, 2015; Butler et al, 2014; Westbrook et al, 2013). Based on this it would appear a suitable approach to facilitate the further exploration of self-disclosure.

Aims and Objectives

The current study aims to explore trainee high-intensity therapist attitudes and views on self-disclosure in clinical supervision using q-methodology for the first time. It is hoped that through further investigating such views, this will allow for further insight and recommendations of how SD can be facilitated within training. To facilitate this the study will use adjunctive semi-structured interviews to explore participants views of the function

and purpose of supervision, individual experiences of supervision, supervisee self-disclosure and supervisor self-disclosure.

Methodology

Design

The study utilised mixed methods approach combining both Q-methodology and Thematic Analysis (TA). This design was chosen as Q-method is a qualiquantological and allows exploration of subjective viewpoints in a reliable, experimental and quantifiable manner (Watt & Stenner, 2012). Also, it has an increasing evidence base for its use within mental health and psychology as means of exploring individuals' attitudes and views to different subjects (e.g., Evans et al, 2015; Butler et al, 2014; Westbrook et al, 2013 & Absalom-Hornby et al, 2012). Q-methodology allows participants to systematically rank a series of statements (Q-Set) in accordance their agreement with them. These comparatively ranked positions reflect surfacing viewpoints regarding the subject area and permits a reliable and quantifiable means of exploring participant opinion (Watt & Stenner, 2012).

Thematic analysis is a method for identifying, analysing, and interpreting patterns of meaning ('themes') within data (Clarke & Braun, 2017). It was also chosen offers a framework to identify and explore and identify patterns within and through data on participants' lived experience, views perspectives and practices. TA also takes 'experiential' research approach that strives to understand what a participant' thinks, feels, and does making it a relevant and flexible method in this area of study. This study had full ethical approval.

Participants

Fifteen Participants were recruited via the University of Chester's Cognitive & Behavioural Therapies: High-Intensity Training Post Graduate Diploma course using a strategic sampling approach. The project was advertised through a research presentation and via the university mailing list. All participants included had experience of training and working as high-intensity therapist. No exclusion criteria were applied.

Q-Methodology Procedure

Q-Set Development

The Q-set was developed following the recommendations made by Watts and Stenner (2012). The information to construct the Q-set was be collected from numerous sources around trainee psychotherapist self-disclosure in the clinical and supervision context. These included; academic literature, supervision competency framework documents, and website resources. Themes, where extracted from these sources and (n = 65) representative statements were generated. These statements were then reviewed and further refined by the research team to construct 42 final statements that were agreed by the research team provided a balanced coverage of opinions on the topic of self-disclosure in clinical supervision (Watts and Stenner, 2012) and a copy of the chosen statements can be found in Appendix A.

Data Collection

Q-sorts

The Q-sorts were completed face to face with each participant by a member of the research team on site in a research laboratory at the University of Chester. Each participant categorised the 42 statements in the order of their opinion (agree, neutral or disagree). Following this they then ranked statements from most agree (+5) to most disagree (-5), using

a forced distribution grid (Figure 1.1). Post-sort questions were asked by the researcher to elicit further information about the statements ranked at +5 and -5 on the forced distribution grid as well as general thoughts about completing the task.

Semi-Structured Interviews

Following their completion of the Q-sort task, each participant was completed a short-recorded interview with a member of the research team to further investigate their views on the topics of clinical supervision, supervisee self-disclosure and supervisor self-disclosure. A copy of the interview schedule and post-sort questions can be found in Appendix B.

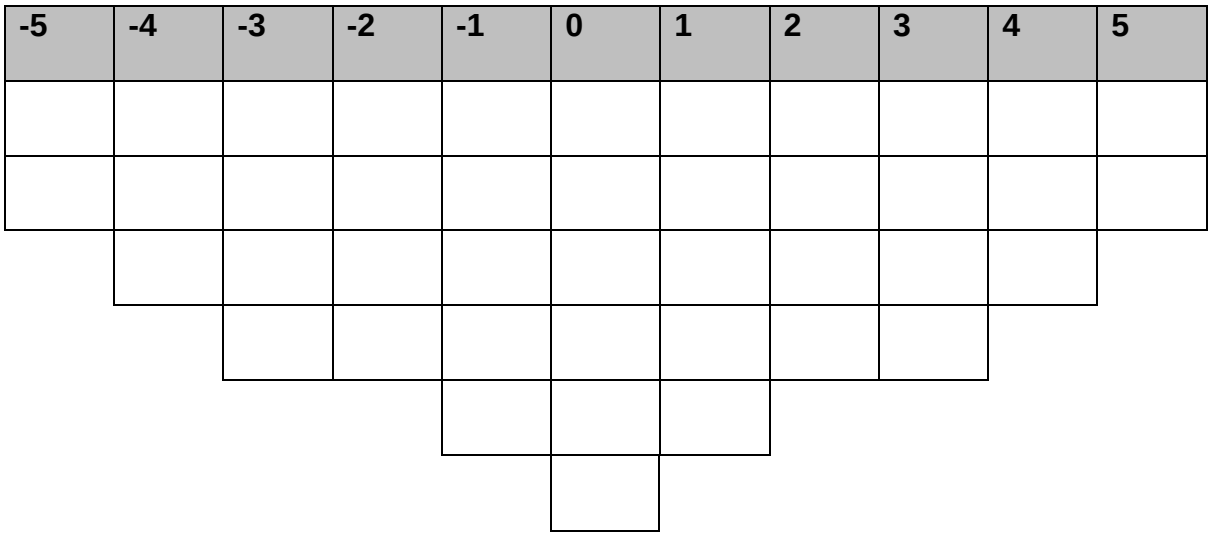

Figure 1. Q-Sort Forced-Distribution Grid

Data Analysis

Q-Sorts

Factor analysis was completed using PQMethod (Schmolck and Atkinson, 2014). Person by person factor analysis is used by q-methodology to identify factors upon which participants load due to similarities in their sort patterns (Watts & Stenner, 2005). A Principle components analysis (PCA) was completed and factors with an eigenvalue of 1> were

extracted and subjected to varimax rotation and then by further hand rotation. Q-sorts with significant factor loadings were merged using a weighted averaging procedure to construct a factor array. Significant factor loads were then determined using several criteria as recommended by Watts and Stenner (2005). A $p< 0.01$ threshold is a common in q-method analysis but should this result in multiple confounding Q-Sorts by where the sort loads significantly onto more than one factor meaning that these sorts would be then excluded from the analysis it is recommended that increasing the loading stringency by raising the significant level is recommended in order to increase the data for analysis.

Factors were then interpreted using factor arrays, demographic information and the post-sort questions completed after the task. Following the analysis indicated that all participants loaded onto the first factor, suggesting it to be a general or consensus factor. These shared views where explored further using the statements placed at the extreme ends of the consensus factor. The presence of further significant loadings on other factors indicated views held by some participants supplemented their own loading on the first consensus factor, also known as specificities of the first factor (Brown, 1999).

Interviews

Interviews were transcribed and subjected to an inductive thematic analysis following the guidance set by Braun and Clarke (2006). The first step of this process involved the researcher becoming familiar with the data via immersion in it, this involved reading and re-reading each interview transcript and taking notes, identified pertinent data and generating ideas of potential codes. The second stage comprised of the generation of initial codes to produce a coding manual from information directly extracted from across all transcribed data. The codes were developed based of the meaning associated with the data (see Appendix C and D for sample of coding manual and interview transcript).

