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COUNTERTRANSFERENCE DISCLOSURE IN TRAINEE PSYCHOTHERAPISTS: IMPLICATIONS FOR SUPERVISORY LEARNING

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A research dissertation submitted in partial fulfilment of the requirements for the degree of MA by Coursework and Research Report in the field of Clinical Psychology in the Faculty of Humanities, University of the Witwatersrand, Johannesburg.

November 2008

DECLARATION

I declare that this dissertation is my own, unaided work. It has not been submitted before for any other degree or examination at this or any other university.

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Karen Lee Berger

21 November 2008

ABSTRACT

This study investigates a specific aspect of the supervisory alliance between trainee psychotherapists and their supervisors: the phenomenon of countertransference disclosure. The study explores the emotionally conflicting role in which supervisees are placed, as they are required to appear capable for their patients and for assessment purposes, whilst still admitting to professional ignorance to their supervisors for educational purposes. Supervisees are required to disclose their countertransference reactions to their patients in the presentation of case material, as well as their emotional reactions to their supervisors within the supervision context. A questionnaire developed by the researcher was answered by fifteen past university students who completed the Clinical Master's psychology course provided by the University of the Witwatersrand (Wits) between the years 2005-2007. Thematic content analysis was conducted in order to analyse the data. The results showed that supervisees chose to fully disclose, selectively disclose or completely withhold such information. All fifteen participants acknowledged that the strength of the supervisory alliance was the main contributing factor to disclosure or nondisclosure of information. The participants who experienced weak alliances with their supervisors felt that their psychotherapy training was compromised and their potential as training psychotherapists was not fulfilled. It is important that supervisors are cognisant of the fact that supervisees are less likely to disclose information if they do not feel secure in their alliance, which, from the supervisees' perspectives will negatively impact upon their training.

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CHAPTER ONE: INTRODUCTION

1.1 Introduction

Long-term psychotherapy supervision occurs in a triad: Patients unload their painful feelings onto their therapists and expect containment; therapists similarly unload their feelings onto the supervisors and expect containment and understanding (Gabbard, 2004). This triadic relationship is particularly significant in training institutions that utilise supervision as a main tool for training psychotherapists. Supervision, together with its complicated underlying dynamics, has thus become the focus of many studies (Gabbard, 2004).

This study investigates the dynamics of the supervisory alliance between trainee psychotherapists and their supervisors. In doing so, the study assesses the emotionally conflicting role in which supervisees are placed: They are required to appear capable for their patients and for assessment purposes. At the same time they are required to acknowledge professional ignorance and mistakes in order to learn. Through their presentation of case material to their supervisors, supervisees are required to disclose their countertransference reactions to patients. However, depending on the strength of the alliance between the supervisees and supervisors, supervisees may not feel safe enough to disclose difficult or negative feelings.

Transference and countertransference feelings that arise in supervision are discussed, along with the dynamics of the supervisory working alliance, and the contribution the supervisor makes to either a strong or weak alliance and thus to either disclosure or nondisclosure. The implications of supervisee nondisclosure on learning are also considered.

1.2 Research Aims

The aim of this study is to assess the extent of self-disclosure of trainee psychotherapists in the supervisory context, possible reasons for avoiding self-disclosure, and the implications of this for the learning process in supervision. The research questions this project addresses are as follows:

Question 1: To what extent do trainee psychologists withhold information in the context of psychotherapeutic supervision?

Question 2: What type of information is not disclosed and what stated reasons are given for not disclosing it?

Question 3: What conditions facilitate or restrict self-disclosure within the supervisory context?

Question 4: What are the possible implications of selective information disclosure in the context of supervision for trainee psychologists?

1.3 Rationale

The University of the Witwatersrand (Wits University) trains clinical psychologists using the psychodynamic approach. This approach requires process notes, self-disclosure, and investigation of the feelings elicited in the trainee psychologist in the course of interactions with psychotherapy patients as well as with supervisors. Trainee psychologists in supervision are expected to acknowledge mistakes, poor interventions, and difficult or uncomfortable thoughts and feelings evoked by interactions with patients. Various factors may affect the supervisory relationship, and hence influence the degree of trainee psychotherapist disclosure. In this study, the extent to which supervisees are open in their disclosure; the nature of the information they choose to disclose or withhold; and their subjective reasons for disclosing or withholding such information will be considered. The supervision considered in this study refers to first year Clinical Psychology Master's students (M1) who received psychodynamic psychotherapy training at Wits University, as well as second year Wits Master's students (M2) who were completing their hospital internship requirements. Supervision refers to individual and group supervision in both settings.

Psychotherapy supervision is the process where "experienced clinician-practitioners sit with those who are training to be members of that same discipline, and discuss with the students their work with patients or clients" (Greben, 1991, p.306). In order to facilitate effective psychotherapy supervision, a strong supervisory working alliance between supervisees and supervisors needs to be established. This supervisory alliance is essential for productive

supervision and therapeutic learning and development for training psychotherapists. The supervisory alliance occurs when supervisees and supervisors have successfully agreed upon the goals for supervision, the tasks for supervision, and have established a strong emotional bond (Ladany *et al.*, 2006). Furthermore, in order to ensure that the alliance continues to grow and to strengthen as the relationship progresses, both need to have agreed to 'the rules' of the supervision process, thus allowing for open communication (Ladany *et al.*, 2006). This open communication, however, is often compromised by anxieties and emotions evoked within the supervisory relationship. In turn, this may negatively impact upon on the trainees' willingness to fully disclose, thus impacting upon their learning and development as professional psychotherapists.

The supervision relationship is a complex one. While in some respects the supervisory alliance is similar to the therapeutic alliance, in other respects it differs. Supervision by nature invites confusion and supervisee transference into the room, as supervisors encourage supervisees to disclose their personal feelings and emotions with regard to their patients and supervisors. Furthermore, the supervisees are encouraged to consider the personal experiences that have influenced their emotional and therapeutic reactions both in therapy and in supervision (Ivey, 2007). However, limitations and boundaries are clearly set within the supervisory relationship, restricting the exploration of supervisees' feelings, attitudes and experiences to those directly relevant to their therapeutic work with particular patients. Supervision, notes Mander (2002) "may thus elicit, identify and highlight the therapist's own personal countertransference, while prohibiting in-depth exploration of this. Supervision thus involves an ambiguous relationship, one comprising both intimacy and abstinence" (in Ivey, 2007, p.59). In other words, supervisees are encouraged to self-disclose and reveal their emotions openly (as in personal therapy), but only in relation to the supervisory task (Ivey, 2007). This highlights the "teach versus treat dilemma in which supervisors have to decide at what level and in what detail to take up supervisees' complexes and conflicts, implicit in their countertransferences to patients and their transferences to supervisors, without the supervisory focus becoming a therapeutic one" (Ivey, 2007, p.58). Whilst Solnit (1970), cited in Ivey (2007), maintains that supervision needs to remain more a teaching relationship than a treatment one, some authors argue that the supervisory relationship should be flexible in this regard. The supervisory relationship, it is claimed, should act as a model for the analytic process as "it encompasses exploration of relational patterns alive in both the supervised

treatment and in supervision", which thus involves "some blurring of teaching and 'treating'" (Frawley-O'Dea & Sarnat, 2001, cited in Ivey, 2007, p.58).

The supervisory relationship may elicit supervisees' narcissistic vulnerability, and their attempts to defend against this. As a training therapist, the supervisee "is caught between the patient's intense criticism on the one hand and the supervisor's disapproval on the other, so that his beleaguered areas of healthy self-esteem very much need our [the supervisors'] support and encouragement" (Searles, 1962 in Gill, 1999, p.229). Narcissistic vulnerability thus arises when supervisees receive negative transference from their patients, and simultaneously fear negative feedback from their supervisors. It occurs when the supervisees are confronted with having to deal with the dual (often conflicting) role of the ideal self and 'experienced self', wherein "the former is an image of oneself that satisfies a specific ideal, and the latter is an image of oneself as one thinks one is" (Schafer, 1967, cited in Gill, 1999, p.228). Supervisees have the task of integrating the two images of themselves: the image of how they view themselves at present ('experienced self') and the image of how they would like to be ('ideal self'). These two opposing identifications are highlighted and sensitised in the supervisory relationship, with the conflicting requirements of professional and personal disclosure, fostering the experience of a sense of inadequacy, anxiety and inhibition known as narcissistic vulnerability (Gill, 1999).

Whilst narcissistic vulnerability is considered to be an inevitable and essential part of the supervisory process for supervisees, the attendant anxiety may lead supervisees to feel the need to protect themselves in supervision through non-disclosure, whether in the context of case material and process notes of their therapeutic interactions with their patients, or personally with their supervisors. One must consider the exposing nature of a supervision relationship, wherein a "non-narcissistic person can sound arrogant or devaluing or empty and idealizing under conditions that strain his or her identity and confidence... psychotherapy training programmes are famous for taking successful, autonomous adults and making them feel like incompetent children" (McWilliams, 1994, p.185).

Thus, when engaging in an exploratory evaluation of the levels of disclosure of psychotherapy trainees in the supervision alliance, one must be sensitive to the particular nature of the supervisory relationship and the vulnerable, self-exposing emotions that it elicits for supervisees. Further, one must be sensitive to the power discrepancy inherent in the supervisory relationship, wherein supervisees are cognisant of being assessed by supervisors, and yet are expected to disclose to professional ignorance, without reciprocation in the form of supervisor disclosure (Ivey, 2007).

Supervision is an integral part of any therapeutic process, and effective supervision is a vital component to the training of beginner psychotherapists. Therefore, there have been a number of studies that attempt to ascertain the extent of openness in supervision (Ladany *et al.,* 1996). Most of this research, unlike the present study, has focused primarily on the supervisors' perspectives in order to ascertain possible reasons for supervisee nondisclosure (Crick, 1991 in Webb, 2000). A study by Webb (2000), however, aimed to investigate the supervisees' perspective. This investigation gathered information through the Supervisory Working Alliance Inventory (SWAI), a quantitative measure of collecting data designed by Efstation *et al.,* 1990 (in Webb, 2000). The participants in Webb's (2000) study were required to rate aspects of the supervisory relationship according to the likert-type scale of the SWAI.

The current study, however, has adopted a qualitative approach to gathering data. Information is based on a researcher-developed survey comprising open-ended questions (see Appendix 2). Thus the data focuses on personal, subjective motivations for participants' use of selective self-disclosure in supervision, and gives insight into supervisees' subjective experiences during their psychotherapy training. It sheds light on the dynamics of the supervisory relationship.

Whilst Wallace & Alononso (1994, p.212) acknowledge that the omission of case material on the part of the supervisee can lead to "diminished clinical effectiveness and loss of key learning opportunities that occur through exposing mistakes as well as 'hidden' strengths", in general there appears to be a paucity of information regarding the various implications of

supervisee nondisclosure for supervisory learning (from the perspective of the supervisees). Yourman (2003) found that while supervisees are generally open to disclosing their work to their supervisors for the purposes of optimising their learning experiences, "psychotherapists-in-training usually have many supervisors over the course of their studies, and in some of the relationships trainees are likely to be less disclosing than in others" (p.608). Supervision is an integral part of the Wits University Clinical Master's M1 and M2 years of psychotherapy training. During this time supervisees are exposed to a number of supervision experiences. In this context it is thus essential to establish the possible implications of supervisee nondisclosure on supervisory learning, if any, from the subjective perspectives of the supervisees.

1.4 Summary of the Report

This research report explores the reasons for supervisee nondisclosure in supervision, regarding countertransference reactions to patients and transference reactions to supervisors, and the impact this has on supervisory learning. A literature review, presented in Chapter Two, considers the various factors that contribute towards supervisee disclosure. These factors include:

- Supervisees' perceptions regarding their countertransference reactions to their patients;
- Possible feelings of shame and fear of judgement from their supervisors regarding such reactions;
- Supervisees' conflict between needing to present themselves as competent psychotherapists to their supervisors and simultaneously admitting ignorance and error for the purposes of learning;
- The strength of the supervisory alliance in the context of which the supervisees feel safe to disclose such errors;
- The supervisors' ability to address conflicting emotions in a non-punitive manner so as to strengthen the supervisory alliance and elicit optimal disclosure.

The research method is qualitative in design. The participants were previous Clinical Psychology students who attended Wits University between the years 2005-2007 and received psychodynamic training. Data was collected as follows: Potential participants were first contacted telephonically. Those who were receptive to the research were then sent the information letter (see Appendix 1) and the researcher-developed survey (see Appendix 2), which they were required to complete. Whilst twenty participants initially agreed to participate in the research, fifteen participants returned the questionnaires, which were then retyped in word-format (see Appendix 3). In returning the questionnaires, the participants provided the consent needed for participation. The research method is described in greater detail in Chapter Three.

The main overarching theme, supported by all participants, was that the supervisory alliance contributes to supervisee countertransference disclosure. In addition, two main themes and twelve sub-themes were identified. The themes that emerged are reviewed with reference to the transcribed data, in Chapter Four. In Chapter Five, these themes are used to support some of the claims made in the literature discussed in Chapter Two. Limitations of the research are considered in this chapter, as are suggestions for future research.

All fifteen participants agreed that the strength of the supervisory alliance contributes to supervisee disclosure, whether it be of countertransference reactions to the patient or of transference reactions in supervision. Furthermore, the participants agreed that the level of disclosure impacted upon their supervisory learning experience during their M1 and M2 years of training. The researcher concludes that a strong supervisory alliance is vital in order to ensure that supervisory learning is optimised. Such an alliance entails a safe, facilitative environment, created by both the supervisor and supervisee, wherein the goals and boundaries of the supervision are explicitly set, thus contributing to the minimisation of experiences of vulnerability on the part of the supervisee.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

Psychotherapy supervision is "an intensive, interpersonally focussed, one-to-one relationship in which one person is designated to facilitate the development of therapeutic competence in the other person" (Ivey, 2007, p.46). It is discussed in relation to the experience of trainee psychotherapists. Possible factors contributing to disclosure or nondisclosure in the supervision context, such as supervisees' feelings of professional competency and self-esteem are explored. It is shown that the supervisee's vulnerability in the supervisory relationship is "in many ways similar to the patient's vulnerability in the therapeutic relationship. Therefore, we can speak of a *supervisory alliance* that has much in common with the therapeutic alliance" (Gabbard, 2004, p.176). The dynamics of the supervisory alliance between supervisee and supervisor are thus examined. These dynamics include: transference and countertransference between supervisee and supervisor; the role the supervisor plays in developing a strong alliance; and the subsequent disclosure of both countertransference reactions of the supervisee to the patient as well as transference reactions within the supervision process.

2.2 Transference and Countertransference

Transference is the process where patients unconsciously transfer past, unresolved feelings and experiences from significant relationships onto their relationships with therapists. Similarly, therapists develop transference relationships with their supervisors and transfer unresolved conflicts from the past onto the 'here-and-now' relationships with their supervisors. Through exploration of these dynamics, therapists can gain insight into their patients' unresolved conflicts as well as their own (Lemma, 2006). Countertransference is the process where the patient's conflicts and feelings in relation to the therapist resonate with and elicit the therapist's own emotional reactions. Similarly, the supervisor's countertransference is elicited in response to the therapist's transference. Freud conceptualised countertransference as the manifestation of the therapists' own 'blind spots' (Lemma, 2006). The original theory of countertransference was that it occurs when therapists unconsciously transfer their own unresolved conflicts from the past onto their patients (Salzberger-Wittenberg, 1975). A shift occurred, however, in the conceptualisation of countertransference. Therapists now regard countertransference as inevitable and also as an

essential tool for the therapeutic process. Countertransference is considered to be a guide for therapists to their patients' unspoken, unconscious feelings and allows them to have access to their patients' internal worlds through their own reactions to their patients' presence and feelings (Lemma, 2006).

Supervision is thus an essential part of the therapeutic process for trainee therapists. It is necessary for therapists and supervisors not only to consider the patients' transferred feelings in therapy and their implications for the process, but also to discern whether the countertransference feelings elicited in the sessions are due to the therapists' own unresolved conflicts or are a reaction to the patient's transferred feelings. Thus the transference to supervisors may convey information about the dynamics of the therapists' transference-countertransference relationship with the patients, the supervisors' countertransference to the therapist, or the therapists' own unresolved conflicts that need to be dealt with in personal therapy. By addressing the countertransference issues that occur in therapy "the supervisor aids the resident in freeing himself from responses that limit therapy" (Book, 1987, p.556). Furthermore, "when understood the countertransference may function as an empathic tool, allowing the resident to understand otherwise uncommunicable intrapsychic experiences of his patient" (Book, 1987, p.556). Over the years there has been a gradual movement away from focusing solely on the patients' difficulties in clinical supervision, towards focusing as well on the therapists' countertransferences (Book, 1987). Similar to feelings transferred from patients onto therapists, therapists' countertransference feelings can include love, hatred and sexual interest (Wallace & Alonso, 1994). However, beginner therapists can become embarrassed by intense feelings towards their patients, as "they view their feelings as inappropriate, rather than as valuable pieces of information that enhance understanding of both patient and therapist" (Wallace & Alonso, 1994, p.222). Consequently, beginner therapists may be inclined to withhold such reactions, fearing that they have reacted unacceptably to their patients and will be judged accordingly by their supervisors. This phenomenon will now be explored in greater detail, along with its implications for supervisory learning in a teaching facility for training psychotherapists.

2.3 Supervision and the Working Alliance

Considerable emphasis is placed on the role of the supervisory relationship in both the Wits Masters first year programme and the second year hospital internship programme. The underlying expectation of supervision in these contexts (as with all psychotherapy supervision) is that the trainees are required to disclose information pertinent both to their clinical interactions with their patients and the supervisory context itself (Pisani, 2005).