Once the coding of extracts had been completed, the last stage involved segmenting the coded extracts into themes. This involved using a word-processed document to sort coded extracts by collating them into potential themes. Primarily, the dominant factor influencing the determination of themes was the presence of similar codes across the data set. Some of the subthemes were determined based on a latent thematic analysis, where a more interpretive approach was required. Once codes had been segmented into themes and subthemes, the proposed themes were discussed with the member of the research team and discussion and adaptations were made.

Results

Participant Information

Fifteen trainee high-intensity therapists participated which was deemed an acceptable sample size for Q-Methodology (Watt & Stenner, 2012). The sample consisted of wholly female participants studying on the same post-graduate diploma course at the University of Chester all also had average of four years experiences of working as low-intensity psychological wellbeing practitioners prior to starting the course with the age range was 29-45.

Q-Sort Analysis

A total of fifteen q-sorts were analysed using PQMethod (Version 2.35; Schmolck, 2014). a number of different analytical procedures were and considered however, a PCA and varimax rotation followed by a by-hand rotation using PQROT program was identified as the most suitable considered because in Q-methodology there are a number of different analytic

possibilities and the aim is to determine a data reduction solution that is both statistically and theoretically informed (Watts & Stenner, 2005).

Both two and three factor solutions were trailed but did not provide the most suitable statistic and theoretical explanation to the data. Following this, a single '*consensus'* factor solution was extracted from the data, as commonly in Q-methodology a number of factors are found from the data, however the current study had only a single factor which indicated that all participants had very similar q-sorts and therefore share opinions on self-disclosure. The factor was extracted using standard convention in Q-Methodology in which the eigenvalue in excess of 1.00 are typically accepted (Watts & Stenner, 2005) as factors with less than 1.00 account for less study variance than a single q-sort. However, despite this convention Q - Methodologists continue to debate their utility in as eigenvalues over one serve no data reduction purpose and serve as an 'arbitrary' criterion. Brown (1980) identifies that using this method can lead to numerous meaningless or 'spurious factors' being extracted from the data and argued that it can lead to significant and meaningful factors with a value of below one can be left behind in the data. Duenckmann (2010) also states that can be useful to include factors with eigenvalues less than one into analysis, due to their potential to represent a relevant and influential view of person.

Consensus Factor 1 had an eigenvalue of 8.69 and accounted for 53% of the study variance. All fifteen therapists loaded on to this factor significantly however three therapists (8,12 & 14) also loaded on to a second factor with an eigenvalue of 0.97 accounting for 12% of the study variance. All significant loadings were taken at $p<0.01$ which reflected a critical value above 0.39. A typical q-sort was derived from the weighted average of all significant loading sorts. These results are referred to in Q-methodology and similar studies as specificities within the first factor (Westbrook et al, 2013). These results suggest that all therapists held the same agreement about the acceptability, importance and benefits of

utilising self-disclosure in clinical supervision, but that a subset of them also held some unique viewpoints that supplemented their agreement with factor 1.

The factors were interpreted using the typical q-sort and analysis of the relevant statements and associated post-sort interview answers. Table 1.1 contains therapist factor specific demographic information.

Table 1. Factor Specific Demographic Information

Factor		Gender	Past Clinical role	Years Experience	Supervisory Experience
1		Female	Psychological Wellbeing Practitioner	4	No
1		Female	Psychological Wellbeing Practitioner	4	Yes
1		Female	Psychological Wellbeing Practitioner	4.5	Yes
1		Female	Psychological Wellbeing Practitioner	4.5	Yes
1		Female	Psychological Wellbeing Practitioner / Assistant Psychologist	4.5 / 2	No
1		Female	Psychological Wellbeing Practitioner / Senior PWP	2 / 2	Yes
1		Female	Psychological Wellbeing Practitioner	4	No
1	2	Female	Psychological Wellbeing Practitioner	4	No
1		Female	Psychological Wellbeing Practitioner	8.5	Yes
1		Female	Psychological Wellbeing Practitioner	8.5	No
1		Female	Psychological Wellbeing Practitioner	4	No
1	2	Female	Psychological Wellbeing Practitioner	2	No
1		Female	Psychological Wellbeing Practitioner / Senior PWP	2.5 / 2	No
1	2	Female	Psychological Wellbeing Practitioner	5	No
1		Female	Psychological Wellbeing Practitioner / Senior PWP	3 / 2	Yes

Table 1.2 shows the factor arrays for participants which represents the ‘typical sort’ associated with that factor which is derived from the weighted average of all the participants that load on to it. The representing values of the factor arrays range between +most agree and -5 most disagree.

Table.2 – Participant Factor Arrays

Q –Statement	Factor 1 array	Factor 2 array
1.Time pressures of clinical supervision mean that self-disclosure is not a priority.	--2	+1
2.Self-disclosure is a hard thing to do in supervision.	0	0
3.Therapists are less likely to self-disclose in supervision if clinical and managerial supervision are combined.	-1*	+3
4.A supervisor would view a therapist as less competent if they disclosed something personal in clinical supervision.	-5*	-1
5.If therapists believe something went wrong during therapy then they should disclose this in supervision.	+5	+5
6.Therapists are more likely to self-disclose in individual supervision compared to group supervision.	+1	+1
7.Self-disclosure in supervision improves treatment outcomes for clients.	0	-1
8.Self-disclosure in supervision is important for the therapists own personal well-being.	+5	+3
9.Therapist self-disclosure would negatively influence the supervisory relationship.	-3*	-2
10.Self-disclosure is unnecessary in supervision.	-5	-4
11.A positive supervisor-supervisee relationship is the most important factor in encouraging therapists to self-disclose.	+4	+4
12.Therapists are more likely to self-disclose in supervision if their supervisor is warm and empathetic.	+3	+2
13.Therapists would be wary about self-disclosure in supervision.	-2	-2
14.Therapists should disclose personal information in supervision if it is relevant to their work.	0	+1
15.Therapists are more likely to self-disclose in supervision to supervisors with more clinical experience.	-2	-3
16.Therapists are more likely to self-disclose in supervision to supervisors who practise more relational therapies (e.g. psychotherapy, cognitive analytic therapy).	-3	-4
17.Self-disclosure in supervision is not important for therapists who practise cognitive behavioural therapy.	-4	-5
18.Therapists should discuss client-therapist relationship dynamics in clinical supervision.	+2	+3
19.Self-disclosure makes supervision more authentic.	-1	-2
20.Therapists should disclose in supervision positive or negative feelings that they may have towards clients.	+1	+2
21.Self-disclosure in supervision improves therapist self-discovery.	+1	0
22.Therapists are encouraged to use self-disclosure in supervision.	0*	-3
23.Self-disclosure in supervision can have negative consequences for a therapist's career.	-3*	-1
24.Disclosing relevant personal information in supervision is concerning as it oversteps personal boundaries.	-4	-4
25.Self-disclosure is more important for qualified therapists than Trainees.	-4	-5
26.Self-disclosure reduces therapist anxiety.	-1	-1
27.Supervisors should model self-disclosure in supervision by disclosing their own relevant experiences.	0	-1
28.Self-disclosure in supervision promotes therapist reflection.	+3	+2
29.The supervisor-supervisee power imbalance negatively impacts therapist self-disclosure.	-1	-3
30.Therapists and supervisors should have a supervision contract which outlines the agreed boundaries around future self-disclosure.	+2*	-2
31.The supervisor-supervisee relationship is stronger following self-disclosure.	+1	0
32.Therapists should discuss their own emotional reactions to client's stories in supervision.	+1	+2
33.If a client makes derogatory comments towards a therapist, this should be disclosed in supervision.	+3	+3
34.Therapists should discuss professional moral dilemmas in supervision.	+4	+5
35.Therapist insecurity would make self-disclosure in supervision less likely.	+2	0
36.Having dedicated supervision time which is free from Interruptions is important for promoting self-disclosure in supervision.	+2	+1
37.Frequent changes in supervisor discourages therapist self-disclosure.	+4*	0
38.Perceived differences in supervisor-supervisee cultural or demographic variables (e.g. age, gender, ethnicity, sexual orientation) would discourage self-disclosure.	-2	-3
39.Therapist self-disclosure in supervision would make other workplace interactions with the supervisor uncomfortable.	-3*	0
40.Self-disclosure to a colleague would be preferred over self-disclosure in supervision.	-1	+1
41.Previous unsuccessful self-disclosure would discourage therapists from future self-disclosure in supervision.	+3	+4
42.Therapists' feelings of shame discourage self-disclosure in supervision	0*	+4