Within the supervision process there are a number of different approaches to ways in which supervisors and supervisees can focus on the analytic material of the supervisees and patients. There is patient-centred supervision, transference-countertransference supervision and an approach that combines these two (Fink, 2007). Furthermore, the data included in supervision depends on the training centre. For example, some encourage the use of videotapes, audiotapes or detailed process notes (Gabbard, 2004). The approach adopted at Wits University, and thus considered for this discussion, utilises all of the above data. It combines a patient-centred and a transference-countertransference approach to supervision, in that the conscious and unconscious dynamics of both the patient and therapist are considered and discussed. This approach is adopted in order to understand better the patient's unconscious dynamics and the therapist's reaction to them, in the attempt to further the therapeutic objectives of the patient. This will be considered further in the discussion of transference, countertransference and parallel processes.

During the supervision hour, supervisees present their accounts and impressions of their patients and sessions. Supervisors listen to these accounts and formulate their own thoughts and fantasies about what has been presented. Thus a "double fantasy" has taken place, first through "the student's ideas regarding his work and his patient and second, the fantasy that the supervisor develops about what he is being told by the student" (Fink, 2007, p.1265). Consequently, the 'real' patient is not truly known by the supervisor, rather, the "supervisor's patient" is known only through an interaction of what the supervisee brings to the supervision session, and the supervisor's interpretation thereof. Thus, in many ways, patients brought to the supervision sessions are not the patients in the therapy room; rather, they are "the joint creation of the student and his supervisor" (Fink, 2007). It is necessary to bear this 'co-

creation of patients' in mind when considering the level of supervisee countertransference disclosure, and the subsequent impact on learning for the therapeutic process.

The underlying tenet of clinical supervision, however, regardless of the theoretical approach, is that it is:

> "an intervention that is provided to a junior member of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the junior member(s), monitoring the quality of the professional services offered to the clients she, he, or they see(s), and serving as gatekeeper for those who enter that particular profession" (Bernard & Goodyear, 2004, p.4).

In the context of this relationship, the imbalance of power and self-disclosure between supervisor and supervisee creates a sense of vulnerability on the part of the supervisee. This feeling of vulnerability is similar to that experienced by patients in the face of their open and complete disclosure in contrast with therapists' nondisclosure (Ivey, 2007). As a result, in the supervisory context there are "similar regressive transference pressures, with the supervisor often unconsciously cast as a parental figure from the supervisee's childhood past" (Ivey, 2007, p.48). The regressive aspects of the supervisory alliance and its impact on supervisee countertransference disclosure will be considered in greater detail later in the discussion. A further similarity between the supervisory alliance and the therapeutic alliance is that a relatively conflict-free environment of mutual respect can be established, allowing for differences to arise during the supervision without jeopardising the whole relationship (Book, 1987).

The role of the supervisor and supervision, especially for beginning therapists, offers hindsight for what has been missed in the session, as well as foresight regarding what can be expected to occur in the following session with a patient (Casement, 1985). However, trainee psychotherapists may rely too heavily on the advice given to them in the supervision session, resulting in a therapeutic "barrier" between the therapist and patient (Casement, 1985, p.30).

As a result of anxieties related to feelings of inadequacy and incompetency, (which will be examined in greater detail later in the discussion), trainee therapists may tend to rely solely on the advice given within the formal supervision context, without utilising personal skill and technique (Casement, 1985). Consequently, "formal supervision alone does not adequately prepare a student to deal with the immediacy of the therapeutic present" (Casement, 1985, p.30). Accordingly, due to performance anxieties, trainees may hold themselves back in the therapy session, relying solely on the advice given by the supervisor. This could result in a poor quality of intervention with the patient, uninformed by the immediate process in the room. An unsatisfactory interaction of this nature might further contribute to the trainees' cyclical pattern of performance anxiety and dissatisfaction regarding the supervision process. In order for successful therapy and supervision to occur, trainee psychotherapists need to develop an "internal supervisor" (Casement, 1985, p.30). The concept of an "internal supervisor" corresponds to the trainees' ability to analyse the therapeutic interaction between themselves and the patients *during* the course of the session, and to utilise adequate interventions accordingly. The function of the "internal supervisor" is "to hold the analyst (or therapist) who is learning to hold the patient... which can help the therapist to find an inner play-space where the clinical options can be explored (silently or with the patient) rather than remaining blinkered by past thinking that often functions too much like a set of rules" (Casement, 1985, p.27).

A requirement of the Clinical Psychology Master's Programme at Wits University is that trainee psychotherapists receive psychotherapy during the course of their training. This is an important part of the training process for several reasons: Firstly, it is necessary that the trainee psychotherapists continue to develop personal insight into their own unresolved conflicts, for personal growth as well as to identify transference-countertransference dynamics. Secondly, it is through their personal experiences of being a psychotherapeutic patient "that therapists establish the first roots of what later becomes the internal supervisor. Something is added to this in each phase of training and subsequent clinical work" (Casement, 1985, p.31). Thus, through the experience of complete vulnerability as a patient, which is then mirrored in the experience of supervision, trainee psychotherapists learn to identify feelings that recur within the psychotherapeutic settings (through transference-countertransference dynamics), and use these experiences to formulate psychotherapeutic interventions.

In order to enable effective and constructive supervision, a strong supervisory working alliance needs to be established between supervisor and supervisee. Three essential components are "the quality of relational bond between the two individuals, agreement of common goals and objectives and engaging in work" (Schultz, 2008, p.37). Investigations into the supervisory alliance have led to the question of what contributes to, or hinders, supervisees' ease with disclosing information – particularly personal information, such as feelings of comfort and competence within the supervision itself (Pisani, 2005). An essential component of the supervisory alliance is the emotional bond between supervisors and supervisees, and the way in which the power dynamic is utilised (or perceived to be utilised) between them (Schultz, 2008). Supervisees are not only cognisant of the power discrepancy inherent to the supervisory relationship, they are also aware of being assessed by the supervisors. However, in spite of this, they are still expected to disclose professional ignorance, without reciprocation from the supervisors in the form of supervisor disclosure (Ivey, 2007). This power discrepancy may be maximised or minimised, made explicit or remain implicit within the boundaries of the working relationship, depending on the personal alliance between supervisor and supervisee. However, a common aspect of all the relationships is that the supervisors are expected to evaluate supervisees, formally through academic assessments or informally by means of feedback. Supervisors are thus considered the "gatekeepers with a higher obligation to the profession and society, they have authority to determine whether supervisees meet criteria formally set forth by the profession" (Murphy & Wright, 2005, p.284).

If the supervisory alliance is not a strong one, the power difference between the two can be utilised in an abusive manner on the part of the supervisor, or can be experienced as abusive by the supervisee. Forms of power abuse on the part of the supervisor can include "over-focussing on supervisee mistakes, psychopathologising the supervisee, verbally attacking the supervisee, assigning excessive caseload to a supervisee without adequate supervision, using supervision to meet a supervisor's social-emotional needs, and forcing supervisees to adhere to a supervisor's theoretical framework" (Murphy & Wright, 2005, p.284). In the event that supervisees fear a supervisor's abuse of power or perceived abuse of power, this can contribute to the withholding of important information regarding patients and psychotherapy sessions (Murphy & Wright, 2005).

There are four ways in which power discrepancy can manifest in the working alliance between supervisor and supervisee: reward power; referent power; coercive power; and legitimate and expert power (Schultz, 2008). Reward power takes place when the supervisor exercises power over the supervisee through the offering of a reward (Schulz, 2008). An element of this may manifest in the supervisory working alliance during the M1 and M2 years at Wits. During this period supervisees experience a need to perform in the face of assessment by supervisors and attainment of academic and professional appraisals. In other words, the supervisees are rewarded for their developing academic and professional proficiency in the field of psychotherapy through formal and informal grading and appraisals throughout the two years of the course. Consequently, depending on the strength of the alliance between supervisor and supervisee, the supervisor may utilise this power to influence the behaviour and performance of the supervisee, or the supervisee may perceive this power to be so utilised.

The second form of power that may occur within the supervisory alliance is referent power, which becomes active when supervisees perceive some similarity between themselves and their supervisors, on a level that is considered to be important to the supervisees (Schultz, 2008). In this way, the interaction between supervisees and supervisors is similar to the therapeutic alliance, in that patients attempt to adopt from therapists what they perceive they lack, such as insight, mental stability, self-acceptance, etc. (Ivey, 2007). The third power dynamic between supervisee and supervisor is coercive power, involving an abuse of power on the part of the supervisor, in which punishment of the supervisee is utilised within the relationship (Schultz, 2008). Lastly, legitimate and expert power occurs when a strong supervisory alliance has developed between supervisee and supervisor. The different roles and goals within the relationship have been clearly defined and respected. Thus, both parties within the alliance recognise that supervisors have a right to guide the behaviour of supervisees by virtue of their position (legitimate power). The resultant therapy conducted by supervisees is influenced by the supervision, by virtue of the supervisees' recognition and respect for the supervisors' authority and expertise in the field (expert power) (Schultz, 2008). The acknowledged role and authority of the supervisors through a strong alliance will thus contribute toward supervisees' open countertransference disclosure.

Another factor that has been found to contribute towards supervisees withholding information is the perceived difference experienced on the part of the supervisees and/or supervisors regarding age, race and gender. As with the therapeutic alliance, these demographic factors can either contribute to strong alliances within the supervision dyad or towards a weak relationship, thus further impacting upon the level of supervisee disclosure. Previous research has found that these demographic factors are strong influences in affecting the alliance between supervisee and supervisor. As Pisani (2005, p.41) noted in her research, "two respondents indicated that they were not comfortable discussing issues of racism within their agency". Furthermore, Granello (2003, p.200) found that supervisors "use different strategies with their male and female supervisees, leading to different supervisory experiences". Thus, based on perceived supervisee experience, male supervisees may choose to either disclose or withhold information more than their female colleagues as a result of their experience of different treatment from their supervisors. Granello (2003, p.200) further found that age was a contributing factor to supervisees' experiences of supervision, where "supervisors may treat their older supervisees very differently based on gender and that older supervisees react differently based on gender". Thus, one may assume that supervisees' gender, age and race are contributing factors to their experiences of supervision, thus affecting the supervisory alliance and subsequent disclosure of information within the supervision context.

2.4 The Role of Transference-Countertransference in Supervision

Within the supervisory alliance, both supervisee and supervisor need to be aware of their own respective transference-countertransference responses to the material brought to the session. For example, the supervisor needs to be aware of "his unconscious needs to be admired, to show off, to prove himself better than the resident, or to intimidate" (Book, 1987, p.557). Similarly, the supervisor might be responding to the supervisee's countertransference of admiration and feelings of intimidation. This can only be distinguished by the supervisory dyad once a strong alliance has been established, and the transference-countertransference responses to the material can be explored (Book, 1987).

There are a number of ways in which the transference-countertransference in the supervisory relationship occurs and can be explored. These include the 'only or never phenomenon',

introspective curiosity and parallel processes (Book, 1987). The 'only or never phenomenon' involves the selective reporting of therapeutic material during supervision, to which the supervisor needs to be sensitive. For example, a supervisee might choose to *only* focus on sexual difficulties with a patient whose core difficulties are not sexual in origin in order to (consciously or unconsciously) avoid or deny the core difficulty of the patient (Book, 1987). On the other hand, a supervisee may *never* report the sexual material elicited in the therapeutic process with a patient whose core problems do appear to be sexual in origin. Thus, through the supervisee's avoidance of the patient's core problem in psychotherapy, either through an incorrect focus or through a denial in the focus, the supervisor may identify a possible countertransference difficulty. It must be borne in mind, however, that an incorrect focus on the part of the supervisee on the patient's presenting problems could be related to inexperience rather than countertransference avoidance (Book, 1987).

Another way in which supervisees' countertransference can be identified in the supervision is through encouraging introspective curiosity, so that supervisees become aware of their own responses to patients (Book, 1987). Supervisees who develop their own 'internal supervisor' (discussed previously) may become more sensitive to patients' internal worlds and emotional experiences through their countertransference reactions in the therapy processes (Book, 1987).

According to Ekstein & Wallerstein (1972, cited in Pisani, 2005, p.30), "the most notable process thought to affect the supervisory experience is known as parallel process, wherein the supervisory relationship closely reflects dynamics that characterise the psychotherapeutic process". The parallel process within the supervisory alliance is considered to occur when the dynamics that characterise the psychotherapeutic relationship between therapist and client are unconsciously re-enacted between the supervisee and supervisor (Pisani, 2005). This process affects the way in which supervisors address the transference-countertransference issues elicited in the supervision (Pisani, 2005). For example, just as the countertransference between therapist and patient gives the therapist insight into the patient's internal world and feelings through the therapist's own feelings and reactions to the patient, so too can the process of countertransference within supervision give supervisees and supervisors insight into the unconscious processes occurring within the therapeutic relationship. Furthermore, as

with the therapeutic relationship, unconscious unresolved conflicts and emotions are elicited within the supervisory relationship, not only as a result of the supervisees' interaction with their psychotherapy patients, but as a result of their interaction with their supervisors as well, due to the supervision requirement that the supervisees reveal both their professional and personal emotions and reactions (Ivey, 2007).

Whilst attention to the parallel processes occurring in the supervisory relationship can be a useful tool to understand the dynamics of the patient/therapist and therapist/supervisor, it can also manifest as a resistance to the transference and countertransference occurring within the supervisory dynamic (Ivey, 2007). It is "the supervisory equivalent of some therapists' default tendency to attribute their countertransference feelings or deviations from the analytic attitude to the patient's projective identifications, rather than first seeking their own psychological contribution to these situations" (Ivey, 2007, p.66). There are a number of reasons why supervisees choose to resist (consciously or unconsciously) the analytic process of exploring their countertransference reactions to their patients, choosing to rather project these reactions onto the supervisory relationship. Supervisees have a need to self-protect within the supervision, and do not want to expose themselves and their perceived faulty therapeutic interventions to their supervisors. The possible contributing reasons for supervisee nondisclosure and the impact of countertransference and supervisee self-exposure on supervisory learning will now be considered in greater detail.

2.5 Narcissistic Vulnerability of the Supervisee

According to Gill (1999), supervision is emotionally hazardous because the process of self-disclosure and vulnerability is so prevalent within the supervisory alliance. Tischler (1968) refers to the vulnerability in the supervisory context, which "leads to censoring process material and careful selection of cases for presentation" (in Gill, 1999 p.229). Previous research has found that training psychotherapists have admitted to screening what they have disclosed in their supervision sessions, and have reflected that their respective disclosures were greatly dependent upon how safe they felt with supervisors (Gill, 1999). This finding is supported by research conducted by Brightman (1984), who found that a powerful determinant regarding trainees' level of disclosure could be directly linked to their perceived

satisfaction with their respective supervisors and the level of clinical training. The trainees interviewed in Brightman's (1984) research all maintained that they had:

> "found something 'special' in their relationship with at least one of their supervisors... he/she really seemed to understand, respect, and care about me and how my training was going... he/she was an excellent clinician whom I admired and would wish to be like professionally" (pp.307-308).

These findings confirm that supervisee satisfaction with the supervisor's academic and professional competence and interpersonal interaction corresponds directly with perceived satisfaction with the supervision process as a whole. Furthermore, supervisee satisfaction appeared to have a direct relationship to the extent to which the supervisees felt comfortable enough to self-disclose within the supervision. In other words, trainees may omit certain information in order to appear more competent and capable within the supervisory context, particularly when the supervisory alliance is felt to be tenuous by the supervisee.

Brightman (1984) used a Kohutian developmental model to describe the developmental progression within the supervisory relationship. In this model, the supervisees pass through four developmental stages, re-enacting the developmental stages of infancy. The four stages described by Brightman (1984) are:

> "(1) an initial defensive denial of data contradicting an image of the therapist-self as omniscient, benevolent, and omnipotent, to (2) identification with an idealised professional figure who supports and values the trainee even as such conflicting data enter the supervision, to (3) a loss and mourning of the grandiose professional self in the face of the evidence that undermines it, to (4) the establishment of a new, less perfectionistic ego-ideal, derived in part from the supervisory identification" (p.312).

These stages reflect the regressive aspects of the supervisory relationship, eliciting the supervisees' unconscious defences such as defensive denial, idealisation, an external portrayal of a grandiose professional self to defend against an inferior self, mirroring and

projecting onto the supervisor and supervisory relationship (Gill, 1999). Supervisors should therefore ideally address supervisees at their respective developmental stages in order to provide a holding environment for the supervisees, thereby aiding the integration of the trainee's professional self (Brightman, 1984). Brightman highlights the necessary developmental transition that must occur for effective supervisory learning to take place, wherein the supervisee must address the emphasized stressors or conflicts that are elicited by the narcissistic vulnerability within the supervisory relationship (Gill, 1999). The term 'narcissistic vulnerability', when applied to supervisees, refers to their fear and insecurity in the face of their supervisors' criticisms, and the subsequent impact on their self-esteem and sense of professional and personal competence (Gill, 1999).

Brightman argues that the stress experienced by the supervisees stimulates a "re-enactment of some of the earlier narcissistic dynamics which, like any developmental phase, are only partially 'resolved' and therefore prone to re-emerge under un-mastered or stressful conditions" (Brightman, 1984, pp.296-297). In other words, a fundamental characteristic of psychotherapy supervision is the observation, and perceived scrutiny, of the supervisees' vocational competence, which elicits stress and narcissistic vulnerability in the supervisee. Thus, through the regression elicited by the stress of the supervisory experience, supervisees become highly sensitive to criticism, and perceive any form of negative feedback as a personal attack.

Furthermore, supervisees are inclined to regress to childhood stages due to the evaluative and exposing nature of the supervision process vis-a-vis 'self', abilities and short-comings, both personal and professional. This situation contributes to supervisees' sense of vulnerability and "evokes memories, associations and fantasies of his personal history as a student vis-a-vis his teachers and a child vis-a-vis his parents" (Gill, 1999, p.229). In other words, supervision as a dyadic power relationship contains unconscious parallels with many other important power relationships for the supervisee, such as the parent-child and teacher-student relationships of the past. The power dynamic between supervisors and supervisees influences the level of supervisee self-disclosure as well as the level of narcissistic vulnerability. Supervisees are dependent upon supervisors for information, reminiscent of the power-

dynamic between teacher and student that the supervisees experienced in school, and further back, parent and child. As Kernberg (1985) states:

> "narcissistic investment (i.e. investment in the self) and object investment (that is, investment in representations of others and in other human beings), occur simultaneously, and intimately influence each other so that one cannot study the vicissitudes of narcissism without studying the vicissitudes of object relationships" (pp.271-272).

Thus, the supervisory relationship is in some way suggestive of the parent-child relationship of the past (Ivey, 2007). According to Kernberg (1985), supervisees experiencing narcissistic vulnerability and injury might use compensatory defences such as bragging, opinionated proclamations or idealisation, which is a 'narcissistic defence' against the stressful situation.

A further reflection of the re-enactment of the parent-child relationship within the supervisory relationship is reflected in the supervisees' empathy, compassion and sensitivity to criticism. Storr (1979, p.177) maintains that individuals attracted to the therapeutic profession have had personal experiences of what it is like "to feel insulted and injured". This personal experience contributes to their compassion and empathy for others. It is likely that individuals attracted to the therapeutic profession have learned as children to become sensitive to the emotions and reactions of their parents. Differently stated, a number of theorists have maintained that individuals attracted to the therapeutic profession have experienced narcissistic injuries as children, which are re-enacted through their work as therapists, supervisees and supervisors. Narcissistic injury refers to "the damage to the individuals' experience of their 'real self'" (Halewood & Tribe, 2003, p.88). Thus, as children, supervisees possibly developed anxieties over the effects their behaviour may have had on their parents, learning as a result to put themselves second (Halewood & Tribe, 2003).

Menninger (1957) maintained that individuals who are interested in the emotionally vulnerable have projected their own needs onto others rather than dealing with them directly, as they have experienced some form of emotional rejection from their parents as children.

Similarly, Ford (1963) maintained that psychotherapy trainees are often attracted to the psychotherapy profession by a need for self-realisation and identity. Thus, feelings of shame and selective disclosure become a possibility as a result of performance anxiety in the face of the evaluative and regressive nature of the supervisory relationship (Ivey, 2007).

2.6 Conditions that Contribute to Supervisee Disclosure in Supervision

Supervisees' feelings of shame impacts upon their levels of disclosure in supervision, and can lead them to omit information from the therapeutic process. Mollon (1989 in Webb, 2000, p.62) maintains that shame is a significant factor affecting the level of openness in supervision, as the supervisees "anticipate the loss of their supervisor's admiration as a result of mistakes made or the potential level of ignorance and confusion displayed". For example, research conducted by Yourman & Farber (1996) found that while most supervisees presented a fairly honest picture of their interaction with patients, between 30% and 40% of supervisees withheld information such as perceived errors from their supervisors.

According to Tompkins (1962), shame is one of the nine inherent human affects that form the core of human motivation. Shame is considered to be a negative affect as it is punishing to the individual. Shame occurs when a positive affect is interrupted, either through the non-responsiveness of another, or due to the realisation of the individual that he/she is as not smart or competent as previously imagined (Yourman, 2003). Thus, the supervisee's "vulnerability to narcissistic injuries, particularly an apprehension of being shamed, humiliated, or being considered ignorant and incompetent by the supervisor" (Nigam *et al.* 1997, p.253) will contribute to the supervisees' feelings of shame within the supervision and influence the supervisee to withhold information (either personal/case material) from the supervisor. As a result of their experience of narcissistic vulnerability, supervisees might feel the need to keep their feelings hidden, not only from others (such as their supervisor) but from themselves as well.

Psychotherapy supervision is by its nature a very exposing, vulnerable relationship, in which the supervisee's "clinical abilities, basic intuition, intelligence, personal feelings and blind

spots are all exposed, making him highly vulnerable. Moreover, he is always holding himself up to ideals that he wishes to achieve" (Gill, 1999, p.230). According to research, trainees are likely to withhold information in supervision as a result of experiencing feelings of shame and self-doubt (narcissistic injury) within the supervisory context (Yourman, 2003). Trainees will, as a result of shame, become fearful of being viewed negatively by their supervisors. Research has shown that supervisees do withhold information within the supervisory context, such as countertransference feelings elicited within their therapeutic relationship between themselves and their patients (Yourman, 2003). Specifically, the research found that supervisee nondisclosure usually involves "what is happening between trainee and supervisor as opposed to what has happened in the patient-therapist dyad" (Yourman, 2003, p.608). Research has shown that while most trainees openly disclose their work with their patients in the interest of optimising their learning experience, "ruptures in the supervisory relationship can disrupt or inhibit trainee disclosure, especially when shame is elicited" (Yourman, 2003, p.608).

According to Yourman (2003, p.602), there is a growing body of empirical research reflecting that it is "common for a portion of supervisee nondisclosure to result from the desire to conceal aspects of the therapeutic hour from the supervisor", as there is an innate need to self-protect against the inherently self-exposing, vulnerable relationship of supervision. Findings have shown that one of the greatest indicators for supervisee nondisclosure is fear of supervisor disapproval (Yourman, 2003). Research conducted by Ladany *et al.* (1996) supports findings that trainee supervisees are more likely to disclose clinical material concerning the therapeutic development between supervisee and patient than about their countertransference feelings regarding the therapeutic dyad and supervision respectively. Other research however, indicates that supervisees are inclined to withhold case material information as well (Yourman, 2003). The supervisees' self-esteem is constantly being challenged and tested within the supervisory context, as the trainees find themselves in a conflicting and confusing role of being viewed as authorities with their patients and students with their supervisors.

Gill (1999, p.228) refers to the supervisees' need to integrate conflicting roles between being the "'knowing' therapist and the 'unknowing' supervisee" (Gill, 1999, p.228). Supervisees

are constantly being required to deal with the contradiction between their need for a sense of professional proficiency and competence and the need to learn to acquire necessary skills. The task of having to integrate two opposing and conflicting roles can often cause role confusion, leading to nondisclosure within the supervisory context. Further contributing to role confusion and thus negatively affecting the level of self-disclosure is the absence of a strong alliance between supervisee and supervisor. The supervision process can thus feel like a double bind for supervisees, as they are expected to disclose areas of weakness regarding the therapeutic process between themselves and their patients whilst fearing criticism from the supervisor (Ladany *et al.,* 2006). The impact of the supervisor and the supervisory alliance on supervisee self-disclosure will now be considered in greater detail.

2.7 Role of the Supervisor and the Supervisory Alliance

The supervisor's ability to reflect on the countertransference that occurs within the supervisory alliance can impact upon the extent to which supervisees feel comfortable enough to disclose information, whether it be case material, process notes or personal impressions regarding the case, supervision or personal competence as a training psychotherapist. Research has found that the supervisor's ability to work productively with the various feelings that are elicited in the supervision room can either model openness regarding reflections on the supervisory relationship or a fear of considering the various feelings and emotions that may be elicited (Pisani, 2005). In other words, as in the therapeutic dyad between therapist and patient, where the therapist needs to create an environment of openness and safety in which the patient's emotions and experiences can be explored, so the supervisor needs to model and create for the supervisee an environment of disclosure in order for learning and development to occur. For example, within the therapeutic relationship, the therapist creates a corrective emotional experience for the patient, and models an experience of safe exploration of emotions and feelings, which will thus be internalised into the patient's experience of relationships (Lemma, 2006). Similarly, in the supervisory relationship, the extent to which the supervisor does or does not reflect on the countertransference and nondisclosure within the supervisory alliance can impact upon the progress that the supervisee is able to make in supervision learning.

The supervisor's capacity to provide a climate of transparency and safe exploration regarding the supervisee's countertransference and non-disclosure, and the extent to which supervisees' interventions are worked through constructively in the supervisory dyad will be internalised by the supervisee. This will affect the extent to which the supervisee chooses to disclose, thus impacting upon the learning process within the supervision. For example, certain parallel processes in supervision may be elicited, stemming from the inevitable occurrence of transference-countertransference within the therapeutic relationship between client and therapist. However, these processes may be missed or misinterpreted by both the supervisor and supervisee if a strong supervisory alliance has not been established, thus not allowing the countertransference emotions to be fully explored. Consequently, both supervisor and supervisee might be failing to engage with crucial material that occurs within the trainee's clinical work (Pisani, 2005).

In addition, research has found that when focusing on the countertransference reactions of supervisees, interventions should be confronted and clarified but not interpreted (Book, 1987). Confrontation in the psychodynamic therapeutic context does not refer to a hostile or aggressive act, rather "it refers to bringing to the resident's awareness an inner experience or external reality of which he may be unaware" (Book, 1987). It is important on the part of supervisors to distinguish whether the countertransference reactions elicited in supervisees are a reflection of the interactions of the therapeutic process between themselves and their patients, or are more characterological in source (Book, 1987). Whether the source of the supervisees' countertransference reactions are due to the therapist-patient interaction or the therapists' personal histories, supervisors should highlight and reflect on these reactions. However, should supervisors realise that the source of the supervisees' countertransferences are due to the latter, these reactions should not be interpreted, as exploring the roots of the supervisees' difficulties can unnecessarily elicit hurt and angry feelings, promoting an elaboration of the transferences towards the supervisors, thus inappropriately changing the supervision into psychotherapy (Book, 1987). This once again highlights the sensitive line between the therapeutic and supervisory relationship, wherein supervisors need to decide the extent to which supervisees' complexes and conflicts, implicit in their countertransferences to patients and their transferences to supervisors, will be explored, without the supervisory focus becoming a therapeutic one (Ivey, 2007).

According to Yourman & Farber (1996), there may be certain predictors of nondisclosure within the supervisory relationship, as there appears to be a positive correlation between supervisee satisfaction with the supervision process and discussion of countertransference within the supervision context. One might thus infer that the level of communication that occurs within the supervision context, and the extent to which both supervisor and supervisee verbally acknowledge and discuss the countertransference in the relationship, can positively or negatively impact upon the extent to which the supervisee discloses. Research has found certain areas that trainees are less likely to disclose in the supervisory dyad, such as erotic attractions and negative reactions to supervisors.

The degree of emotional comfort between supervisor and supervisee in the relationship is another possible indicator regarding the extent to which a supervisee might disclose or withhold information in the supervisory context. Trainee psychotherapists might feel the need to withhold information in supervision as they feel that through the supervisory interactions, the supervisor has questioned their professional and academic skills. Supervisors may need to take into account the individual temperaments, personalities, learning styles and needs of supervisees when providing individual supervision. For example, some supervisees may need more acknowledgement, guidance and support than others. Supervisors need to be sensitive to the different learning and interactive styles of each supervisee, whether on an individual or group basis, in order for a strong supervisory alliance to develop, thus contributing to supervisory countertransference disclosure and constructive supervisory learning (Yourman, 2003).

2.8 Summary

Supervision is an important part of therapeutic learning. It is necessary for therapists and supervisors to consider both the patients' transferred feelings in therapy and the implications thereof for the process, as well as the countertransference feelings elicited by the therapists' own unresolved conflicts. This however, can be intimidating for training psychotherapists, who might feel embarrassed or hesitant to admit to such feelings as love, hate or sexual interest toward patients. Furthermore, the knowledge that they are being assessed for professional and academic competency can increase the anxiety felt within the supervision

context. These feelings can lead to supervisees withholding material from their supervisors, for fear that they will receive negative feedback or poor assessments. As supervision is an integral part of the training for beginner therapists, withholding of information will have implications for learning.

It must be established between supervisees and supervisors whether the feelings brought to the session are the supervisees' countertransference feelings to the patients, transference feelings to the supervisors, or their own unresolved conflicts. Similarly, supervisors need to make this distinction, and to decide whether their countertransference feelings are their own, or a result of what is brought to the session. Thus a strong working relationship needs to be established between the supervisors and supervisees in order for these sensitive emotions to be safely discussed. Supervision is akin to the therapeutic relationship in many ways, as supervisees are expected to display a certain level of emotional vulnerability to a supervisor, who does not reciprocate such disclosure. These similarities allow for the term 'supervisory alliance' to be used, and it is understood that a strong supervisory alliance will allow for more open disclosure on the part of the supervisee than a weak alliance. Furthermore, the attitude of the supervisor can also contribute to the extent of supervisee disclosure. If supervisees perceive their supervisors as personally judgemental and punitive, they will disclose less openly than with those who are accepting and create a safe space for exploration of the dynamics of the therapy and supervision process[1].

[1] For additional readings on supervision and its impact on supervisory learning refer to: Bush, G. (1969). Transference, countertransference, and identification in supervision. *Contemporary Psychoanalysis,* 5, 158-162.; Goin, M.K.. & Kline, F. (1976). Countertransference: A neglected subject in clinical supervision. *American Journal of Psychiatry,* 133, 41-44.*;* Margolis, B.D. & Margolis, D.P. (1989). The Transference-Countertransference Matrix: The Emotional-Cognitive Dialogue in Psychotherapy, Psychoanalysis and Supervision. Robert J. Marshall & Simone V Marshall. New York: Columbia University Press. 1988. 348, pp.. Modern Psychoanalysis, 14, 221-222.; Springmann, R.R. (1986). Countertransference: Clarifications in Supervision. *Contemporary Psychoanalysis,* 22, 252-277.; Vaslamatzis, G. (2008). On: Supervision, Transference and Countertransference. *International Journal of Psychoanalysis,* 89, 655-656.

CHAPTER THREE: RESEARCH METHOD

3.1 Research Design

The research design is qualitative and exploratory in nature. It is informed by the interpretivist approach to research, which maintains that individuals are constantly engaged in a process of making sense of their lives and world. Qualitative analysis aims to address questions that are concerned with people's lives and their social worlds. Thus, the research participant's "subjective meanings, actions and social contexts, as understood by them, are illuminated" within the analysis of the report (Fossey *et al.,* 2002, p.717). As the research aims to consider the subjective experiences of the supervisees in their psychotherapy training, the qualitative approach to research is adopted, since this approach allows the researcher to "share in the understanding and perceptions of others" (Berg, 1995, p.7). Thematic content analysis falls under the umbrella of the interpretivist approach to research, and is therefore guided by the steps required of this analytical framework.

The data collected for the research comprises written responses to a researcher-developed survey that will be discussed in greater detail in section 3.3 ('Instruments used'). Thematic content analysis was chosen by the researcher, as opposed to other qualitative measures, such as grounded theory, because of its flexibility. It is not restricted to a particular theoretical approach, and can thus be applied in different contexts. Since the research focuses on how the participants made meaning of their experiences as supervisees, as well as how the training programme and environment of supervision contributed to their construction of their experience, it was decided that thematic content analysis, as a contextualist method, was best suited to the research. This form of analysis is appropriate as it sits "between the two poles of essentialism and constructionism... which acknowledges the ways individuals make meaning of their experience, and, in turn the ways the broader social context impinges on those meanings, while retaining focus on the material and other limits of 'reality'" (Braun & Clarke, 2006, p.81).

3.2 Sample

A sample of 20 past Wits Clinical Masters students was invited to participate in the study, and asked to answer an open-ended postal survey (see Appendix 1) aimed at assessing the

level of self-disclosure and the impact that the supervisees' experience of the supervision relationship had on supervisory learning. The participants were selected using non-probability, purposive sampling, based on their research suitability (Cohen & Manion, 1997). Furthermore, criterion sampling was employed. Participants needed to meet the criteria of having attended and completed the Clinical Psychology Master's training at Wits University between the years 2005-2007, and thus have received the psychodynamic training discussed previously. The participants were contacted telephonically and were requested to participate in the study. Initially all twenty participants agreed to participate. They were first sent the information letter via email, and then sent the questionnaire and self-addressed envelope. However, as time drew on, the researcher noted that she was not receiving any returned questionnaires, and decided to email the participants to confirm that they had received the questionnaires. After contacting the participants, the researcher learned that the questionnaires had been lost in the post and not received by the participants. The researcher resent the questionnaires and information letters by email. The participants agreed to return the completed questionnaires by email, hand-delivery to the original postal address at the university, or by post. Fifteen participants returned the completed questionnaires, which were all used in the study. Fifteen returned questionnaires is a 75% response rate, and it is likely that the remaining 25% were affected by the postal complications. It would appear that this is in line with the response rate of other research conducted with mailed questionnaires, which typically receive a 75% response rate (Bernard, 2005). It must also be considered, however, that upon reading the questions, some participants may have decided to remove themselves from the study because they were reluctant to disclose information regarding their personal experiences of supervision. As qualitative research focuses on the quality and richness of the data gathered, rather than the volume or quantity, a sample of fifteen participants could still be appropriate for the research, since the responses were rich in content (Erlandson *et al.*, 1993). By returning the completed questionnaire, the participants provided the consent needed to conduct the research.

3.3 Instruments Used

A researcher-developed survey comprising five demographic questions (age, race and gender of participant, and race and gender of supervisor) and fourteen open-ended questions, was sent to the participants (see Appendix 2). The countertransference of the supervisees was not

referred to explicitly in the questionnaire, as it was the aim of the researcher to keep the questionnaire as open-ended as possible and to allow the participants the opportunity to provide natural and unbiased responses that would not limit the questionnaire. Although the countertransference of the supervisees was not referred to explicitly in the questionnaire, data from questions informed the researcher of the countertransference and its impact on the supervisory interaction. The surveys that were returned via email were returned in the word-document required for the analysis. Those that were hand-written and returned by post were re-typed into the word-document format. This was to ensure that all the surveys appeared the same and were only identifiable by the number assigned to each questionnaire for analysis purposes, e.g. Participant 1, etc. (see Appendix 3). Confidentiality of participants was thus ensured.