***Statistically distinguishing statement for factor (*p<0.01*)**

Consensus Factor 1: *"Important, particularly for morals and well-being; but the supervisor is crucial"*

Fifteen therapists loaded onto this explaining 53% of the study variance, this factor represented the positive acceptance, current, continued moral and ethical importance of self-disclosure and the role it has on individual professional practice, personal wellbeing and the supervisory relationship.

All therapists agreed that disclosing problems and mistakes within therapy is the most important thing to do (e.g., S5: *'If therapist believe something went wrong in therapy then they should disclose this in supervision' ; +5)* and identified that disclosing moral dilemmas is of particular importance due to its implications on the therapist and client (S34*: 'Therapists should discuss professional moral dilemmas in supervision' +4)* indicating a theme of ethical and moral importance of self-disclosure. The following therapists explicitly acknowledges this in their post-sort interview response:

"'If something goes wrong in therapy then I feel like you need to discuss it in supervision so that you can look to put it right and stop it happening again… you can reflect on it and look at how you can improve and make sure the client is getting the best treatment."

(Participant 6)

"Being in a job that were in you are going to come across moral dilemmas with patients and I have done in the past and think it's been really helpful to actually air them out and kind of discuss ways you can limit the impact that it has on your relationship with the patient."

(Participant 7)

Therapists also endorsed that self-disclosure in supervision plays an important part in supporting and maintaining their wellbeing (S8: '*Self-disclosure in supervision is important*

for the therapists own personal wellbeing +5). Again therapists overtly express this endorsement:

"It is (self-disclosure) and it's actually really beneficial to my future practise and found that the more I've done it the more its actually helped with other patients who I've worked with… but also with my own wellbeing especially when I've been frustrated… just being able to explore that and get a bit more of understanding of that… and how I can learn from it."

(Participant 5)

In terms of development and competence therapists disagreed that using Self-disclosure is more important after training (S25: *'Self-disclosure is more important for qualified therapists than trainee's* supervisors would view a supervisee as less competent *(*S4: *'a supervisor would view a therapist as less competent if they disclosed something personal in clinical supervision' -5).*

Therapists noted that the supervisor-supervisee relationship is very important in determining self-disclosure, alongside consistency in supervision and the absence of previous negative experiences (S11: *'A positive supervisor-supervisee relationship is the most important factor in encouraging therapists to self-disclose' +4;* S37: *'Frequent changes in supervisor discourages therapist self-disclosure' +4 and* S41: *'Previous unsuccessful self-disclosure would discourage therapist from future self-disclosure in supervision' +3).* Therapists also distinguished supervisor interpersonal characteristics and group supervision dynamics being critical in the likelihood of self-disclosure occurring (S12: *'Therapists are more to self-disclose in supervision if their supervisor is warm and empathetic'* +3 and S6: *'Therapists are more likely to self-disclose in individual supervision compared to group supervision'* +1*)*. Therapists also reinforce these statements through the following quotes:

"I think if you've got a good relationship with your supervisor and to me if they're nice and empathic and things then you're going to have good relationship with them you'll gonna be more likely to disclose to them and if you've not really got that positive relationship"

(Participant 3)

"I strongly agree that if you tried to disclose information previously and they haven't been warm or encouraging about it or you've felt a bit shot down then I think I'd be very reluctant to do it again with that particular supervisor anyway and I think it's very important to have that strong relationship between yourself and your supervisor to then feel encouraged to be able share that information and know that you're doing it in a safe environment"

(Participant 4)

In terms of practical considerations for supervision therapists also noted the benefit of having allocated time and space for disclosure, coupled with the aversive impact of changing supervisors on supervisee self-disclosure (S36: *'Having dedicated supervision time which is free from interruptions is important for promoting self-disclosure in supervision'* +2 and S37: *'Frequent changes in supervision discourages therapist self-disclosure'* +4). However, therapists did not particularly endorse that it would make the supervisory relationship stronger or make it more authentic (S31: *'The supervisor-supervisee relationship is stronger following self-disclosure'* +1 and S19: *'Self-disclosure makes supervision more authentic'* -1). They also disagreed that relational supervisors were important (S39*: 'Therapist self-disclosure in supervision would make other workplace interactions with the supervisor uncomfortable'* -3).

Therapists strongly disagreed that self-disclosure is unnecessary in CBT practice and that sharing relevant personal information is not a violation of boundaries within the supervision environment (S10: *' Self-disclosure is unnecessary in supervision' -5;* S17: *'Self-disclosure in supervision is not important for therapists who practise cognitive behavioural*

therapy' -4;) and *(*S24: *'Disclosing relevant personal information in supervision is concerning as it oversteps personal boundaries' -4).* Therapists also identified a continued importance of self-disclosure use throughout their career development and no concerns around the impact of its use on their perceived competence from others (S25*: 'Self-disclosure is more important for qualified therapists than trainees'* -4 and S23: *'self disclosure in supervision can have negative consequences for a therapists career'* -3).