The answers were analysed using thematic content analysis. The questions devised for the survey were created in an open-ended format in order to invite rich and detailed responses from the potential participants (Babbie & Mouton, 2001). It was decided that a questionnaire would be sent out to the participants in order to ensure anonymity, thus allowing the participants to respond in an honest, unbiased manner, without feeling intimidated by an interview process. The questions formulated for the questionnaire were informed by the literature gathered for the research. The aim of the questions was to assess whether themes of a similar nature would occur in the participants' answers, thus either supporting or challenging previous related research findings. The researcher-developed questionnaire was formulated under the guidelines provided by Kanjee, 2004, which stipulate that "drafting of questions is a crucial aspect of developing any assessment since 'what you ask for is what you get'" (p.293). The final layout of the questionnaire format roughly followed Malaka's (1995) format (cited in Kanjee, 2004), which included three main sections. First the questionnaire included a demographics section, asking the participants' age, gender and race and the gender and race of the supervisor/s. This was asked in order to ascertain whether these are possible contributing factors in non/disclosure in the supervisory context. This issue is analysed in greater detail in the results and discussion sections of the report. The questionnaire then requested the participants to answer the questions as fully as possible, and the third section of the questionnaire included the fourteen open-ended questions. A number of lines were provided per question in order to elicit as in-depth a response as possible from the participants.

The questions in the survey are divided into three clusters. The first five questions (see Appendix 2), look at whether the participants chose to withhold information in the supervision context by way of editing or withholding transcripts, process notes and experiences of therapy and supervision. Three of the questions (questions Four, Six and Seven) look at whether any colleagues admitted to editing or withholding information from their respective supervisors, and the third cluster focuses on the supervisory alliance and whether from the participants' perspective the supervisors may have contributed to a stronger alliance, thus facilitating more open disclosure (questions Five to Thirteen).

3.4 Data Collection Procedure

The Clinical Psychology Masters students who attended Wits university from 2005-2007, and were thus still on the Wits database, were contacted telephonically and invited to participate in the research study. Those potential participants who were receptive to the process were emailed the information letter. The participants who agreed to complete the questionnaire gave the researcher their postal information and confirmed with the researcher via email. The questionnaires were sent to the participants with a stamped self-addressed envelope. This ensured respondents' confidentiality and anonymity. Furthermore, the researcher ensured that the names of people who responded to the email were not divulged to anyone, including the researcher's research supervisor. All of the participants were posted the questionnaires and information letters during the month of July 2008. Due to the postal complication discussed above, the questionnaires were resent via email at the end of July 2008. The questionnaires were all returned to the researcher by mid August 2008.

3.5 Data Analysis

The questionnaires returned to the researcher were analysed using thematic content analysis. Thematic content analysis is a form of qualitative analysis. It is a method utilised for analysing data through a process of analysing and reporting the patterns or themes that occur within the data. It "minimally organises and describes your data set in (rich) detail. However, frequently it goes further than this, and interprets various aspects of the research topic" (Braun & Clarke, 2006, p.79). Thematic content analysis is a widely used form of qualitative

data analysis largely because there is no specific rule regarding how to conduct the analysis. This contributes to the flexibility of the analysis procedure, and thus the appeal.

According to Braun & Clarke (2006), a theme "captures something important about the data in relation to the research question, and represents some level of patterned response of meaning within the data set" (p.82). The researcher needed to use her judgement and discretion when deciding what constituted a theme. In order to ascertain whether a theme captured 'key elements' of the data set, the researcher needed to consider whether it captured important aspects in relation to the overall research question. Secondly, the researcher needed to specify whether her analysis was going to be inductive or deductive. As the researcher remained open to the possibility that data could emerge from the results of the study that had not been predicted by the predetermined themes or the literature found, the researcher adopted a partially inductive approach. However, as the literature had already been gathered for the report, and the questionnaire was established based on the gathered literature, the approach was also partly deductive, as the data gathered was informed by the literature and clustered accordingly (Braun & Clarke, 2006). Thus the analysis of the research was both inductive and deductive. This raises the question of researcher bias. As the researcher was so actively involved in the data collection and analysis, (a characteristic of qualitative thematic analysis), one has to consider that a certain level of bias informed the theme identification and interpretation. This will be discussed further in reflection on the research process.

In order to analyse the research according to the thematic content approach, the researcher adhered to the six procedural steps outlined by Braun & Clarke (2006), whereby she: (1) familiarised and immersed herself in the data; (2) generated initial codes; (3) searched for themes; (4) reviewed the themes; (5) defined and named the themes; and (6) wrote up the report. These steps will now be discussed in greater detail.

Step 1: Immersion in the data

The researcher ensured that she was familiar with the content of the data through a process of 'repeated reading'. The entire data set was read in an active way, through a process of reading

and re-reading the questionnaires. The researcher thus immersed herself in the raw data in order to search for meanings and patterns. During this process, important aspects of the data were highlighted and reflected upon. The responses were divided into the three question clusters in order to make the reading a more streamlined process (Braun & Clarke, 2006).

Step 2: Generation of initial codes

The second phase of analysis involved the production of initial codes from each data set. This initially involved a vertical analysis as each set was analysed individually when considering the possible codes. The data was coded manually and the researcher highlighted potential patterns with coloured pens in order to identify the segments of data. The data extracts were coded and then collated within each code. The process of coding allowed the researcher to organise the data into meaningful groups. The researcher then began to identify potential themes that were starting to emerge within the raw data, as seen in the example below:

Question 1: *In the course of your psychology masters training (including your internship year) did you ever find yourself withholding information from your psychotherapy supervisor/s pertaining to your psychotherapeutic work with one or more patients...?*

Data Segment: P2: *"...If I felt I had made what I considered a stupid or inappropriate verbal intervention I would not disclose to my supervisor..."*

Coded Theme: Withholding information about verbal intervention

Step 3: Searching for themes

Once the data for each respondent had been coded and collated, the third phase of analysis could take place, in which the different codes were sorted into potential themes, and the relevant coded data extracts were collated within the identified themes. The different codes were also reviewed to see if they formed an overarching theme. Through the process of a horizontal analysis, or cross-coding and analysis, the relationships between the codes, themes and sub-themes were considered. The themes and sub-themes were placed in tables drawn up on the computer which were used as visual aids in order to help organise the themes into "theme piles" (Braun & Clarke 2006, p.89).

Step 4: Reviewing the themes:

Once the themes had been identified, the fourth phase of analysis occurred, and the themes were reviewed. Some themes were considered to be part of other themes, and others were deleted as they were considered not to be substantive. Horizontal analysis of the data was used to compare themes between participants. Thus the researcher aimed to establish whether certain themes were common to a number of respondents or were idiosyncratic. As such, thematic trends could be established and analysed for discussion. An example of this horizontal analysis and common thematic trend is indicated below:

Cross Analysis of Participants:

Thematic Trend:

Supervisory alliance contributes to supervisee countertransference disclosure

Quotes:

P2: *"If they don't have your confidence for whatever reason, they're not going to get the full story in supervision. Conversely, if they're mature, professional and knowledgeable, they'll get a close to accurate account"*.

P7: *"When one does not trust a supervisor's integrity, disclosure would be self defeating and unproductive"*.

Sub-Theme:

Developmental element to the supervisory alliance and subsequent supervisee disclosure

Quotes:

P11: *"the information that was withheld would depend on whether or not I felt comfortable with my supervisor and it was more prominent at the beginning of the year as opposed to the rest of the year, as I felt more comfortable with my supervisor and became more comfortable with myself as a therapist"*.

P13: *"…towards the beginning of training it was generally when I felt I had done something 'wrong', such as said something inappropriate"*.

Step 5: Reviewing, defining and naming of themes:

The fifth stage of the process involved a comprehensive analysis and discussion of each specific theme that emerged. Sub-themes were also discussed. The researcher considered in what way each theme and sub-theme fitted into the overall 'story' of the data in relation to the research question, thus ensuring that there was no "overlap between the themes (Braun & Clarke, 2006). At the end of this stage each theme could be clearly defined and named in order for the reader to have a clear understanding of what the theme includes (Braun & Clarke, 2006).

Step 6: Written report

Once each theme had been defined and named, the final stage of analysis could take place. Examples and data extracts were provided to highlight the emerging themes and to present a comprehensive argument for the research question. The extracts chosen were considered to be "embedded within an analytic narrative that compellingly illustrates the story that [you] are telling about [your] data, and [your] analytic narrative needs to go *beyond* description of the data, and make an *argument* in relation to the research question" (Braun & Clarke, 2006, p.93). The aim was to bring the reader as close to the experiences of the participants as possible, so that through the examples and quotes provided the reader would get a true sense of the ways in which the participants experienced their supervision and learning during their first and second years of Masters training for Clinical Psychology, and which factors contributed to and hindered the process (Fossey *et al.,* 2002). Through the steps of analysis delineated above, the main thematic trends of the study were established, discussed and analysed.

3.6 Reflection on the Research Process

As discussed previously, due to the sensitive nature of the questions asked it was decided by the researcher that an open-ended questionnaire would be sent to the participants in order to ensure anonymity of the participants, thus allowing for a greater response rate. However, when contacting the participants for the study, one participant remarked that she would have been more comfortable with a face-to-face interview in order to discuss and reflect upon the

topic and the nature of the survey. Whilst most of the participants' responses were rich in information, it is possible that other participants felt the same way as the above mentioned participant, and this would have contributed to more in-depth responses to some of the questions. For example, for the most part, Participant 9 provided in-depth responses in her questionnaire. However, she wrote "*See above"* in response to Question 9 in lieu of providing a full, independent answer to the question. Similarly, Participant 4 responded in a closed way such as "*N/A"* (Qu.4) or "*no"* (Qu.3) to questions that she felt did not apply to her, which prevented the researcher from gaining additional information in those areas. Fuller responses might have been encouraged or facilitated through an interview setting. Furthermore, the questionnaire format might have contributed to the percentage of participants who chose not to participate in the research after their initial acceptance. Considering the sensitive nature of the questions, it is possible that the participants would have appreciated the personal contact of a one-on-one interview, which would have allowed for a more engaging, interactive process.

The research focused on past trainee psychologists' experiences of supervision and training. Considering I am currently a trainee psychologist, it would be naive of me not to consider my own biases in the research process. Reflexive reporting is an important aid to help distinguish the "participants' voices from that of the researcher in the report, as well as enhancing the permeability of the researcher's role" which is a necessary task in qualitative, thematic content analysis (Fossey *et al.*, 2002, p.730). Firstly, as I had researched the literature for the research prior to the data collection, significant themes and research trends were already in mind when analysing the data. Secondly, when drawing out the relevant themes in the data, I had to be cognisant of what the participant wrote specifically, and what was being interpreted by me. I had to separate my own emotions and reactions to the questions, in light of my own personal experience of the topic, and I had to ensure that I interpreted the themes of the questionnaires according to answers of the participants. For example, a number of participants spoke about their anxieties related to the evaluative element in supervision, which they felt added extra pressure to the relationship, and to their need to protect themselves in their disclosure. As a training psychotherapist, I have been exposed to my supervisors' evaluation throughout the academic year, and I thus identified strongly with the participants' reflections and comments. I therefore needed to separate my own emotional responses to the questions from the answers given by the participants when identifying the

different themes. Upon reflection on the research process, it might have been helpful for me to have engaged in one-on-one interviews rather than questionnaires in order to have the opportunity to clarify certain questions, thus enabling me to distinguish participants' responses and themes from my own subjective inferences.

3.7 Ethical Considerations

This research study abided by ethical codes of conduct according to the ethical research guidelines established by the committee for Research on Human Participants (Humanities) of the University of Witwatersrand. Confidentiality and anonymity of the participants was strictly maintained and ensured throughout all documentation and reporting of the findings of this project. Participants in the research were invited to participate in the study and emphasis was placed on the voluntary nature of the participation. This information was outlined in a detailed letter of explanation to the participants (see Appendix 1) prior to the commencement of the study. The participants were informed that a summary of the results of the study would be available on request, on completion of the study.

One ethical consideration was the fact that the invited participants were past Wits students, who may have disclosed negative responses to their previous Wits supervisors, including the researcher's own research supervisor. The researcher addressed this consideration by stipulating that no supervisor names should be used in survey responses. Furthermore, the participants were encouraged to omit any information pertaining to the supervision context that they considered sensitive or private. They were not required to specify if the supervisor they were referring to was from the department or from the internship site. The anonymity of both the participants and the supervisors was thus ensured. Furthermore, the researcher typed out the raw data, so that no identifying information was given to the research supervisor, but merely the answers for analysis. The researcher informed the participants that direct quotes from the surveys would be used in order to illustrate particular themes. However the participants were assured that no identifying information would be included in such quotes. This confidentiality guarantee was stipulated in the information letter, ensuring the protection of both participants and supervisors.

CHAPTER FOUR: RESULTS

4.1: Introduction

This chapter presents the results of the findings on the major themes and sub-themes of the research. Qualitative material in the form of summaries and excerpts from the interviews are used to highlight the participants' responses. All the participants' results are compared to see if there are any thematic commonalities. The findings are presented in an overall summary.

Participants are identified by number. For example, P1 refers to Participant 1, etc. These numbers refer to the answers to the questionnaires (see Appendix 3). It should be borne in mind that when participants refer to either their therapy or supervision experiences, they could be indicating either their M1 or the internship (M2) years. Thus some participants related supportive experiences in M1, but negative experiences in M2 (or vice versa), as in the instance of P14, who explained that in her M1 year she felt comfortable with her supervisor, and was encouraged to look at her countertransference reactions to her patient, whilst in her M2 year, her psychotherapy supervisor changed. She felt "*scrutinised"* and was thus tempted to omit aspects of her therapy session from her process notes:

> *"I felt very comfortable with my supervisor and not judged. I was committed to learn and look at my own countertransference issues. It felt like a safe space... In my M2 year I had an external supervisor for my long term case. With her I did feel more scrutinised and more tempted to omit bits of my session"* (P14).

Furthermore, the supervision could refer either to individual supervision or group supervision. As P2 explained, he chose to withhold information regarding problematic aspects of the therapeutic process and dynamics with his patient in his group supervision as he found the supervision was "*dragging on and becoming boring and tiring listening to several other's cases, I would withhold problematic parts of the therapy deciding to do my own reading up or, if I thought I had insight into the dynamics behind the 'problem', simply not highlighting it"* (P2).

4.2: Description of the Themes and Sub-themes

The main coded themes that arose from the participants in response to the questions are:

1) The supervisory alliance contributes to supervisee countertransference disclosure
2) Nondisclosure of countertransference reactions to the therapeutic process with the patient
3) The impact of disclosure on supervisory learning

These themes were then refined into 12 sub-themes. The first theme was 'The supervisory alliance contributes to supervisee countertransference disclosure'. This gave rise to the following sub-themes, including factors that appear to have influenced or been influenced by the strength of the alliance, namely:

1.1 Disclosure of transference-countertransference reactions to supervisors and supervision

1.2 Performance anxiety of supervisees and fear of negative assessment from supervisors

1.3 Demographics of supervisors and supervisees

1.4 Theoretical orientation of supervisor

1.5 Punitive supervisor and effect on supervisee disclosure

1.6 Developmental relationship to alliance and supervisee disclosure

1.7 Colleague disclosure of transference-countertransference reactions to supervisors and supervision

Within theme 2: 'Nondisclosure of countertransference reactions to the therapeutic process with the patient', the following sub-themes were extrapolated:

2.1 Boundary/frame deviations

2.2 Verbal interventions and emotional responses

2.3 Dreams and fantasies about the patient and

2.4 Colleague disclosure about withholding countertransference information.

Within theme 3: ‘Impact of disclosure on supervisory learning’, there was one sub-theme:

3.1 Withholding information had a negative effect on supervisory learning

Ninety-three per cent (14/15) of the participants openly acknowledged selective disclosure or nondisclosure in their supervision, suggesting that it was a common occurrence. It is possible to hypothesise that the remaining 6% (1 participant - P10) maintained that he disclosed fully in supervision because there was a level of anxiety linked to the divulging of sensitive information for the questionnaire. Thus he chose to protect himself by limiting his responses to the questionnaire. He did however openly acknowledge that he felt that his positive relationship with his supervisor impacted upon his comfort to disclose information openly in the supervision process, and this has been taken into account in the analysis of the results.

4.3 Theme One: Supervisory alliance contributes to supervisee countertransference disclosure

The results show that all fifteen participants felt that the quality of the supervisory alliance was the main contributing factor to full disclosure or nondisclosure in their supervision, Nondisclosure in this instance includes partial or selective disclosure of information and will be specified accordingly with each participant. Disclosure in supervision within this theme related to transference-countertransference reactions to supervisors, or countertransference reactions to the therapy process with patients.

For example, P5 found her supervisor to be “*open*” and “*gentle*” in her supervision style. This contributed positively to P5’s experience of being able to talk “*openly and honestly”* in the supervision regarding her countertransference reactions in the therapeutic process with her patient, as well as her reactions in the supervision process. P5 found her M1 supervisor to be nondirective, encouraging her supervisees to discover their own therapeutic styles, which P5 experienced as valuable. On the other hand, P8 did not experience her supervisors as open, and did not feel comfortable to openly discuss *“any thoughts or feelings I had about my supervisors during my training”* (P8).

Eighty per cent of the participants (12 out of 15) acknowledged that open disclosure of their transference-countertransference reactions to their supervisors and the supervision process was affected by the strength of the supervisory alliance. The perceived negative supervisory experiences that contributed towards supervisory nondisclosure will be examined first, and then the perceived positive experiences.