Specificity Factor 1*: "generally supportive of self-disclosure, but a few more problems and a little more wary"*

In addition to the therapist's agreement with the consensus Factor, three therapists (8, 12 and 14) loaded on to a second factor with an eigenvalue of 0.97 accounting for 12% of the study variance. These therapists also had significant but diminished loadings on Factor 2 (0.67, *p<0.01;* 0.59*, p<0.01; 0.53, p<0.01).* This would suggest that in addition to their positive agreement with Factor 1 these therapists had other viewpoints regarding self-disclosure that where loaded onto Factor 2 but given the high intercorrelation between the two factors provided evidence that they were both likely to be the same factor. Therapists loading onto Factor 2 expressed more nuanced views regarding concerns regarding the practicalities of supervision and a slight hesitancy towards the use of self-disclosure. Therapists noted time pressures, priorities and promotion of self-disclosure in supervision causing a perception of wariness in using it (S1:*'Time pressures of clinical supervision mean that self-disclosure is not a priority'* +1; S3: *'Therapists are less likely to self-disclose in supervision if clinical and managerial supervision are combined'* +3; S22: *'Therapists are encouraged to use self-disclosure in supervision'* -3 and S30: *'Therapist's and supervisors should have a supervision contract which outlines the agreed boundaries around future self-disclosure'* -2) Comments made by following therapists highlighted this significance:

"I don't think we are encouraged to do that at all I think but it's set up as a supervisor to encourage you to be able to disclose things within supervision I think it's very much this is what we've got to work on this is the time we've got how many people are you bringing what's the question that you want to speak about and that's really it there's no other kind of area to talk about you" *(Participant 5)*

"…normal confidentiality contract within supervision if that was breached I'd be a bit wary about disclosing anything" *(Participant 8)*

Another theme identified by therapists was the impact of negative personal emotions can have on engaging with self-disclosure (S42: *'Therapist' feelings of shame discourage self-disclosure in supervision'* +4; S39: *'Therapist self-disclosure in supervision would make other workplace interactions with the supervisor uncomfortable'* 0):

"…I think so if you felt that that there would be some element of shame or embarrassment or you'd be looked down upon by your colleagues…" *(Participant 1)*

"I suppose your insecurity I know at times I've held back because it seems that I don't know what I am doing" *(Participant 10)*

Thematic Analysis

Following the thematic analysis, four main themes were identified across the complete data set. These were as follows: 1. Function and Purpose of Clinical Supervision, 2. Experiences of Self-Disclosure, 3. Supervisee Self-disclosure and 4. Supervisor Self-Disclosure. A thematic map of these themes can be found in Figure 2.

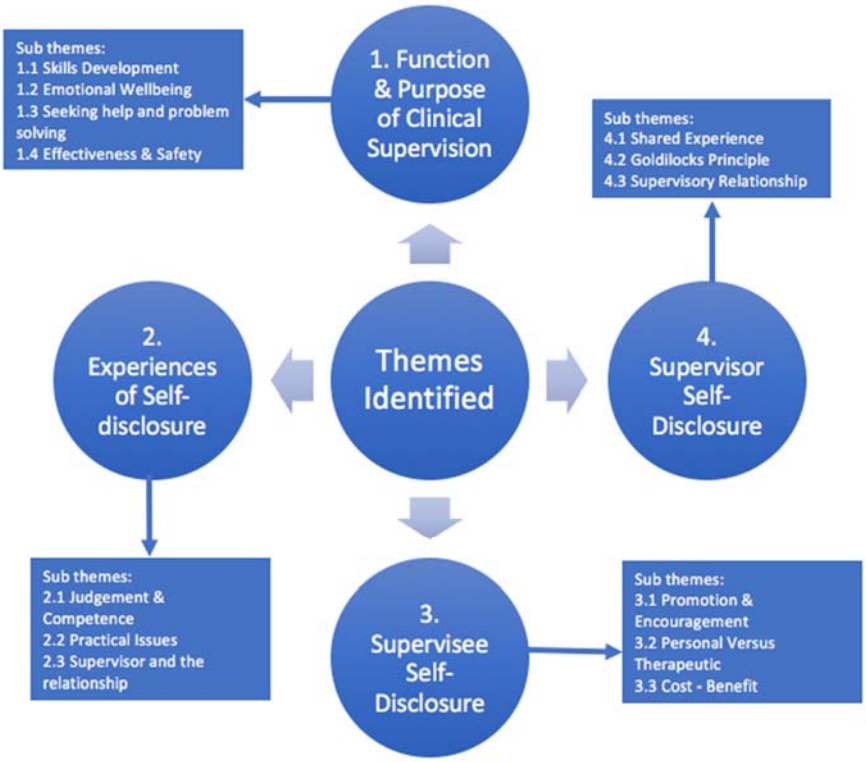

Figure 2: Thematic Map

1. Function & Purpose of Supervision

A key theme identified throughout the data was around the function and purpose of clinical supervision in CBT. This theme comprised of four sub-themes including *skills development, emotional well-being, seeking help and problem solving and effectiveness and safety*. This theme was evidenced through statements about the practical functions and purpose associated with clinical supervision particularly, relating the function it serves in developing theoretical and practical knowledge associated with training and professional practice. Therapists viewed supervision as multifaceted in its function and as a forum to discuss mistakes, ask questions and focus on individual clinical skills. They also conveyed a strong sense of importance around the restorative function of supervision through emotional

expression associated with the pressures of delivering psychological therapy on the individual and self-disclosure being a key component of this expression:

"Clinical supervision there are lots of different parts to it one about building new clinical skills so seeking very specific guidance on skills your using… some time to reflect on how I'm doing on the course just the general process rather than specifically with patients and if anything, that that I'm struggling with I guess."

(Participant 11)

"Clinical supervision is to enable well if you're a trainee or a CBT trainee to enable the therapist to become a qualified therapist to be able to help them develop in their skills professionally and academically and to I think self-disclosure is a big part of that because it helps to iron out whether there are any issues in relation to one development as a therapist and two whether there are any wider issues going on in relation to personal circumstances that might impact their ability to do their job basically"

(Participant 13)

Therapists also felt strongly that supervision provides an opportunity for them to help seek and problem solve, a common statement referred to in the data set was around 'struggling with patients' inferring to the demands and stresses associated with learning and delivering treatment protocols associated with the training. Extracts of data showed the additional function that supervision increases effectiveness of practice and provide an assurance of safety for both therapist and client:

"…risk issues any clients I was struggling in following certain protocols and getting general feedback on videos, making sure that I was staying on the right track and if anything has happened with a certain client that you're not too sure of or you maybe feel you made a bit of

a mistake or any relationship issues that I feel is relevant to talk about and also to problem solve issues." *(Participant 2)*

In all fifteen therapists had previous knowledge and understanding due to their past professional experiences as Psychological Wellbeing Practitioners (PWP) which appeared to influence their expectations of clinical supervision being the forum to disclose therapeutic mistakes, difficulties and apply this prior experience to their high-intensity training as which would appear to link to the moralistic and ethical component of the consensus factor.

2. Experiences of Self-Disclosure

This theme focused on experiences of self-disclosure in clinical supervision and the positive and negative characteristics associated with these. This theme consisted of three sub-themes; *Judgement & Competence, Practical Considerations, and Supervisor and the relationship*. Therapists reported experiences in which they felt anxious and apprehensive about using self-disclosure for fear of negative criticism, judgement or having their professional competency brought into question:

"I've been put off say showing some videos and self-disclosing say my personal self-disclosure around that but also knowing that it might come back to how you are viewed clinically but how your viewed in terms of how you have tried to manage that already it comes back not only on your character but on your clinical competence as well I know that has discouraged me from self-disclosure especially at the moment."