Six participants (40%) experienced weak alliances with their respective supervisors (either in M1 or in M2), which they felt compromised their full disclosure in the supervision context. The participants were asked whether they found themselves avoiding disclosure of particular thoughts or feelings related to their psychotherapy supervisors and their interaction with them. They were also asked what thoughts or feelings they avoided disclosing, whether they felt that the relationship with their respective supervisors impacted upon their ability to disclose their thoughts or feelings and whether or not they felt their supervisors could have said or done anything to contribute positively towards open disclosure.

Participant 2 explained that he did not openly disclose his feeling that his supervisor displayed "*inappropriate and unprofessional behaviour*" within the supervision, as he feared the supervisor would become "*narcissistically wounded"* and that the supervisor would perceive him as "*too big for my boots"* (P2). Thus, P2 had an experience of a punitive supervisor and felt that this weakened the supervisory alliance. As a result his level of disclosure was reduced:

> "*If they don't have your confidence for whatever reason, they're not going to get the full story in supervision. Conversely, if they're mature, professional and knowledgeable, they'll get a close to accurate account"* (P2).

Participant 7 had a similar experience to Participant 2, and found that she would withhold thoughts and feelings about her supervisor that related to the supervisor's "*character such as perceived emotional maturity, aggression or questionable integrity"* (P7). Participant 7 felt that it would be unproductive to disclose negative personal feelings regarding her supervisor, as "*it would take a very mature supervisor not to feel insulted or threatened. When one does*

not trust a supervisor's integrity, disclosure would be self defeating and unproductive" (P7). Thus in this instance P7 chose to withhold feelings regarding her supervisor's character as well as regarding the supervision process. She found that due to an insecure alliance between herself and her supervisor, she did not feel secure enough to disclose particular feelings of dissatisfaction regarding the supervision process, and thus felt the need to self-protect through nondisclosure.

Participant 8 never discussed her thoughts or feelings about the supervision process with her supervisor, as she did not feel that she "*had that kind of a relationship*" with her supervisor (P8). She further explained that even if they did, she would still have withheld from disclosing "*for fear of retaliation"* (P8). This suggests that the power discrepancy between supervisor and supervisee, together with fear of negative assessment from supervisors, is a major contributing factor towards transference-countertransference nondisclosure during the supervision process. Similarly, Participant 12 had an experience with a supervisor with whom she felt "*too vulnerable"* to "*address the personal nature of how she conducted supervision"* (P12). Participant 12 thus experienced her to be a "*punitive"* supervisor, which negatively affected P12's feeling able to talk openly to her. Participant 13 reported an experience with a supervisor with whom she did not get on well, "*and found very difficult, but was never able to share these feelings"* (P13). She further explained that "*the supervisors with whom I had good relationships and who made me feel comfortable, were the supervisors who I was most open with regarding disclosure of information"*. Participant 15 explained that he chose not to disclose feelings of "*frustration"* and "a*gitation"* that he felt towards his supervisor, as he feared that he would be "*judged if I disclose negative feelings about her and the process"* (P15).

Participant 6 did not experience her supervisor as punitive or judgemental, but rather as responding to her interventions in a "*curious way"*, therefore encouraging her to "*think about rather than feel embarrassed about my less helpful interventions"*. She did, however, feel that her supervisor could have "*normalised the anxiety that goes with supervision and opened a space to talk about this"* (P6).

Seven participants (47%) found that the evaluative element in the M1 year negatively impacted upon their open disclosure of the therapeutic interactions with their respective patients as well as their feelings regarding the supervision. For example, Participant 2 feared "*negative feedback or poor marks"* should he openly disclose his feelings regarding the supervision process (P2). Thus the power discrepancy between himself and his supervisor negatively impacted upon his level of open disclosure as he did not want to receive a negative assessment. P2 stated that the "*analytic community is small so don't queer your pitch at this early stage of your career*" (P2). Therefore Participant 2 not only felt anxious about his immediate training environment, but was also concerned about who would be part of the professional analytic community. He was concerned that his poor interventions at the stage of his training could have a negative impact upon his image during his professional career. Participant 6 explained that she did not disclose her feelings of anxiety when presenting her work to her supervisor, as she too experienced "*anxiety*" regarding the "*judgement/evaluation*" aspect of the M1 year.

When asked what the supervisors could have said or done to make the participants feel more comfortable about accurately reporting psychotherapy session material and feelings about the material, P15 answered:

> "*... if there was less of an evaluative element to the supervisory process. Supervisors would have created a more comfortable environment, by perhaps being more transparent and clear about their evaluations and the effect this may have on disclosing fully perceived blunders or difficulties"* (P15).

Furthermore, P7 explained that she was inclined to withhold information from her supervisors for fear of evaluation as well as "*fear of supervisors at times"*. This statement further indicates that a weak alliance resulting from fear hinders open disclosure.

Another contributing factor to incomplete disclosure is the personal need "*to get it right"* in the eyes of the supervisor/s. P7 explained that "*subsequent supervision where evaluation is not a component of the relationship has been a freeing experience"* (P7).

There appears to be a developmental element to the level of performance anxiety felt by four of the participants (P1, 11, 13 and 15), who all felt most vulnerable at the beginning of their M1 years, which contributed to their need to withhold information in the supervision. However, as the alliance strengthened between themselves and their respective supervisors, they felt more comfortable to openly disclose interventions as well as thoughts and feelings regarding the supervision process. As Participant 11 explains:

> "*the information that was withheld would depend on whether or not I felt comfortable with my supervisor and it was more prominent at the beginning of the year as opposed to the rest of the year, as I felt more comfortable with my supervisor and become more comfortable with myself as a therapist"* (P11).

Six participants (40%), reported positive experiences with their supervisors, which contributed towards the development of a strong alliance. Their supervisors were able to normalise the learning experiences, thus allowing for comfort and more disclosure within the supervision. For example, Participant 10 explains *"I was able to share my thoughts without fear of being judged. It helped me to understand that I was just a learner and would make mistakes"* (P10). However some participants reported that in spite of the strong alliance and comfort that developed between their supervisors and themselves, a certain level of nondisclosure still remained, due to the nature of the supervisee-supervisor relationship. For example, Participant 3 maintained that while he had a strong alliance with his supervisor, he still did not openly disclose feelings of frustration regarding the supervision process. Whilst he was not fearful of receiving a negative assessment from his supervisor, thus reflecting a strong supervisory alliance, he was aware of his supervisor's own personal difficulties. P3 felt frustrated that feedback on process notes and transcripts were not being handed back in a timely fashion. However, he explained that his supervisor "*was going through a lot of her own personal problems which could not be avoided, thus it felt wrong for me to insist on something that she was already battling with"* (P3). In other words, the boundaries between P3 and his supervisor appear to be more open. However this was problematic for him as it restricted his expression of his frustration. He knew the reason for her not being able to provide supervision and feedback in a timely fashion. As a result he sought supervision "*through many other sources"*. P3 explained that:

> "*because of our relationship I felt comfortable bringing all aspects of therapy to supervision. However, because of our relationship I also struggled to disclose certain feelings towards my supervisor and supervision which meant things were not always discussed and processed"* (P3).

Other participants (P4 and P6) maintained that while they were comfortable in the supervision session, and did not experience their supervisors as "*punitive*" (P6), they still chose to withhold "*transference feelings*" evoked in the supervision, and take them rather to their "*personal therapy*" as "*it felt more of a therapy issue than a supervision issue"* (P4).

Participants 8, 9 and 14 all felt the need to withhold information from their respective supervisors, as they found that their M1 psychodynamic training did not agree with the theoretical orientation of their internship supervisors. For example, Participant 9 explains:

> "*I had several different supervisors and some had not been trained at Wits. For these supervisors I found that I would 'modify' sessions and I would focus less on psychodynamic aspects and would emphasise different aspects. For example, in order to get the best supervision, if the supervisor had a CBT/systemic training I would focus on those aspects rather than psychodynamic aspects"* (P9).

A comparison of demographic details was made between participants who reported positive experiences and strong alliances with their supervisors and those who reported weak alliances. This was done it to assess whether age, gender and race could be possible contributing factors to the strength of the alliance. Of the fifteen respondents, four were male and eleven were female. The age of the participants ranged between 20 and 30 years. The participants reported on experiences with a number of supervisors, including the M1 internship supervisors. Demographic differences did not appear to be a contributing factor to the strength of the alliance. For example, Participants 4 and 6 were both white females and their supervisors were both male. Participant 4's supervisor was a white male, and Participant 6's supervisor was a black male. In spite of the difference in gender and race, both

participants reported positive experiences with their supervisors. Similarly, Participant 3, who is a white male and whose supervisor was a white female experienced a strong alliance in spite of the gender difference. Participant 5, who was a white female and her supervisor a white female, also reported a positive experience with her supervisor. However, while Participants 8 and 12 were also white females, as were their respective supervisors, they reported negative experiences. Thus it would seem that the race and gender of both the supervisees and supervisors do not necessarily play a contributing role to the strength of the alliance, and thus the level of disclosure within the supervision. Rather, the personal characteristics and transference-countertransference reactions elicited within each specific relationship, and how these are handled between supervisor and supervisee, are the main contributing factors to the strength of the supervisory alliance and subsequent open disclosure.

Eleven (73%) of the participants reflected that colleagues had admitted to withholding comparable information from their respective supervisors during their M1 and M2 years. Three participants claimed that four or five of their colleagues had avoided disclosure of their thoughts or feelings to their respective supervisors regarding their supervisory interaction. Two participants said that *"several"* (P2) and *"many"* (P7) colleagues had admitted to withholding such information. Participant 3 mentioned that two or three of his colleagues did not disclose their thoughts or feelings regarding their supervisors, and Participant 4 said that about six of her colleagues acknowledged to her that they withheld such information. Both Participant 5 and 6 commented that about three of their colleagues respectively acknowledged to them a similar lack of disclosure. Participant 8 said that five or six of her colleagues acknowledged that they withheld their thoughts and feelings regarding their respective supervisors, and Participant 11 said that nine of her colleagues admitted to this. A total of 37 students between the years 2005-2007 could have been included in the research study, of whom 15 agreed to respond as participants. From the numbers reported above, the 15 participants reported that approximately 37 of their colleagues, at one point in time or another, admitted to withholding information from their respective supervisors. One must consider however, that the different participants could be referring to the same colleagues and the number '37' could thus be misleading.

4.4 Theme Two: Nondisclosure of countertransference reactions to the therapeutic process with the patient

The results show that ten participants acknowledged having withheld countertransference reactions to the therapeutic process from their supervisors. Withholding information within this theme referred to boundary or frame deviations with a patient. Therapists' verbal interventions that were *"embarrassing"* (P6), or felt to be *"inaccurate"* (P8) were not reported to their respective supervisors. Emotional responses that were considered to be inappropriate, such as *"erotic countertransference"* and if the therapist *"disliked a client"* were also not reported (P2). The participants' countertransference reactions to their patients also included dreams and fantasies about patients. For example, P13 found it difficult to *"take dreams to supervision"* (P13). This element will be discussed in greater detail, with reference to participant responses relevant to this theme. Withholding disclosure of countertransference reactions within this theme includes non-reporting of therapists' verbal communication in the therapy and omitting session information in the process notes, as well as editing verbatim transcripts.

P1 explained that she withheld information about boundary and frame deviations, as well as her emotional responses to her patients. She explained that she withheld information:

> *"usually around boundary/framework deviations – I struggled with play therapy and had a few occasions where I may have crossed the boundaries and I chose not to reveal this to my supervisors... On one occasion I felt that I became too emotionally involved with a patient and there was physical contact which I chose not to reveal to my supervisor – but rather changed the course of events in that session. I did however reveal it at a later supervision and it was dealt with then"* (P1).

P2 explained that he withheld information regarding his verbal interventions and emotional responses to his patient, as well as dreams and fantasies about his patient. He explained that if he felt that he has made *"a stupid or inappropriate verbal intervention I would not disclose it to my supervisor. On a few occasions I altered a transcript because I was too embarrassed to accurately report a verbal intervention. Withheld mention of erotic countertransference*

always. Wouldn't disclose if I disliked a client". P6 said that while she was generally quite open with her supervisor, she occasionally:

> "*held back on disclosing the extent of the anxiety I felt in response to some patients. This anxiety related to feelings of worry about patients (one patient who seemed quite fragile and distressed) and also related to my own anxiety about my competence in my work with this patient"* (P6).

From this, it can be seen that P6 withheld disclosure of her emotional responses to her patients about the therapeutic process. She also admitted to withholding information regarding her verbal interventions with her patient, and explained that on two separate occasions she edited the verbatim transcripts required for supervision. She explained the reason for editing her verbatim transcript as "*feelings of embarrassment"*. She reflected that "*it's quite exposing to show an authority figure a verbatim account of an interaction, especially when your intervention is meant to be therapeutic and sometimes comes out quite silly"* (P6).

Participant 8 stated that she withheld disclosing her countertransference reactions to her patients. She explained that in the beginning of her M1 year the concept of countertransference reaction was "*new*" to her. She felt:

> "*very exposed at disclosing information about my personal feelings towards my patient – in particular because at times I felt that I could personally identify with the issues my patient presented with. This caused anxiety as I wasn't sure if it was appropriate or not to feel this way and so thought that it would be better to keep it to myself"* (P8).

P8 also explained that she withheld information from her supervisor regarding verbal interventions in her internship year, as she feared that her supervisor would "*disapprove or comment negatively on the way that I had intervened, as I had many experiences of my transcripts of sessions being criticised. Most of what I would withhold would be interpretations or reflections that I judged inaccurate or wasn't sure of the usefulness of what*

I had said". Furthermore, P8 admitted to editing her verbatim transcripts as she was "*criticised*" for her transcripts being "*too long"*. As a result of this P8 explained that she often felt:

> "*attacked and so edited my transcripts to make them appear more like what my supervisor expected, to avoid criticism. My difficulties often were related to the length of my transcripts which I was told were far too long and so I would take out exchanges that I was unsure of – leaving only portions of the session remaining. I would hand in a transcript about every two weeks and I had to shorten them to make them more appropriate, so they would be edited each time"* (P8).

Participant 11 stated that she withheld information from her supervisor regarding her verbal interventions with her patient. She explained that she often felt uncomfortable disclosing incidents in which her patient asked her a question and she was unsure how to answer correctly. Instead of overtly asking her supervisor, she chose to rather pose her query as a "*hypothetical question"* in order to protect herself. Furthermore, P11 intentionally misrepresented accounts with her patient to her supervisor when she:

> "*knew that my intervention was not going to go down well with my supervisor as it was not an intervention that should have been used. For example, giving in to countertransference and being directive or overtly frustrated with the patient"* (P11).

Thus it is possible to see that P11 chose to withhold her countertransference reactions to her patient, particularly her feelings of frustration, and perceived incorrect directive interventions from her supervisor, as she feared receiving negative feedback.

Participant 12 recorded that she withheld disclosing information regarding a frame deviation in which she feared that her patient overheard her talking about him in the university canteen. P12 saw a man who looked similar to her patient standing near to her when she was talking about him to a colleague. Eventually P12 chose to disclose the incident to her supervisor and

it was worked through in supervision, and it was decided that it was "*unlikely*" that the man she saw was in fact her patient. P12 was initially afraid to disclose this boundary violation to her supervisor for fear that she would get into "*big trouble"* as she had "*violated confidentiality"* (P12). She was also afraid that she had somehow "*hurt"* her patient. P12 also explained that she chose to edit out information from transcripts that she considered to be *"waffle"*. P12 explained that "*I sort of made or kept on making some long winded summaries at the end of one particular session and I cut one or two of them back... I was embarrassed by the extent of my waffle more than content"* (P12).

P13 explained that he would attempt to present himself in a positive light to his supervisor, and would withhold information when he feared that he had "*done something wrong"* or said something inappropriate. He found it difficult to take dreams to supervision, as well as sexual countertransference. P14 explained that she felt the need to "*omit bits of my session"* with her M2 supervisor as she felt "*less safe"* with that supervisor. These 'bits' referred to a therapy plan that had been set up the previous year with her M1 supervisor, with which her M2 supervisor did not agree, but which P14 continued to utilise. She thus did not want to be perceived as an incompetent therapist by her M2 supervisor.

Participant 15 maintained that he withheld information from his supervisor regarding verbal interventions and expressions, as he feared that "*they may have not been useful or may be interpreted incorrectly or judged to be inappropriate by my supervisor"* (P15).

Six (40%) of the participants maintained that colleagues admitted to withholding comparable information from their respective supervisors during their M1and M2 years. P1 stated that all 11 students in her class revealed to her that they had withheld countertransference disclosure from their respective supervisors at some point during the year. P3 similarly explained that two or three students had divulged to him that they had withheld comparable disclosure. While P7 did not provide a specific number regarding the number of colleagues who had withheld information from their supervisors, he commented that "*certain colleagues at two internship sites in particular seemed to really battle with their supervisors and reported having endured rather than benefited from supervision experiences"*. P8 reported that at least

two other colleagues in her M1 supervision group had also chosen to withhold information regarding the therapeutic process with their respective patients, whilst P13 reported three colleagues and P15 reported five colleagues who testified to making the same choice.

4.5 Theme Three: Impact of disclosure on supervisory learning

This theme focused on whether or not the participants found that nondisclosure negatively impacted upon their learning process in the Clinical Masters years. Disclosure in this context refers to the countertransference reactions to patients as well as emotional reactions to the supervisor and supervisory process.

Eight (53%) of the participants felt that withholding information from their respective supervisors, whether regarding their patients or the supervision process, had a negative effect on their learning process. Participants 1 and 13 both felt that in retrospect, withholding information regarding countertransference reactions to patients and the supervision process had affected their learning. P1 explained that she felt that the selective reporting had:

> "*hindered my chance of learning all that I could to becoming a great psychologist. I found that once I was more honest in supervision and got useful feedback I was able to make the necessary changes in my therapy sessions and it made me more confident as a therapist"* (P1).

Similarly P13 explained that withholding information had influenced her learning negatively as she had "*missed some very useful opportunities to learn about therapy and myself as a therapist – once I was completely comfortable with my supervisors I shared everything and found that I learnt so much more and felt much more capable"*. Participant 7 concurred with this, feeling that "*important themes were missed"* and that consequently, as a result of her nondisclosure, her "*learning was stunted"* (P13).

Participant 8 had a very negative experience with one of her internship supervisors. She reported:

> "*In retrospect, I don't think that I experienced my supervision (one rotation) during my internship as a learning experience at all. It was rather something that had to be endured each week and I knew that I had to show that I was seeing patients and thinking about them theoretically, but I didn't experience it as a collaborative space where I gained insight into patients or myself as a therapist... I don't think any learning could take place within a relationship like the one I had with my internship supervisor anyway. Editing the transcripts made it worse because I felt angry that I did so much work and put so much effort into producing something that was at the end of the day valueless. It probably would have been more helpful to be honest and try and speak about how difficult it felt to please her and the dilemma that she put me in"* (P8).

Participants 2, 4 and 15 all maintained that while their nondisclosure had not had a "*permanent impact"* on the learning process (P2), it had slowed down the process and affected their feelings "*about attending supervision"* (P4), "*transference issues"* (P2), and "*confronting particular personal issues or challenging ideas that were misunderstood either by myself or my supervisor"* (P15).

Five participants, on the other hand, did not feel that their learning had been negatively impacted in any way. Whilst Participant 6 acknowledged withholding information regarding the therapeutic process with her patients, in the form of process notes and transcripts at times, she also explained that she was "*generally quite open even when it felt difficult"* (P6) and that her supervisor responded to her interventions in a "*non-punitive"* way. She thus did not feel that her selective disclosure of information negatively impacted on her learning. Whilst P9 chose to withhold information from her supervisors in order to cater to their theoretical orientation, she did not feel that she lost out on any learning experiences as she chose to "*focus on their field of expertise, for example CBT/systemic and thus would get supervision in these areas/modalities"*.

4.6 Summary

Three coded themes emerged from participants' responses to the questionnaires: 'The supervisory alliance contributes to supervisee countertransference disclosure'; 'nondisclosure of countertransference reactions to the therapeutic process' and 'the impact of nondisclosure on supervisory learning'. Nondisclosure of information either involved selective or partial disclosure or full nondisclosure. These three themes were then refined into twelve sub-themes.

The analysis shows that 93% of the participants openly acknowledged selective or nondisclosure in their supervision, which suggests that it was a common occurrence within the M1 and M2 years between the years 2005-2007. Furthermore, all fifteen participants agreed that the main contributing factor to either disclosure or nondisclosure of the therapy and supervision process was the level of security participants felt in the supervisory alliance.

The results showed that the evaluative role of the supervisor was a contributing factor to the extent of supervisee disclosure. Supervisees were hesitant to bring incorrect interventions to supervision, as they feared they would receive poor assessments and feedback. The results also reflected a developmental aspect in the degree of disclosure. Supervisees disclosed more information towards the end of the year than they did at the beginning of the year. This was based on their personal feelings of professional competency and confidence as well as the strength of the supervisory alliance that grew over the course of the year.

The participants who felt their learning was negatively affected by selective reporting and nondisclosure are the same participants who experienced weak alliances with their supervisors. Those participants who did not feel that their learning was negatively impacted by nondisclosure are those who reported a strong alliance and positive experiences with their supervisors. This supports the finding that the main contributing factor to either full disclosure, selective disclosure or nondisclosure of the supervisees, whether regarding countertransference reactions to the therapeutic process with the patient or with regard to the supervision process, is the strength of the working alliance between the supervisees and supervisors, and the comfort and safety supervisees feel in disclosing their sensitive feelings

and experiences to authority figures. Furthermore, the findings show that the strength of the alliance and subsequent level of disclosure has an impact on supervisory learning. The main themes and sub-themes have been summarised and presented in a table on the following page.

TABLE 1: SUMMARY OF THE THEMES AND SUB-THEMES IDENTIFIED AFTER THEMATIC CONTENT ANALYSIS OF THE FIFTEEN RETURNED SURVEYS

IDENTIFIED THEMES	PARTICIPANTS														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
THEME ONE															
Supervisory alliance contributes to Supervisee countertransference disclosure	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
SUB THEME															
1.1 Disclosure of Transference-countertransference reactions to supervisors and supervision	√	√	√	√	√	√	√	√			√	√	√		√
1.2 Performance Anxiety of supervisees and fear of negative assessment from supervisors	√	√				√	√	√					√	√	√
1.3 Demographics of Supervisees and Supervisors supervisee disclosure															
1.4 Theoretical Orientation of Supervisor								√	√					√	
1.5 Supervisor normalises the learning experience effects supervisee disclosure						√					√		√	√	√
1.6 Punitive Supervisor and effect supervisee disclosure		√										√	√	√	
1.7 Developmental element to the supervisory alliance and subsequent supervisee disclosure.											√		√	√	
1.8 Colleague Disclosure of transference-countertransference reactions to supervisors and supervision		√	√	√	√	√	√	√			√		√	√	

	PARTICIPANTS														
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**
THEME TWO															
Nondisclosure of Countertransference Reactions to Therapeutic Process with the Patient	√	√				√		√	√		√	√	√	√	√
SUB-THEME															
2.1: Relating to boundary/frame deviations	√							√				√			
2.2: Relating to verbal interventions and emotional responses	√	√				√		√	√		√	√	√		√
2.3: Relating to dreams/fantasies of patients		√											√		
2.4: Colleagues admitted to withholding countertransference information	√		√				√	√					√		√
	PARTICIPANTS														
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**
THEME THREE															
Impact of disclosure on supervisory learning	√	√		√	√	√	√	√	√			√	√	√	√
SUB-THEME															
3.1: Withholding information had a negative effect on learning	√	√		√			√	√				√	√		√

CHAPTER FIVE: DISCUSSION

5.1 Discussion of Findings

This study set out to investigate the extent of self-disclosure of trainee psychotherapists in the supervisory context, possible reasons for avoiding self-disclosure, and the implications of this for the learning process in supervision. The findings suggest that the dynamics that contribute to supervisee disclosure within the supervisory alliance, as addressed in the literature review, are present to a greater or lesser degree in this sample of trainee psychotherapists reflecting upon their supervision experiences during their M1 and M2 years of training at Wits University. The survey was developed to gather information in terms of these related areas. The relationship between the results of this study and the existing literature on supervision and supervisee disclosure is discussed below.

The results show that almost all of the supervisees (93%), withheld information from their psychotherapy supervisors. Nondisclosure in supervision took two forms: supervisees either did not disclose their feelings about the supervision process, or they withheld their feelings about the therapy process and the nature of interventions they used. These results were supported by the research findings of Yourman (2003) and Ladany *et al.,* (1996).

All the participants agreed that the main contributing factor to disclosure, either of their countertransference reactions to their patients and the therapy process, or their feelings about their supervisors and supervision, was the strength of the supervisory alliance, and the safety they felt in disclosing such information. This concurs with the claim in the literature review that the strength of the supervisory alliance, and the role of the supervisor in identifying and acknowledging the transference-countertransference interactions between supervisee and supervisor, are the main contributing factors to supervisee disclosure (Book, 1987; Gill, 1990; Ivey, 2007; Ladany *et al.* 1996; Lemma, 2006; Nigam *et al.,* 1997; Pisani, 2005; Yourman & Farber, 1996; Yourman 2003).

The results showed that participants engaged either in selective or partial disclosure, or complete non-disclosure. For example, selective disclosure involved participants choosing to

disclose to their supervisors certain aspects of the therapy process, whilst omitting other aspects of the therapy process, in order to avoid negative feedback from their supervisors. For example, three participants (8, 9 and 14) maintained that they chose to withhold certain therapeutic interventions with their patients when those interventions did not adhere to the theoretical framework of their supervisors. In the M1 year of training all participants are trained psychodynamically, however in the M2 internship year they might have had supervisors adhering to different theoretical orientations, such as Cognitive Behavioural Therapy (CBT). Those participants were therefore inclined to disclose selectively treatment plans and interventions that did not adhere to the supervisors' theoretical orientation, to avoid receiving negative feedback from their supervisors. This research finding was in line with Murphy & Wright (2005), who noted that the theoretical orientation of the supervisor is a contributing factor to supervisee nondisclosure. Supervisees feel the need to be seen to adhere to their supervisors' theoretical framework in order to avoid receiving negative feedback from their superiors.

Selective disclosure could also involve a supervisee choosing to disclose information about the therapy process, but to withhold information about the supervision process. For example, Participant 3 explained that he and his supervisor had a strong alliance and he thus felt comfortable to bring all aspects of the therapeutic process to supervision. However, he felt uncomfortable to talk about his feelings of frustration regarding the supervision process, as he did not want to offend a supervisor he respected. He thus selectively withheld certain information from his supervisors whilst disclosing other information.

It would appear however, that complete nondisclosure was the most common way in which the participants chose to withhold information from their supervisors, in the attempt to protect themselves from negative feedback and scrutiny. This was reflected in the accounts of 47% of the participants. For example, situations in which supervisors were experienced as punitive and overly judgemental by their supervisees contributed negatively to the strength of the working alliance and thus to the level of supervisee disclosure. As Murphy & Wright (2005) noted, supervisors could abuse their power by over-focussing on supervisees' mistakes, pathologising supervisees and verbally attacking them. Participants 2, 12, 13 and 14 had experiences of punitive supervisors, and as Participant 12 explained, she experienced her

supervisor to be "*personally attacking"* (P12) and thus did not disclose her feelings about the therapeutic process or the supervision process with her supervisor. She thus chose to withhold information in an attempt to protect herself from a punitive and judgemental experience with a supervisor.

In the context of withholding information about feelings in the therapy process, the participants admitted to omitting information from their supervisors about disliking certain patients, having dreams about patients as well as having erotic countertransference reactions towards some patients. Information about some verbal interventions and boundary deviations such as physical contact was also withheld, as participants feared they might be criticised by their supervisors. This finding is supported by the literature, which argues that beginner therapists are likely to withhold countertransference reactions from their supervisors regarding feelings of love, hate and sexual interest, as they feel that these feelings might be inappropriate and would reflect poorly on themselves as developing professionals (Wallace & Alonso, 1994).

Seven (47%) of the participants maintained that the evaluative element in the M1 year impacted negatively upon their feeling able to openly disclose their therapeutic interactions with their patients as well as their feelings regarding the supervision. This concurs with the literature that shows that supervisees are cognisant of being assessed by the supervisors while still expected to disclose professional ignorance (Ivey, 2007). Thus selective disclosure may result from performance anxiety in the face of assessment within the supervisory relationship, the nature of which is evaluative and regressive (Ivey, 2007). Furthermore, supervisees' personal feelings of competence contribute to levels of disclosure (Gill, 1999). Supervisees' levels of vulnerability and unconscious fear of narcissistic injury were found to affect the extent to which the supervisees disclose sensitive information to their supervisors (Halewood & Tribe, 2003). This was supported by the findings in this study, as ten out of fifteen of the participants maintained that their personal feelings of inadequacy and incompetence impacted upon their levels of disclosure, as did their awareness of the evaluative aspects of the Master's course. The fear of being judged as incompetent thus impacted upon their levels of disclosure. Furthermore, the participants in the research acknowledged that they did not disclose countertransference reactions to patients (such as verbal interventions, emotional

reactions and boundary and frame deviations) to their supervisors as they feared their supervisors would accuse them of "*doing something wrong*" (P13), and they were "*embarrassed*" to report verbal interventions they considered incorrect or "*stupid"* (P2).

Mollon (1989, in Webb, 2000) also suggests that supervisees' feelings of shame impact upon the level of disclosure in supervision, leading them to omit information about the therapeutic process. Shame is thus a significant factor affecting the level of openness in supervision. Supervisees fear the loss of their supervisors' respect as a result of mistakes made in therapy or professional ignorance shown in their training. This was found in the results of this study, with ten participants who acknowledged having withheld their countertransference reactions to the therapeutic process from their supervisors. As Participant 6 explained, the reason she withheld information from her supervisor was due to "*feelings of embarrassment"*. Participant 6 explained that she felt ashamed and exposed when she presented verbatim accounts of her interventions that she had intended to be therapeutic but which had turned out rather to appear *"silly"*. She reflected upon her fear of losing the respect of her supervisor as well as her insecurity regarding her professional competence in the light of having to disclose her mistakes and ignorance. These conflicting emotions and demands led Participant 6 to withhold information from her supervisor in an attempt to protect herself from narcissistic injury, as a result of shame caused by the emotionally vulnerable and exposing nature of supervision.

In addition, 40% of the participants maintained that their colleagues also acknowledged withholding information from their supervisors regarding the therapeutic process, for example case material, or feelings about their patients or interventions. The statistics reflect a substantial percentage of students who chose to withhold information from their supervisors. This is in line with research found by Yourman & Farber (1996) who found a similar frequency of supervisee nondisclosure regarding case material (deriving from the desire to appear more competent to their supervisors as a result of experiencing feelings of shame). This high frequency of nondisclosure suggests that due to the evaluative element of supervision, especially in training facilities, feelings of shame and narcissistic vulnerability may be common emotions amongst trainee psychotherapists. It would therefore appear that Yourman & Farber (1996) are correct in their assertion that a certain level of nondisclosure

from supervisees is an inevitable occurrence in supervision. Thus, unless a strong alliance has been developed within the supervisory dyad, it is likely that supervisees will withhold information from their supervisors.

Furthermore, 73% of the participants maintained that their colleagues withheld information regarding their feelings about the supervision process. The discrepancy in the two statistics reflect that supervisees are more inclined to withhold information about feelings related to the supervision process than about feelings related to the therapy process. Their sensitivity to the emotional connection and comfort within the supervisory alliance influences their level of disclosure. This finding is supported by Yourman & Farber (1996) who maintain that there is a positive correlation between supervisee satisfaction with the supervision process and communication within the supervision context. This however, may be due to the level of communication within the supervision context, as Ladany *et al.* (2006) explain, in that the rules and goals for supervision need to be explicitly stated and agreed upon by both parties within the alliance. For example, Participants 4 and 6 reported that they did not feel that "*supervision was the place to discuss these anxious feelings"* (P6), and that the anxieties about supervision were best suited for their personal therapies. This further highlights the ambivalence implicit in every supervisory alliance regarding 'teach versus treat' (Ivey, 2007). Perhaps if the participants had known that their anxieties could be safely explored within the supervision, it would have encouraged further communication within their alliances and thus increased disclosure of both the therapy process as well as the supervision process. The rules underlying each supervisory alliance need to be agreed upon by the individuals comprising the relationship, and thus the extent of personal communication and exploration is a personal decision agreed upon within each alliance (Ivey, 2007; Ladany *et al.*, 2006).

The results of the study indicate that there is a developmental element in the establishment of the supervisory alliance and in supervisee disclosure. As Bernard & Goodyear (2004) noted, supervision is a relationship that extends over time, thus allowing for an alliance to develop. Consequently, the supervisory relationship will not be as secure at the beginning of the relationship as it will be further into the relationship, once trust has been developed, common goals have been set and rapport has been built. This progression in communication is similar to the developing relationship between patient and therapist. The similarity in this instance

between the therapeutic and the supervisory relationship supports the assertion that the supervisee's vulnerability in the supervisory relationship is similar to the patient's vulnerability in the therapeutic relationship. Thus the term 'supervisory alliance' is used, since this relationship has much in common with the therapeutic alliance (Gabbard, 2004). Therefore, just as patients need to feel safe and secure within the therapeutic alliance to disclose their vulnerable information and feelings, supervisees similarly need to feel safe and secure within their alliance. Additionally, as with the therapeutic alliance, the supervisory alliance between supervisee and supervisor takes time to develop. Supervisees will thus disclose more information later in the relationship than they did earlier in the relationship.

Furthermore, Brightman (1984) noted that there is a regressive component to the supervisory relationship. Supervisees regress to infantile states at the beginning of the supervisory relationship, and through the growing alliance with their supervisors, they progress through the developmental stages delineated by Brightman (1984). This is noted by four of the participants (P1, 10, 11, 13 and 14) who admitted to withholding more information from their supervisors at the beginning of the relationship, earlier in the year, when they felt less secure in the alliance and less confident professionally, as compared to later in the year, once an alliance had been built and professional skill had developed. Thus the participants progressively disclosed more information to their supervisors once they felt more competent within themselves as professionals and once they felt more comfortable within the supervisory alliance.

While previous research conducted by Pisani (2005) and Granello (2003) found that race, age and gender are contributing factors to the supervisory alliance and subsequent supervisee disclosure, the results of this study indicate that these are not significant factors in supervisee disclosure. As mentioned in the results, of the fifteen participants in the study, four were male and eleven were female. The average age of the participants ranged from 20-30 years. The participants reported on a number of supervisors, including the M1 and the M2 internship supervisors. Thus it is difficult to establish whether the ages of the supervisees relative to the ages of the supervisors is a significant contributing factor to disclosure. However, it is possible to conclude that the age of the supervisees does not influence the different personal experience of supervision, in contrast to the findings of previous research conducted by

Granello (2003) who found that older supervisees had qualitatively different experiences of supervision from the younger supervisees as a result of being treated differently by their supervisors. Furthermore, race did not appear to be a contributing factor to the strength of the alliance. Participants experienced strong alliances with supervisors from the same race as well as with those from different races. Similarly, participants experienced poor alliances with supervisors from the same and different races. However, this issue needs to be researched in its own right.