(Participant 10)

"….case but sometimes may fabricate or maybe not tell the whole truth and maybe embellish bits or maybe play down bits erm that was the only one that I really struggled with because of that I mean I don't necessarily think it would stop them disclosing but maybe stop them disclosing effectively" *(Participant 14)*

Conversely, therapists also reported positive experiences in which self-disclosure was received in a supportive and non-judgemental manner and reduced their anxieties. The sub-theme of practical considerations highlighted the impact of the environment and logistical issues associated with successful disclosure. Specifically, time pressures on self-disclosure due to the emphasis on skills development and overvalued emphasis on clinical and therapeutic disclosure rather than personal. This theme was consistently referred to through the interview data with an added nuance around the absence of protected space within supervision to allow for a therapist to disclose personal content. Other considerations expressed by therapists included the importance of having suitable environments in which to such as privacy, being free from distraction, rooms, location etc:

"…I think environmentally often in supervision where I am at the moment take place in therapy rooms and I think that is a good environment the therapy room is for a purpose and usually pretty relaxing." *(Participant 1)*

"…I don't think it's possible to have more time for supervision (cough) to fit that in to have more time to self-disclose or anything like that…" *(Participant 5)*

This theme identifies the experiences the role of the supervisor and the supervisory relationship in the use of self-disclosure. Therapist viewed supervisor characteristics and

supervisory style being directly attributable to increased self-disclosure, and also stressed that initial negative reactions from supervisors following trainee self-disclosure can significantly and negatively impact the relationship. Most importantly they reported that the relationship is the key and most important factor in supervision:

"I think the relationship that I have with my supervisor would be the most important thing that would promote me self-disclosing personal and therapeutic issues If they can make you feel comfortable if you feel at ease that you can talk to them about something but also if you've mentioned something in the past to them and had a positive experience then you're more likely to-do it again I think it's just knowing when its right to say something any they're not going to judge and promote my own wellbeing by being able to talk about something difficult and getting guidance from it erm it will help patient work and build that relationship with you and the supervisor as well.'

(Participant 2)

Characteristics of the supervisor's style include being warm, encouraging, empathetic and comfortable with the therapist and the most important aspect of the supervisory relationship being a sense of mutual trust in both the supervisor and therapist:

" ... I think that they do need to be empathic and they do need to look at the individual that they're supervising as well as the work erm I think that would help self-disclosure.."

(Participant 4)

.. it is important if you're a supervisor it comes across that your warm and empathic…I think if you've got a good relationship with your supervisor and to me if they're nice and empathic and things then you're going to have good relationship…"

(Participant 3)

"…but feeling that I could open up to them honest with me warm understanding they made me feel like they were listening to me also feeling non-judgemental taking a non-judgemental stance because I wouldn't really want to open up with someone that I felt would judge me for it for example having an opinion on a patient maybe that I'd be worried about talking about if it was someone who I felt I couldn't open up to about or didn't trust I wouldn't say it so I'd have to feel that I trusted them…"

(Participant 8)

Negative experiences of self-disclosure expressed by therapist stated that in absence of the characteristics in the above leads to a perception of 'power imbalance' and directly discourages therapists from using self-disclosure:

"...but with the power imbalance I don't think be inclined to talk about personal things even through really sometimes that might be quite helpful to do that"

(Participant 8)

3. Supervisee Self-Disclosure

The third theme focused on the importance of supervisee's use of self-disclosure and the challenges, benefits and perceived pitfalls associated with it. Sub-themes identified within this theme were as follows; *promotion and encouragement, personal versus therapeutic disclosure and cost-benefit*. Therapists identified a lack of promotion of self-disclosure

within supervision and general practice with a sense of insecurity around its acceptability within the relationship.

"I don't think you are always encouraged to use it during supervision" *(Participant 5)*

"…the one about being encouraged I don't think I don't think we are encouraged to do that at all…" *(Participant 8)*

"…way we have supervision isn't like that from what I can see the way we have supervision isn't about the therapist or that aspect it isn't tended to"

(Participant 12)

"…more openness to say how that made you feel or you know asking the question I think kind of showing that it's ok to talk about that" *(Participant 14)*

Therapists felt acceptable towards two different types of disclosure; therapeutic and personal. In that on the whole, reported a more acceptability towards therapeutic disclosure (e.g. shared experiences with clients, clinical mistakes, therapeutic ruptures, unsuccessful attempted interventions etc).

"I think that its a lot easier to focus on patients than it is to bring in your own personal difficulties into supervision if I'm honest" *(Participant 15)*

"it's really important when it's in the terms of work (.) erm when you ((pause)) need to reflect or when you've done something wrong to bring it I think it's really important to bring

that and get the guidance from it and be able to admit that I didn't do great here…"

(Participant 6)

" I feel that I utilise the supervision a lot more just to have a look at what I've done wrong if somethings not right with the relationship erm if somethings not right with a specific skill that I need to use I think at the moment for being a trainee I'm using it more for kind if something went wrong…" *(Participant 11)*

They also stated an increased sense of anxiety and trepidation around the relevance of personal disclosure to their overall practice:

"I think say regularly I would self-disclose about the therapy treatment side of things I'd say I haven't (.) I don't feel I've necessarily needed to erm divulge personal information that much during the time I've worked as a therapist" *(Participant 10)*

"…that little bit of anxiety beforehand about what their response might be the supervisor's response…" *(Participant 2)*

The perception of acceptability could be linked to the ambiguity associated with its promotion coupled with their clinically pragmatic approach to supervision. Therapists who did routinely use personal self-disclosure reported the importance of personal choice in their decision-making process and describe taking a cost-benefit approach to its use. In which, they consider their initial apprehension of the impact on their personal and professional image of themselves and compared it with the potential gains associated with disclosure such as alleviation of anxiety, reassurance and normalisation of experience. For these therapists, they

reported that the benefits outweighed the initial cost and investment in the decision to use personal self-disclosure in supervision.

"…you think what will they think of me if I say this or erm ask yourself do I talk about this or not? But then once you do talk about it you feel better (.) but there's that little bit of anxiety beforehand about what their response might be…"

(Participant 2)

"I think it's really important when it's in the terms of work when you ((pause)) need to reflect or when you've done something wrong to bring it I think it's <u>really</u> important to bring that and get the guidance from it and be able to admit that I didn't do great here ((pause)) and I think maybe if opportunity arose to talk perhaps about kinda personal things and how they'd impacted on you but in reality I probably wouldn't do that myself (laughs) although I think that it would be good and just think you just wouldn't have the time anyway I think you just wouldn't have the time to do that not unless it was something absolutely <u>major</u> that it was directly relating to client for instance…"

(Participant 6)

4. Supervisor Self-Disclosure

The final theme concentrated on therapist's perceptions of supervisor self-disclosure within clinical supervision. It contained the following sub-themes; *Shared experience, the Goldilocks Principle, and Supervisory relationship*. All therapists stressed that supervisor therapeutic self-disclosure (particularly shared training and clinical practice) was helpful and provided reassurance, normalises their own experiences and provides a means to problem solve in supervision:

"…hearing your supervisor say that they have felt like that before or and I remember when I was doing my training I felt like this and if a supervisor says I still get this now (.) it's like phew (laughs) it's not just me because even though you might discuss it with your colleagues and when you hear your supervisor if say I still get that no (.) it normalises it as part of the process sometimes you can feel that it's just you and your doing it wrong but knowing that a supervisor telling you that it sometimes happens to me and this happened the other day etc. can be really boosting and means I can look up them and allow them to help me problem solve it a bit better…" *(Participant 1)*