It was interesting to note that while there was a large quantity of literature investigating the various reasons for nondisclosure (Book, 1987; Gill, 1999; Ivey, 2007; Ladany *et al.* 1996; Ladany *et al.,* 2006; Pisani, 2005; Crick, 1991 in Webb, 2000; Yourman & Farber, 1996; Yourman 2003) there was limited information on implications for supervisory learning. Whilst Wallace & Alonso (1994) acknowledged that supervisee nondisclosure does impact on learning, the specific implications for learning from the supervisees' perspective has not been fully investigated. This could be because past research has been conducted mainly from the supervisor's perspective and did not consider the supervisees' subjective experiences regarding nondisclosure and the implications for learning. Furthermore, the studies that did focus on the supervisees' perspectives were quantitative and thus did not include the implications for supervisory learning (Webb 2000).

While all the participants concurred that the strength of the supervisory alliance had a direct effect on the levels of disclosure, the results gathered from this study revealed that over half of the participants (53%) concluded that withholding information from supervision had a negative impact on supervisory learning. This is a high statistic, indicating that over half of the students leave their training feeling that their training has been compromised due to feelings or experiences that they could not openly communicate with their superiors. The implications of this should be considered.

For example, Participant 8 explained that her supervision during her internship year had to be '*endured*' rather than enjoyed. Consequently, she felt that she fell short of developing her full potential as a psychotherapist during her training in her M2 year. She thus felt the need to

seek her own external supervisor to compensate for the poor experience and insufficient learning that occurred. This is relevant, as supervision is an integral part of the learning experience at training institutions. If students do not feel safe enough to disclose their feelings regarding their psychotherapy or supervision experiences, learning is going to be hampered. Another participant (13) shared these sentiments. She said that she felt she had missed useful learning opportunities due to her nondisclosure, and that this had impacted upon her ability to reach her potential as a psychologist during her training years.

Furthermore, the findings suggest that participants who did not feel that their learning had been compromised either had positive experiences with their supervisors, or their selective disclosure resulted solely from personal insecurities. In this case the supportive relationship with the supervisor outweighed the selective disclosure, thus allowing learning to take place. For example, Participants 1, 3, 8 and 10 explained that they experienced strong alliances with their supervisors and thus did not feel the need to withhold any information from their supervisors, and did not experience any negative impact on their learning. Participant 6 explained, that her selective disclosure was triggered by her own anxieties related to presenting her work, and not due to an unsupportive supervisor. She therefore did not feel that her work suffered in any way. The same is true for Participant 3 who felt secure enough to bring his therapeutic case material to his supervisor, but chose to withhold information related to the supervision context for fear of damaging the positive bond.

5.2 Conclusion of Findings

The results reflect that it is common for supervisees to withhold information from their supervisees, whether it concerns the therapy process or the supervision process. Supervisees appear to be more inclined to withhold their feelings about supervision than therapy. The level of disclosure in this instance is largely influenced by the degree of safety felt within the alliance. Disclosure is facilitated if rules are agreed upon regarding disclosure and emotional exploration. Supervisees are also inclined to withhold information, either partially or completely, regarding case material or interventions of the therapy process if they fear negative feedback from their supervisors. The level of disclosure in this category is influenced by supervisees' feelings of vulnerability in supervision and their insecurity

concerning their competence. The supervisors have an evaluative role, which influences supervisees' fear of being assessed negatively for incorrect interventions. Thus the degree of vulnerability in supervision and consequent level of disclosure is influenced by the strength of the alliance. The results reflected a developmental aspect to the strength of the alliance and subsequent supervisee disclosure, so that supervisees would disclose more information later in the year as the supervisory alliance was strengthened over time through developing rapport and trust. Thus the supervisory alliance could be likened to the therapeutic alliance, as trust, goals and rapport need to be built within the dyad in order to allow for disclosure. Furthermore, as supervisees' confidence developed regarding their professional competency, they felt progressively more comfortable to disclose errors without fearing feedback from the supervisors.

The results showed that irrespective of the supervisory experience, all of the participants agree that the main contributing factor to disclosure, whether it relates to the therapy or supervision process, is the strength of the supervisory alliance together with the comfort felt within supervision.

The participants who felt that their learning was negatively impacted upon as a result of selective or nondisclosure were those who did not feel secure enough to bring case material to their supervisors, and who feared negative feedback from them. The participants who had a generally negative supervisory experience felt that their learning was diminished. This is important, as supervision is an integral part of the learning process for training psychotherapists at learning institutions. Supervisors thus need to be aware of supervisees who do not feel secure in the alliance, since the latter will withhold information from the supervision, whether relating to the psychotherapy or supervisory process. Consequently, supervisees will ultimately feel that the quality of their training has been compromised to some degree if they do not feel secure enough to bring all aspects of their learning experiences to their supervision.

5.3 Limitations of the Research

As discussed previously, it was decided by the interviewer that an open-ended questionnaire would be sent to the participants so as to ensure a greater degree of anonymity, thus allowing for an optimal response rate. Participants would be likely to feel comfortable to disclose openly in the security of anonymity and confidentiality. One participant, however, remarked during the data collection stage that she would have been more comfortable with a face-to-face interview in order to discuss and reflect upon the topic and the nature of the survey.

Whilst most of the participants' responses were rich in information, after grouping the questions into their three question clusters (discussed in Chapter 3), the researcher noticed that many of the questions 'elicited' the participants' answers. Whilst the researcher attempted to frame each question in an open-ended format to encourage in-depth responses from the participants, upon reflection it became apparent that each question was framed around a specific theme, for example 'countertransference reactions to their patients', 'transference reactions to their supervisors', 'implications for supervisors learning', etc. As one-to-one interviews were not conducted, further reflection on any particular question or answer provided by the participants was not possible. While an attempt was made to encourage reflection through the questions, specifically with an additional 'reflection question' at the end of the survey, (Question 14, see Appendix 2), this question did not appear to yield significantly more information.

5.4 Suggestions for Future Research

Given that the aim of the research was to assess experiences of supervision from the supervisees' perspectives, together with their subjective reasons for nondisclosure and the implications of this for supervisory learning, it is recommended that future data be collected via a one-to-one interview format. Upon reflection on the process, it appears that the participants were willing to engage with the study in spite of the sensitive nature of the subject, and found the process of communicating their supervision experiences cathartic. This can be inferred from the honest responses of the participants, who willingly reflected on their training experiences. For example, Participant 12 stated in the questionnaire that:

> *"I did register some anger during this process towards the one supervisor despite my understanding why she is the way she is in the world. This has possibly helped in a sense that it has given me a voice where before I didn't have one"*

It can thus be assumed that future participants will be open to the study and interview process, once anonymity and confidentiality have been assured.

CHAPTER SIX: SUMMARY AND CONCLUSION

6.1 Summary

This research report set out to explore the extent of self-disclosure of trainee psychotherapists in the supervisory context. In doing this, possible reasons for avoiding self-disclosure and the implications of this for the learning process in supervision were examined. This study aimed to explore the possible reasons for nondisclosure and subsequent implications from the subjective perspectives of the supervisees. Prior research in the field has focused primarily on the supervisors' perspectives or has adopted a quantitative approach. Thus an in-depth exploration into the motives and experiences of the supervisees has not been undertaken previously.

A sample comprising fifteen past students who attended Wits University between the years 2005-2007 returned the researcher-developed questionnaire, and a thematic content analysis of the data was undertaken. Three main themes and twelve subthemes emerged as a result of the analysis. The main coded themes were: The supervisory alliance contributes to supervisee countertransference disclosure; nondisclosure of countertransference reactions to the therapeutic process with the patient; and the impact of disclosure on supervisory learning. The data was analysed vertically and horizontally in order to identify the themes that related to each participant individually and recurred between the participants.

The results of the data analysis were discussed in relation to the themes in the literature. The similarities and differences in the responses were analysed in terms of the extent to which the themes supported or challenged the arguments regarding the relationship between supervisee disclosure and the supervisory alliance, and its subsequent implications on supervisory learning, as discussed in the literature review.

6.2 Conclusion

The results of the research support the argument that the strength of the supervisory alliance is the main contributing factor to supervisee disclosure of feelings about the therapy process with patients or the supervision process with supervisors. Supervisees choose either to be

completely transparent within the supervisory alliance and fully disclose information to their supervisors, partially disclose information by selectively choosing which information they disclose and which information they withhold, or to resort to total nondisclosure, omitting entire aspects of either the therapy or supervision process.

The evaluative role of the supervisor is a contributing role to incomplete disclosure as supervisees are hesitant to bring incorrect interventions to supervision for fear that they will be judged negatively and receive poor assessments and feedback. The results also reflected a developmental aspect in the extent of disclosure, so that supervisees disclosed more information towards the end of the year than they did at the beginning of the year. This developmental aspect was based on their personal feelings of growing professional competency and confidence as well as the strength of the supervisory alliance, which grew over the course of the year. This supervisory alliance could therefore be compared to the therapeutic alliance in many ways as common goals, trust and rapport had to be developed in order for disclosure to take place.

The participants who experienced a strong alliance with their supervisors generally engaged in either full or partial disclosure of information. The participants who manifested high levels of nondisclosure of both the therapy process as well as the supervision process were those who experienced a weak alliance with their supervisor. In this context they did not feel secure enough to bring their feelings of inadequacy to the supervision process for fear of being judged or assessed negatively by their supervisors. This group of participants felt that their learning experiences were negatively affected, since important learning opportunities had been missed. Consequently they felt that during their M1 and M2 years of training they did not reach their full potential as training psychotherapists. This finding was relevant as supervision is an essential part of the training for the Clinical Master's psychology course. The study highlights the conclusion that supervisees who do not feel secure in their supervisory alliances will withhold important information from their supervisors, which will subsequently compromise their training and development in the course.

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APPENDIX 1: Participant Information Letter

Hello,

My name is Karen Berger and I am currently completing my Masters degree in Clinical Psychology at the University of the Witwatersrand (Wits). I obtained your name and contact details from the Wits psychology data base. I am conducting research to assess the extent of self-disclosure of trainee psychotherapists in the supervisory context. I am attempting to explore the degree of self-disclosure, possible reasons (if any) for trainee psychotherapists' avoiding self-disclosure within the supervision context, and the self-perceived implications of this for the learning process in supervision. The psychotherapy supervision referred to pertains to both first year and/or the internship year of your training.

Participation will entail completing an anonymous questionnaire relating to your experience of disclosing information in the context of psychotherapy supervision. There are no consequences, benefits, or risks of participating in this research. You are not required to provide your own, or your supervisor/s name. Please do not provide any information pertaining to your supervision that you consider sensitive or private. You are not required to specify if the supervisor/s you are referring to is/are from the department or from your internship site. I will type out your answers, so that no identifying information will be given to my research supervisor, merely the answers required for analysis. This will ensure that confidentiality and anonymity is maintained throughout the research study. All the raw data will be destroyed upon completion and evaluation of the research. Relevant quotes from the questionnaire will be included in the research report, in order to illustrate particular themes. However, no identifying information will be included in such quotes. The results may be reported in the form of a journal article. Should you wish to receive it, a summary of the results of the study will be available on request, once the study is completed.

Should you wish to complete the questionnaire, contact me via email, and it will be sent to you with a stamped self-addressed envelope. This will ensure your confidentiality and

anonymity. Furthermore, the names of people who respond to this email will not be divulged to anyone, including my research supervisor.

Should have any further queries regarding my research please feel free to contact me via email on karen@berger.org.za or telephonically at (011) 440-9550.

Your assistance is very much appreciated.

Sincerely,

Karen Berger

MA Clinical Psychology Student

Wits University

APPENDIX 2: Questionnaire

Supervisee Experience of Supervision

Date: _____

DEMOGRAPHIC DETAILS

1. Your Age:_____
2. Your Gender:
   [Female/Male]_____
3. Supervisor/s Gender:
   [Male/Female]_____
4. Your Race:
   Black/Indian/Coloured/White/Other_____
5. Supervisor/s Race:
   Black/Indian/Coloured/White/Other_____

QUESTIONNAIRE

I am interested in your answers and opinions, whether positive or negative. Please answer all of the questions as fully and as honestly as possible.

1. In the course of your psychology masters training, (including you internship year) did you ever find yourself withholding information from your psychotherapy supervisor/s pertaining to your psychotherapeutic work with one or more patients? [For example: boundary/framework deviations; emotional responses to patients; fantasies/dreams about patients; specific verbal interventions, etc]. [Yes/No]. If so, what kind of information was this? (Please be as specific as possible).

2. In the course of your training, did you ever find yourself intentionally misrepresenting your interaction or interventions with one or more patients to a psychotherapy supervisor? [Misrepresenting in this context means modifying/altering an account of what actually occurred in the therapeutic interaction, rather than reporting events as accurately as possible]. [Yes/No]. If so, could you please provide details about what was modified.

3. In your psychotherapy transcripts and process notes submitted to your supervisor/s, did you ever edit your verbatim interventions to make them appear better in some way? If so, on approximately how many occasions would you estimate you did so?

4. If you answered positively to any of the above questions, could you please provide your reasons for editing, withholding or misinterpreting the information concerned?

5. Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about accurately reporting psychotherapy session material and your feelings about this material? [Yes/No]. If so, what?

6. If you answered positively to any of the first three questions, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?

7. In the course of your training, did any fellow students acknowledge to you having engaged in the activities outlined in the first three questions. [Yes/No]. If so, approximately how many students do you recall having done so?

8. In the course of your training, did you ever find yourself avoiding disclosure of particular thoughts and feelings related to your psychotherapy supervisor/s and your interaction with him/her/them? [Yes/No]. If so, what specific thoughts and feelings did you avoid disclosing?

9. If you answered positively to Question 8, what made you feel that you could/should not disclose those thoughts or feelings?

10. If you answered positively to Question 8, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?

11. In the course of your training, did any fellow students acknowledge to you that they avoided the disclosure of thoughts or feelings regarding their supervisory interaction to the supervisors concerned? If so, approximately how many students do you recall having done so?

12. Did you feel that your relationship and interaction with your supervisor/s impacted upon your comfort/ease in openly disclosing information relevant to the supervision process? If so, in what way?

13. Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about disclosing thoughts or feelings relating to them and the supervisory process? If so, what?

14. Did you register any particular emotional responses to this questionnaire? If so, what were these?

Thank You for taking the time to complete this questionnaire, your assistance is very much appreciated.

*In correspondence with the participants, the researcher indicated that the data would be destroyed. However, following this the researcher's supervisor indicated that the data should be available for examination purposes. No identifying data was included in the appendices and thus the confidentiality of the participants was not breached.

APPENDIX 3: Participant Responses to Questionnaire (1-15)

Supervisee Experience of Supervision

Participant 1

DEMOGRAPHIC DETAILS

Age: 29 years

Gender: Female

Supervisor/s Gender: 4 Females (M1) Male (M2)

Race: Indian

Supervisor/s Race: All White

QUENSTIONNAIRE

I am interested in your answers and opinions, whether positive or negative. Please answer all of the questions as fully and as honestly as possible.

In the course of your psychology masters training, did you ever find yourself withholding information from your psychotherapy supervisor/s pertaining to your psychotherapeutic work with one or more patients?

Occasionally, usually around boundary/framework deviations – I struggled with play therapy and had a few occasions where I may have crossed the boundaries and I chose not to reveal this to my supervisors.

In the course of your training, did you ever find yourself intentionally misrepresenting your interaction or interventions with one or more patients to a psychotherapy supervisor?

Yes. On one occasion I felt that I became too emotionally involved with a patient and there was physical contact which I chose not to reveal to my supervisor – but rather changed the course of the events in that session. I did however, reveal it at a later supervision and it was dealt with then.

In your psychotherapy transcripts and process notes submitted to your supervisor/s, did you ever edit your verbatim interventions to make them appear better in some way?
Yes. Only at the very beginning for about 3 sessions, but then I realized the value that those mistakes I made had on my learning.

If you answered positively to any of the above questions, could you please provide your reasons for editing, withholding or misinterpreting the information concerned?
I think for all three questions I did what I did, as I was nervous to do anything wrong – I wanted to give a good impression to my supervisors. And in group supervisions, I guess I didn't want to look like a bad therapist in the eyes of peers. I soon realized, though, that making the mistakes (that I had edited etc) was part of the process and that by being honest I would learn how to overcome them.

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about accurately reporting psychotherapy session material and your feelings about this material? [Yes/No]. If so, what?
I think my supervisors did say and do whatever they needed, in order to make me believe that making mistakes were ok and part of the process. That's how I was able to be completely honest with them and myself.

If you answered positively to any of the first three questions, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?
I think that when I was being selective over what I reported, it hindered my chance of learning all that I could to becoming a great psychologist. I found that once I was more honest in supervision and got useful feedback I was able to make the necessary changes in my therapy sessions, and it made me more confident as a therapist.

In the course of your training, did any fellow students acknowledge to you having engaged in the activities outlined in the first three questions. [Yes/No].
Yes, maybe all (11) at some point or another.

In the course of your training, did you ever find yourself avoiding disclosure of particular thoughts and feelings related to your psychotherapy supervisor/s and your interaction with him/her/them? [Yes/No]. If so, what specific thoughts and feelings did you avoid disclosing?

Yes, when they made certain reflections that I didn't agree on about either my or one of my colleagues psychotherapies.

If you answered positively to Question 8, what made you feel that you could/should not disclose those thoughts or feelings?
Once again I think it was that feeling of uncertainty – they are the professionals, so they should know better. Once I became more confident in my own skin as a therapist I was able to speak out more.

If you answered positively to Question 8, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?
To a certain degree I guess I held myself back from sharing my opinions and offering my thoughts –which could have helped in my own development, and could have shown my supervisor my perspective on certain issues, which would have helped them understand me better, leading to a more connected supervisory relationship.

In the course of your training, did any fellow students acknowledge to you that they avoided the disclosure of thoughts or feelings regarding their supervisory interaction to the supervisors concerned? If so, approximately how many students do you recall having done so?
Yes, maybe 4/5

Did you feel that your relationship and interaction with your supervisor/s impacted upon your comfort/ease in openly disclosing information relevant to the supervision process? If so, in what way?
Yes, in the beginning I felt daunted by them – once a more trusting relationship was built it was easier.