"…one of my supervisors now has done the HIT training like two years ago now so can remember the training quite well and he's saying things he struggled with at first or protocols or things he didn't quite get at first so that I think is quite helpful for me erm it's quite reassuring for me if I've tried it once and not done it right an beat myself up about it so it's good to kind of have that perspective…" *(Participant 11)*

Therapists also advocated personal self-disclosure in supervision was generally acceptable in context (i.e. relevant to the topic of discussion) to represent this 'Goldilocks Principle' sub-theme was coined. This referred to supervisors use of self-disclosure in that too much therapeutic or personal self-disclosure becomes unhelpful in that effects the power dynamic in the supervisory relationship, whereas not enough or no self-disclosure directly impacts the core inter-personal aspect of the relationship. However, a structured and balanced approach of the amount and relevancy of self-disclosure is 'just right' and facilitates successful supervision and enhances the bond between supervisee and supervisor:

"I think that can be really helpful because it can normalise that all therapists do experience barriers or successes and the self-disclosure of a supervisor makes it feel more acceptable for me to disclose I think it could also impact negatively if a supervisor was to tell me that they are stressed I would think I'll make sure I just keep with the key points and be compassionate to them." *(Participant 5)*

Exploring the similarities between emergent factors and themes

To further aid interpretation and conceptualisation of the results the thematic and q-sort analysis findings were combined (Figure 2.1). From this a number of commonalities were found across the themes and sub-themes that emerged from both the q-sort and the interview methodologies. Factor 1 *important, particularly for morals and well-being; but the supervisor is crucial*. This consensus construct shared similarities with a number of themes and subthemes that were found in the thematic analysis namely 1. Function & Purpose of Clinical Supervision; 1.1 *Skills development, 1.4 Effectiveness & safety* in that therapists viewed clinical supervision as an important way of developing their skills through the disclosure of moral and ethical issues encountered in professional practice. This theme was also linked to the other subthemes of *1.2 Emotional Wellbeing* which highlights the similar importance the therapists held for supervision in providing restorative and therapeutic benefits. Factor 1 also showed a direct link to the theme of 2. Experiences of Self-disclosure; *2.3 Supervisor and the relationship* and also theme 4. Supervisor Self-disclosure; *4.1 Shared Experience and 4.3 Supervisory relationship* as therapists agreed that the supervisor and the components of the relationship including specific characteristics such as empathy, warmth and reciprocation by the supervisor are essential to self-disclosure occurring.

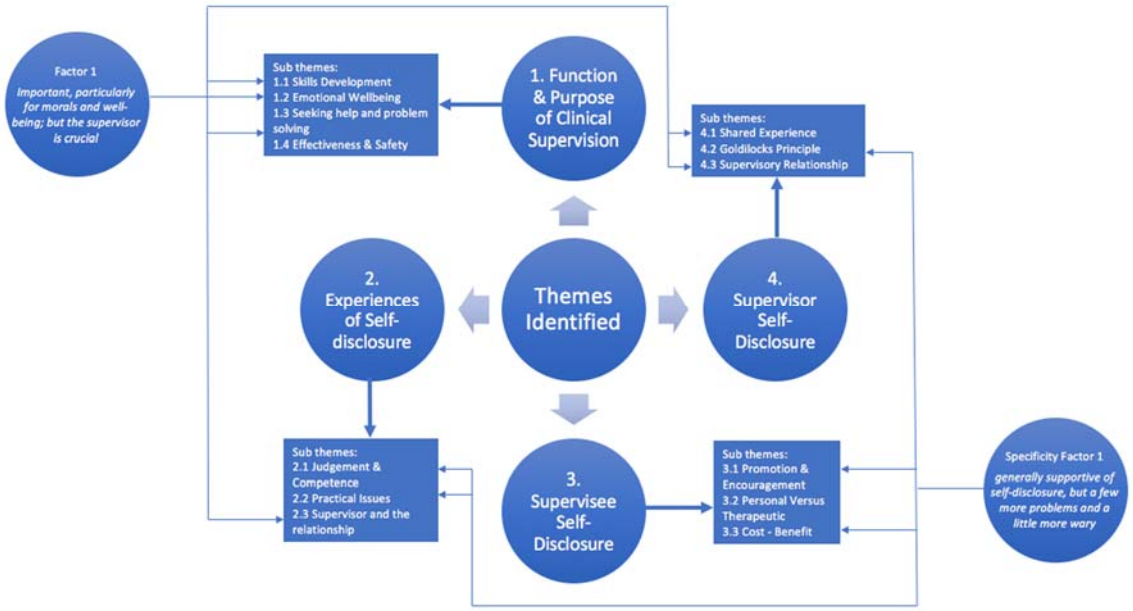

Figure. 3 Combined Emergent Factors & Themes

Given the similarities between the consensus factor, the thematic analysis results supported a more nuanced interpretation of specificity factor 1 *generally supportive of self-disclosure, but a few more problems and a little more wary.* This related to theme two. Experiences of Self-disclosure; *2.1 Judgement & Competence* and *2.2 Practical Issues* given the considerations of individual therapist's slightly negative interpretation of self-disclosure within supervision and how this could potentially impact others. This linked to the perception of negative evaluation of their competence by the supervisor, peers and also practical considerations associated (such as confidentiality, time, environmental conditions) potentially inhibiting the frequency of self-disclosure. Other links between analyses showed that specificity factor linking to theme three. Supervisee Self-Disclosure; *3.1 Promotion & Encouragement and 3.3 Cost/Benefit* with therapists views of support and encouragement as important in decided to use self-disclosure in supervision and to the cost-benefit analysis that a therapist will complete before making a decision on whether to act due to feelings of wariness. The final commonality relates to theme four. Supervisor Self-Disclosure; *4.3*

Goldilocks Principle in therapist's acceptability of supervisee self-disclosure within the supervisory relationship in that the wariness that a therapist would be influenced by how much or how little a supervisor would disclose would affect their feelings about doing so.

Discussion

The aim of the current study was to explore trainee high-intensity therapist attitudes and views on the use of self-disclosure in clinical supervision using q-methodology and inductive thematic analysis from the adjunctive semi-structure interviews. This section will now discuss the results of both analyses, consider clinical implications of the data and reflect on its limitations and directions for future research.

Q-Methodology

This study was the first to explore fifteen trainee therapists' views on self-disclosure in clinical supervision. Using q-methodology, one consensus factor 1: *Important, particularly for morals and well-being; but the supervisor is crucial* was identified, but also additional specificities existed within this factor and it explained the highest variance and reflected a validated approach of current and continued importance of self-disclosure in a professional capacity, but also the emphasis of disclosing moral and ethical information and experiences as part of common practice. The factor also highlighted the important role of the supervisory relationship in supporting the emotional wellbeing and the personal impact of self-disclosure on therapist. Specificities associated with this factor 1 were labelled as specificity factor 1: *generally supportive of self-disclosure, but a few more problems and a little more wary,* also shared the view above but acknowledged the impact of practical considerations of self-disclosure and a slightly cautious approach to engaging in it due to the possible negative emotions associated with the process.

This exploratory study highlights that due to the professional background of the participants they appeared to possess a consensus of understanding of the purpose and importance of self-disclosure within CBT supervision. The recognition of this importance and the existence of a single consensus factor shows potentially the teaching and expectations of supervision in this population was consistent across the sample. This possibly reflected both therapist's prior experience working in IAPT services and their familiarity with the Roth and Pilling (2008) supervision competencies and were all studying the same university course.

Methodological Limitations

The study's main strength is that no previous research has been completed in the area of trainee high-intensity therapist's views of self-disclosure in clinical supervision. Therefore, it addresses an under researched area in the literature, the utilisation of a q-methodological approach was considered best suited to successfully explore this topic and identify subjective viewpoints in a reliable, experimental and quantifiable manner (Watts & Stenner, 2012). Although using researcher-generated statements can be criticised as being restrictive and reductionist, it has been found that doing so allows participants who may not consider themselves to be able to freely generate extensive narratives around a topic, to participate (Evans et al, 2015). This is important for self-disclosure as gaining different perspectives from other therapists is important to individual reflection, practice and wellbeing. It is also an important topic to explore given the IAPT programme is built on the premise of evidence-based approaches to both treatment and supervision it would beneficial to contribute using clinically relevant research such as this study.

One of the main limitations of the research was that all participants were high-intensity therapists from one cohort of the University of Chester and all had prior experience working as low-intensity practitioners (PWP). Furthermore, given this all participants

reported similar experiences of a supervision model that splits clinical skills and clinical case management into separate meetings with different frequencies. In this model of supervision primary focus is to facilitate effective case management skills (due to the large caseloads associated with low-intensity work) through weekly meetings and less emphasis around clinical skills development with monthly meetings being preferred. Due to trainee's experiences of this, it is likely that the transition to a conventional supervision model may have led to therapists to hold a more didactic and problem orientated expectations towards clinical supervision whilst in training.

Also, given the recruitment strategy adopted by the research use only one cohort from the University of Chester high-intensity training course and this could have introduced a potential bias on the participant response by assuming their participation in the research could have potential negative repercussions both in their own supervision and progression through the course. This was addressed by the researchers through anonymising data, stressing the nature of and aims of the study and conducting the post-sort and semi-structured interviews to reduce the possibility of participants interpreting and arranging the q-set data in a socially desirable manner.

A further limitation of the current study is linked to the intrinsic nature of Q-methodological research and its inability to generalise the findings to the population. As large samples sizes are not required for meaningful research, the responses from the fifteen trainee' therapists who have all used self-disclosure in clinical supervision create a contextually bound outcome that is not necessarily applicable of all trainee therapists. As q-methodology focuses on subjective opinion this means it is also not inherently generalizable (Watts & Stenner, 2012).

Another potential criticism of the study could be in relation to the q-statement development. As in an attempt, not to personal the statements due to concerns around the

potential ethical considerations, the researchers constructed the statements using the prose of 'therapists should'. This could have inferred an idealistic response from participants during and after the q-sort task had been completed. This limitation has also been present in other q-methodological research such as Evans et al. (2015) who identified that some of their q-set statements might have been highly endorsed as result of the reflection on best practice in the profession which would influenced the validity of the opinions identified. To address this the current study completed the post-sort interview to delve into the nuances of the individual therapist's responses following the q-sort task to aid analysis and interpretation.

Thematic Analysis

Regarding the interview data and subsequent thematic analysis, this part of the study allowed the researchers to take a flexible and accessible approach to exploring within and across the data for the themes associated with trainee's views of self-disclosure in clinical supervision.

The analysis builds upon existing research on supervisee's perspectives of clinical supervision (Spence et al. 2014) but provides a fresh perspective in that it explores perspectives of supervisees from a cognitive behavioural therapy background rather than from clinical psychology. From the semi-structured interview data four key themes emerged*; 1. Function and purpose of supervision 2. Experiences of self-disclosure 3. Supervisee Self-disclosure and 4. Supervisor Self-disclosure.* From these it was identified that therapists view supervision as a forum for practical skills development with a central focus on problem-solving therapeutic issues. Within this, also highlighted the importance of using self-disclosure to facilitate the process and increase their effectiveness in practice. There was also a strong emphasis on the role of supervision providing a place to support a therapist's emotional wellbeing. This finding links to Inskipp and Proctor's (1993) model of supervision

serving normative, formative and restorative functions. In terms of self-disclosure, all trainees expressed its importance for developing practice but also reported a general agreement that disclosing therapeutic mistakes and difficulties was preferred over personal self-disclosure (such as personal issues and challenges not directly related to therapy etc) due to a perception of it not being relevant or meaningful.

Many trainees also expressed that the outcome of their first attempt at self-disclosure had a direct relationship to future disclosures, in that if it were negatively received by their supervisor they would refrain from using self-disclosure again due to fear of further negative judgement or appraisal. Themes also identified the importance of characteristics of the supervisory relationship but not the supervisor as an individual. Ladney et al. (2010) identified the same importance of supervisor's utilisation of clinical skills such as empathy, positive regard and reflection would make trainees more adept at disclosing information. They also identify that the higher a trainee's anxiety the greater the amount of non-disclosures, this coupled with the current study's finding regarding negative first impressions of self-disclosure raises some interesting implications for how supervisors respond to their trainee's disclosure attempts. Bernard and Goodyear (2009) provide some guidance around strategies that supervisors can use to minimise trainee anxiety such as providing a balance between supportive and challenging behaviour, providing more structure in supervision, and engaging in role induction with them. On this point it is worth asking the question is the anxiety associated with initial use self-disclosure, one of the elements that influences the trainee's negative interpretation of their supervisors reaction? Or possibly could it be the supervisors attempt to minimise their supervisee's anxiety? Either way it suggests a level of consideration and transparency on both parts.

Trainee's also identified by supervisor's self-disclosure that provided shared therapeutic experience was the most helpful component of supervisee self-disclosure as it helped to normalise and conceptualise problems encountered in training and practice. This theme can be linked back to Ladany and Walker's (2003) category of disclosure around therapy experiences in which they can be used as a model for the training in the ways in which to be a therapist. This is important as it can again provide some guidance to supervisors in the benefits of self-disclosure.

Methodological Limitations

One of the main limitations of this study is that the researchers of the study worked in the same field as the participants and have both received and delivered clinical supervision and supervision trainee to other professionals. This knowledge and awareness of the supervision process, competency frameworks and guidance may have biased the active engagement in the data and potentially influenced the results of the present study. However, the nature of thematic analysis and qualitative research, in general, means that there is a risk that the data may be interpreted according to their subjective perspective. In order to address this, the researcher followed best practice guidance (Braun & Clarke, 2006) for thematic analysis in an attempt to minimise the potential for bias by discussing potential themes with fellow researchers and keeping a reflective project log of the different stages of the study and experiences whilst completing it.

Combining Approaches

Due to the subsequent limitations of both methodological approaches, the researchers adopted a mixed method approach. However, as with all approaches, this is not free of criticism within the research. Although post sort interview questions are usually used in q-

methodology, more extensive semi-structured interviews were introduced in the current research to allow for further exploration and understanding of the q-sort results and help interpretation of the factors extracted. This allowed for both methods to produce a more nuanced analysis of social understanding of the role of self-disclosure in supervision. For example as discussed, the construction of the statements and their wording presented a potential 'ideal world' interpretation around what self-disclosure should look like in clinical supervision. Using the subsequent interview procedure may have allowed more individualised understanding of how self-disclosure is used in actual practice, therefore, increasing the breadth of findings, and minimising the potential problems arising from 'idealised' q-sorts.

The study's approach shares similarities with other the research with the same methodological model (Lazard, Capdevila & Roberts, 2011) in that the use of both Q methodology and thematic analysis produced a deeper and more valuable analysis than would have otherwise been possible. These similarities as both studies undertook a pattern analytic, and relevant themes were identified. In doing this allowed for researchers to theoretically reframe the boundaries around our object of knowledge (supervisee self-disclosure) to include both Q methodology and thematic analysis which in turn allowed for a subtler understanding of the research aims and implications in a real-world setting.

Clinical and Research Implications

The results highlight an important and relevant message for both trainee' high-intensity therapists, supervisors and academic institutions providing training in that self-disclosure is an important component of supervision as it provides a vehicle to collaboratively problem solve, develop skills and maintain wellbeing in a therapist. It also provides means to develop the supervisory relationship and the findings of this study mirror

previous research around the important characteristics and clinical skills that supervisors should demonstrate to nurture self-disclosure with their supervisees (Davidson, 2011; Knight, 2014; Knox, Edwards, Hess & Hill ,2011; Ladany & Walker, 2003; Ladany, Walker & Melincoff, 2001). The study also provides subtle indications that self-disclosure is something that requires time, promotion and encouragement from both supervisors and training course providers as the therapists who participated in the study identified this as being a potential barrier and with the added real-world practical issues of working within a primary care setting and studying full-time. A potential resolution to these issues in the clinical context could be around increasing the promotion of positive supervisory relationships and by proxy self-disclosure through regular discussion in supervision, training and experiential learning tasks. Also, with the research recently completed by Milne and Reiser (2016) presenting further support for the implementation of an evidence based approach to supervision and its training could provide a more effective approach towards address this and the others points raised from this research.

Replication of this study in other Post-graduate training courses with a larger and more diverse sample would be recommended to expand upon and validate the study's findings. It would be beneficial to explore this transition of therapists from a low-intensity background to identify how this experience of clinical case management supervision impacts the acceptability and expectations around CBT clinical supervision and self-disclosure in training and practise. Regarding overall and ongoing efficacy it would be useful to revisit the q-set to refine further and develop the statements in light of the current results to allow for more explicit and representative content to successfully tap and frame the viewpoints of participants. Another future consideration would be to expand the sample population by recruiting clinical supervisors, course leaders and qualified therapists and clinicians.

In terms of future research it would be useful to revisit the q-set to refine further and develop the statements to allow for more explicit and representative content to successfully tap and frame the viewpoints of participants. Ordinarily, q-methodology would involve initial interviews with participants to help to develop the q-set statements, however this was not possible in the current study due to the restricted turnaround for the project as an MSc dissertation study. The current results could however be used to refine the statements for further studies.

Conclusion

In conclusion, this was the first study to investigate trainee high-intensity therapists views of the use of self-disclosure in clinical supervision using Q-Methodology and Interview methodology. Following analysis of the q-sort data a consensus factor with a specificity within it was identified and endorsed that most participants shared similar views on the current, continued moral and ethical importance of self-disclosure and the role it has on individual professional practice, personal wellbeing and the supervisory relationship. An inductive thematic analysis of the interview data identified four themes around self-disclosure. The study identified that all participants held a similar positive and acceptable view of the use of self-disclosure with subtle nuances around the anxieties and practicalities that can influence its use both in training and professional practise.

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Appendix A

Final Q-Set Statements

1. Time pressures of clinical supervision mean that self-disclosure is not a priority.
2. Self-disclosure is a hard thing to do in supervision.
3. Therapists are less likely to self-disclose in supervision if clinical and managerial supervision are combined.
4. A supervisor would view a therapist as less competent if they disclosed something personal in clinical supervision.
5. If therapists believe something went wrong during therapy then they should disclose this in supervision.
6. Therapists are more likely to self-disclose in individual supervision compared to group supervision.
7. Self-disclosure in supervision improves treatment outcomes for clients.
8. Self-disclosure in supervision is important for the therapists own personal well-being.
9. Therapist self-disclosure would negatively influence the supervisory relationship.
10. Self-disclosure is unnecessary in supervision.
11. A positive supervisor-supervisee relationship is the most important factor in encouraging therapists to self-disclose.
12. Therapists are more likely to self-disclose in supervision if their supervisor is warm and empathetic.
13. Therapists would be wary about self-disclosure in supervision.
14. Therapists should disclose personal information in supervision if it is relevant to their work.
15. Therapists are more likely to self-disclose in supervision to supervisors with more clinical experience.
16. Therapists are more likely to self-disclose in supervision to supervisors who practise more relational therapies (e.g. psychotherapy, cognitive analytic therapy).
17. Self-disclosure in supervision is not important for therapists who practise cognitive behavioural therapy.

18. Therapists should discuss client-therapist relationship dynamics in clinical supervision.

19. Self-disclosure makes supervision more authentic.

20. Therapists should disclose in supervision positive or negative feelings that they may have towards clients.

21. Self-disclosure in supervision improves therapist self-discovery.

22. Therapists are encouraged to use self-disclosure in supervision.

23. Self-disclosure in supervision can have negative consequences for a therapist's career.

24. Disclosing relevant personal information in supervision is concerning as it oversteps personal boundaries.

25. Self-disclosure is more important for qualified therapists than Trainees.

26. Self-disclosure reduces therapist anxiety.

27. Supervisors should model self-disclosure in supervision by disclosing their own relevant experiences.

28. Self-disclosure in supervision promotes therapist reflection.

29. The supervisor-supervisee power imbalance negatively impacts therapist self-disclosure.

30. Therapists and supervisors should have a supervision contract which outlines the agreed boundaries around future self-disclosure.

31. The supervisor-supervisee relationship is stronger following self-disclosure.

32. Therapists should discuss their own emotional reactions to client's stories in supervision.

33. If a client makes derogatory comments towards a therapist, this should be disclosed in supervision.

34. Therapists should discuss professional moral dilemmas in supervision.

35. Therapist insecurity would make self-disclosure in supervision less likely.

36. Having dedicated supervision time which is free from interruptions is important for promoting self-disclosure in supervision.

37. Frequent changes in supervisor discourages therapist self-disclosure.

38. Perceived differences in supervisor-supervisee cultural or demographic variables (e.g. age, gender, ethnicity, sexual orientation) would discourage self-disclosure.

39. Therapist self-disclosure in supervision would make other workplace interactions with the supervisor uncomfortable.

40. Self-disclosure to a colleague would be preferred over self-disclosure in supervision.

41. Previous unsuccessful self-disclosure would discourage therapists from future self-disclosure in supervision.

42. Therapists' feelings of shame discourage self-disclosure in supervision.

Appendix B

Post-Sort Questions and Semi-Structured Interview Schedule

Post Sort Questions

1) Please explain why you rated these items at +5

2) Please explain why you rated these items at -5

3) Are there any other items you would like to comment on?

Semi structured interview schedule:

1) Do you have any general thoughts or reflections on the process of completing the q-sort task for this issue?
2) What is your view of the general purpose of clinical supervision?
3) What are your general views on supervisee self-disclosure in supervision?
4) What are your general views on supervisor self-disclosure in supervision?

Appendix C

Ethics Approval & Amendment Forms