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about disclosing thoughts or feelings relating to them and the supervisory process? If so, what?
Nothing that I can think of.

Did you register any particular emotional responses to this questionnaire? If so, what were these?

Nostalgia – it's funny to look back and see how I've grown as a person and a psychologist. The relationships with ALL my supervisors were very valued and I hold utmost respect and gratitude to them.

Participant 2

DEMOGRAPHIC DETAILS

Age: 30+
Gender: Male
Supervisor/s Gender: White
Your Race: White
Supervisor/s Race: Black & White

QUENSTIONNAIRE

I am interested in your answers and opinions, whether positive or negative. Please answer all of the questions as fully and as honestly as possible.

In the course of your psychology masters training, (including you internship year) did you ever find yourself withholding information from your psychotherapy supervisor/s pertaining to your psychotherapeutic work with one or more patients?
Yes: If I felt I had made what I considered a stupid or inappropriate verbal intervention I would not disclose it to my supervisor. On a few occasions I altered a transcript because I was too embarrassed to accurately report a verbal intervention. Also in group supervision, if it was dragging on and becoming boring and tiring listening to several other's cases, I would withhold problematic parts of the therapy deciding to do my own reading up or, if I thought I had an insight into the dynamics behind the 'problem', simply not highlighting it. Withheld mention of erotic countertransference always. Wouldn't disclose if I disliked a client.

In the course of your training, did you ever find yourself intentionally misrepresenting your interaction or interventions with one or more patients to a psychotherapy supervisor?
Yes – same as above. On occasion if I was embarrassed about a verbal intervention I would alter the transcript.

In your psychotherapy transcripts and process notes submitted to your supervisor/s, did you ever edit your verbatim interventions to make them appear better in some way?
Yes. Perhaps half a dozen over the two years.

If you answered positively to any of the above questions, could you please provide your reasons for editing, withholding or misinterpreting the information concerned?
Scared of being seen as not being adequate and lagging in my progress as a developing therapist. Narcissistic motivation to appear better than I was. Some fear of supervisor getting angry with me or judging me in some way. Re erotic countertransference, uncertain about the usefulness of disclosure as well as my own shame. Some supervisors failed to inspire adequate confidence in either their abilities as supervisors or their personal professionalism. Information withheld from supervisor who had just finished Comm. Service since he/she failed to inspire any confidence and had little knowledge/experience of psychodynamic therapy. Regarding not liking some clients, felt it was 'not ok' to dislike a client and that, although the supervisor may work with it professionally, they would still look down on me for disliking someone.

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about accurately reporting psychotherapy session material and your feelings about this material? [Yes/No]. If so, what?
Maintain a high level of professionalism at all times. Demonstrate competence.

If you answered positively to any of the first three questions, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?
Probably slowed specific learning areas down somewhat, but looking back, don't think in any permanently damaging way.

In the course of your training, did any fellow students acknowledge to you having engaged in the activities outlined in the first three questions. [Yes/No].
No.

In the course of your training, did you ever find yourself avoiding disclosure of particular thoughts and feelings related to your psychotherapy supervisor/s and your interaction with him/her/them? [Yes/No]. If so, what specific thoughts and feelings did you avoid disclosing?
Yes. Most often about inappropriate and unprofessional behavior or comments in supervision, as well as an inability to appropriately manage group supervision. Choice of supervision venue was inappropriate with one supervisor. Sometimes wished supervisor was less boundaried, although appreciated this same thing as well.

If you answered positively to Question 8, what made you feel that you could/should not disclose those thoughts or feelings?
Possibility of supervisor being narcissistically wounded. Possibility of supervisor seeing me as 'too big for my boots'. Likelihood of supervisor giving negative feedback or poor marks. Analytic community is small so don't queer your pitch at this early stage of your career.

If you answered positively to Question 8, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?
Certainly, regarding transference issues.

In the course of your training, did any fellow students acknowledge to you that they avoided the disclosure of thoughts or feelings regarding their supervisory interaction to the supervisors concerned? If so, approximately how many students do you recall having done so?
Several

Did you feel that your relationship and interaction with your supervisor/s impacted upon your comfort/ease in openly disclosing information relevant to the supervision process? If so, in what way?
Yes. If they don't have your confidence for whatever reason, they're not going to get the full story in supervision. Conversely, if they are mature, professional and knowledgeable, they'll get a close to accurate account.

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about disclosing thoughts or feelings relating to them and the supervisory process? If so, what?
As above

Did you register any particular emotional responses to this questionnaire? If so, what were these?
Yes. Some disdain and anger for some of the poor quality supervisors we were subject to – interestingly the poorer supervisors were encountered in group supervision (but that's not to say that all group supervisors were poor. Indeed two of my group experiences were with

superb supervisors). Also some renewed admiration and appreciation for the excellent, professional, knowledgeable and competent supervisors we were exposed to.

Participant 3

DEMOGRAPHIC DETAILS

Your Age: 24
Your Gender: Male
Supervisor/s Gender: Female
Your Race: White
Supervisor/s Race: White

QUENSTIONNAIRE

I am interested in your answers and opinions, whether positive or negative. Please answer all of the questions as fully and as honestly as possible.

In the course of your psychology masters training, (including you internship year) did you ever find yourself withholding information from your psychotherapy supervisor/s pertaining to your psychotherapeutic work with one or more patients? [For example: boundary/framework deviations; emotional responses to patients; fantasies/dreams about patients; specific verbal interventions, etc]. [Yes/No]. If so, what kind of information was this? (Please be as specific as possible).
No

In the course of your training, did you ever find yourself intentionally misrepresenting your interaction or interventions with one or more patients to a psychotherapy supervisor? [Misrepresenting in this context means modifying/altering an account of what actually occurred in the therapeutic interaction, rather than reporting events as accurately as possible]. [Yes/No]. If so, could you please provide details about what was modified.
No

In your psychotherapy transcripts and process notes submitted to your supervisor/s, did you ever edit your verbatim interventions to make them appear better in some way? If so, on approximately how many occasions would you estimate you did so?
Not as far as I can recall.

If you answered positively to any of the above questions, could you please provide your reasons for editing, withholding or misinterpreting the information concerned?

_____

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about accurately reporting psychotherapy session material and your feelings about this material? [Yes/No]. If so, what?
I feel the supervisors were open and supportive, thus I never felt I couldn't bring what really happened to supervision.

If you answered positively to any of the first three questions, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?

_____

In the course of your training, did any fellow students acknowledge to you having engaged in the activities outlined in the first three questions. [Yes/No]. If so, approximately how many students do you recall having done so?
Yes, maybe two or three

In the course of your training, did you ever find yourself avoiding disclosure of particular thoughts and feelings related to your psychotherapy supervisor/s and your interaction with him/her/them? [Yes/No]. If so, what specific thoughts and feelings did you avoid disclosing?
Yes. I avoided disclosing how I felt annoyed at times when transcripts that were handed in on time were only handed back to me between one and one and a half months later.

If you answered positively to Question 8, what made you feel that you could/should not disclose those thoughts or feelings?
My supervisor was going through a lot of her own personal problems, which could not be avoided, thus it felt wrong for me to insist on something that she was already battling with.

If you answered positively to Question 8, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?

It meant that often I only got feedback much later and as a result I found myself trying to seek supervision through many other sources. I feel my supervisor had a lot more knowledge to give which I then missed out on.

In the course of your training, did any fellow students acknowledge to you that they avoided the disclosure of thoughts or feelings regarding their supervisory interaction to the supervisors concerned? If so, approximately how many students do you recall having done so?
Yes. One or two.

Did you feel that your relationship and interaction with your supervisor/s impacted upon your comfort/ease in openly disclosing information relevant to the supervision process? If so, in what way?
Yes because of our relationship I felt comfortable bringing all aspects of therapy to supervision. However, because of our relationship I also struggled to disclose certain feelings towards my supervisor and supervision which meant things were not always discussed and processed.

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about disclosing thoughts or feelings relating to them and the supervisory process? If so, what?
Not really

Did you register any particular emotional responses to this questionnaire? If so, what were these?
I felt quite uncomfortable at times because it felt like I was detracting from what was essentially a great supervision experience. The issues I had regarding my supervisor were not in her control and mentioning them felt like taking away from the type of person she really is.

Participant 4

DEMOGRAPHIC DETAILS

Age: 29
Gender: Female
Supervisor/s Gender: Male
Your Race: White
Supervisor/s Race: Black

QUENSTIONNAIRE

I am interested in your answers and opinions, whether positive or negative. Please answer all of the questions as fully and as honestly as possible.

In the course of your psychology masters training, (including you internship year) did you ever find yourself withholding information from your psychotherapy supervisor/s pertaining to your psychotherapeutic work with one or more patients?
No, not really. The supervision space felt safe enough to explore various aspects of the psychotherapy.

In the course of your training, did you ever find yourself intentionally misrepresenting your interaction or interventions with one or more patients to a psychotherapy supervisor?
No. Supervision was treated as a safe learning experience. My supervisor was not punitive about the therapeutic intervention and interaction and it felt safe to explore my process with my patient in supervision.

In your psychotherapy transcripts and process notes submitted to your supervisor/s, did you ever edit your verbatim interventions to make them appear better in some way?
No.

If you answered positively to any of the above questions, could you please provide your reasons for editing, withholding or misinterpreting the information concerned?
N/A

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about accurately reporting psychotherapy session material and your feelings about this material? [Yes/No]. If so, what?
My supervisor provided criticism in a constructive way and although at times it was difficult to receive criticism, especially on transcripts, I feel that my supervisor was generally sensitive and thoughtful about the criticism he gave.

If you answered positively to any of the first three questions, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?
N/A

In the course of your training, did any fellow students acknowledge to you having engaged in the activities outlined in the first three questions.
No

In the course of your training, did you ever find yourself avoiding disclosure of particular thoughts and feelings related to your psychotherapy supervisor/s and your interaction with him/her/them? [Yes/No]. If so, what specific thoughts and feelings did you avoid disclosing?
Yes. Some transference feelings that I chose to rather take to my own personal therapy.

If you answered positively to Question 8, what made you feel that you could/should not disclose those thoughts or feelings?
It felt like more of a therapy issue than a supervision issue.

If you answered positively to Question 8, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?
I feel that it did not really impact on my academic growth in supervision, but possibly impacted on some feelings about attending supervision.

In the course of your training, did any fellow students acknowledge to you that they avoided the disclosure of thoughts or feelings regarding their supervisory interaction to the supervisors concerned? If so, approximately how many students do you recall having done so?
Yes. Probably about 6 fellow students.

Did you feel that your relationship and interaction with your supervisor/s impacted upon your comfort/ease in openly disclosing information relevant to the supervision process? If so, in what way?

No. It felt comfortable in the supervision process, but kept the process very much about my work with my patients and sometimes the impact of that work on me. I would speak about my own countertransference and projective identification from my interactions with patients in supervision.

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about disclosing thoughts or feelings relating to them and the supervisory process? If so, what?

No

Did you register any particular emotional responses to this questionnaire? If so, what were these?

I registered an awareness that my responses will be seen by someone else. Perhaps a feeling of exposure.

Participant 5

DEMOGRAPHIC DETAILS

Age: 26
Gender: Female
Supervisor/s Gender: Female
Your Race: White
Supervisor/s Race: White

QUENSTIONNAIRE

I am interested in your answers and opinions, whether positive or negative. Please answer all of the questions as fully and as honestly as possible.

In the course of your psychology masters training, (including you internship year) did you ever find yourself withholding information from your psychotherapy supervisor/s pertaining to your psychotherapeutic work with one or more patients?
No, I always felt it was important to be as clear as possible about my clients as I felt this was the only way to get accurate help with my patients.

In the course of your training, did you ever find yourself intentionally misrepresenting your interaction or interventions with one or more patients to a psychotherapy supervisor?
No

In your psychotherapy transcripts and process notes submitted to your supervisor/s, did you ever edit your verbatim interventions to make them appear better in some way?
No

If you answered positively to any of the above questions, could you please provide your reasons for editing, withholding or misinterpreting the information concerned?
N/A

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about accurately reporting psychotherapy session material and your feelings about this material? [Yes/No]. If so, what?
N/A

If you answered positively to any of the first three questions, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?
N/A

In the course of your training, did any fellow students acknowledge to you having engaged in the activities outlined in the first three questions. [Yes/No].
No

In the course of your training, did you ever find yourself avoiding disclosure of particular thoughts and feelings related to your psychotherapy supervisor/s and your interaction with him/her/them? [Yes/No]. If so, what specific thoughts and feelings did you avoid disclosing?
No, later in my master's year I found it was very important to discuss my feelings of being uncontained and inadequately directed by my supervisor as this had impacted upon my case conference mark and experience.

Yes, in my internship. My new supervisor has shown certain subjective views which I have not challenged her on as I feel it would be counterproductive to our group dynamic.

If you answered positively to Question 8, what made you feel that you could/should not disclose those thoughts or feelings?
See Qu.8, but in relation to my first answer although my supervisor was not very instructive or structured in her supervision style and expected us to discover our own styles – she was quite gentle and open and this made it easy to talk to her openly and honestly.

In the case of the internship supervision our supervisor feels quite inexperienced herself and so it feels more like a team effort rather than a place of 'teacher' to 'learners'. Another factor is that in my first internship site I received very valuable supervision and so did not at any stage feel like my supervisor's subjectivity was detrimental to my patients.

If you answered positively to Question 8, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?
It definitely benefited our supervision in my master's year as I felt more confident about our 'alliance' after being honest with her.

In my internship I have learned that any input can be beneficial but it is the way you apply it in the therapy that remains your own challenge.

In the course of your training, did any fellow students acknowledge to you that they avoided the disclosure of thoughts or feelings regarding their supervisory interaction to the supervisors concerned? If so, approximately how many students do you recall having done so?
+/- 3 students

Did you feel that your relationship and interaction with your supervisor/s impacted upon your comfort/ease in openly disclosing information relevant to the supervision process? If so, in what way?
Yes, as previously discussed.

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about disclosing thoughts or feelings relating to them and the supervisory process? If so, what?
I believe in the master's year a very structured and containing environment (supervision) is imperative for trust and beneficial learning.

Did you register any particular emotional responses to this questionnaire? If so, what were these?
Yes – through reflection on both master's and internship supervisors I am aware at how much I have learned and grown in the last 18months and despite any negatives that is a good and proud feeling.

Participant 6

DEMOGRAPHIC DETAILS

Age: 25
Gender: Female
Supervisor/s Gender: Male
Your Race: White
Supervisor/s Race: White

QUENSTIONNAIRE

I am interested in your answers and opinions, whether positive or negative. Please answer all of the questions as fully and as honestly as possible.

In the course of your psychology masters training, (including you internship year) did you ever find yourself withholding information from your psychotherapy supervisor/s pertaining to your psychotherapeutic work with one or more patients?
I was generally quite open, even when it felt difficult or embarrassing. At times I may have held back on disclosing the extent of the anxiety I felt in response to some patients. This anxiety related to feelings of worry about patients (one patient who seemed quite fragile and distressed) and also related to my own anxiety about my countertransference in my work with this patient.

In the course of your training, did you ever find yourself intentionally misrepresenting your interaction or interventions with one or more patients to a psychotherapy supervisor?
No – I can't remember intentionally misrepresenting, although some interventions were quite embarrassing to report on.

In your psychotherapy transcripts and process notes submitted to your supervisor/s, did you ever edit your verbatim interventions to make them appear better in some way?
I would say probably 2 occasions. I generally handed in full verbatim transcripts but may have edited on few, isolated occasions.

If you answered positively to any of the above questions, could you please provide your reasons for editing, withholding or misinterpreting the information concerned?
I think mainly feelings of embarrassment – it's quite exposing to show an authority figure a verbatim account of an interaction, especially when your intervention is meant to be therapeutic and sometimes comes out quite silly.

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about accurately reporting psychotherapy session material and your feelings about this material? [Yes/No]. If so, what?
Yes. I think it would have helped for them to normalize the anxious feelings associated with being a trainee psychologist and having to report to an authority figure/supervisor. Also to normalize some of the discomfort experienced in presenting verbatim accounts of therapy sessions. I think to show empathy for our experience of being new therapists and the difficulties associated with this.

If you answered positively to any of the first three questions, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?
No – not really. Perhaps had I shared some of the powerful (anxious) countertransference feelings evoked by my first client, this would have helped us to understand the client's dynamics more deeply.

In the course of your training, did any fellow students acknowledge to you having engaged in the activities outlined in the first three questions.
No

In the course of your training, did you ever find yourself avoiding disclosure of particular thoughts and feelings related to your psychotherapy supervisor/s and your interaction with him/her/them? [Yes/No]. If so, what specific thoughts and feelings did you avoid disclosing?
I did not disclose the feelings of anxiety evoked by presenting my work and the anxiety about judgment/evaluation.

If you answered positively to Question 8, what made you feel that you could/should not disclose those thoughts or feelings?

I did not really think that supervision was a place to discuss these anxious feelings. I think I also realized that this anxiety was something that was part of the learning curve and that I needed to just go with it.

If you answered positively to Question 8, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?

_____

In the course of your training, did any fellow students acknowledge to you that they avoided the disclosure of thoughts or feelings regarding their supervisory interaction to the supervisors concerned? If so, approximately how many students do you recall having done so?
3 that I can recall.

Did you feel that your relationship and interaction with your supervisor/s impacted upon your comfort/ease in openly disclosing information relevant to the supervision process? If so, in what way?
Yes. The supervisor usually responded to 'mistakes' or unhelpful interventions I had made in a non-punitive, curious way and I think this helped put me at ease to think about rather than feel embarrassed about my less helpful interventions.

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about disclosing thoughts or feelings relating to them and the supervisory process? If so, what?
I was not really aware that it was appropriate to share thoughts or feelings related to supervision – perhaps the supervisor could have, again, normalized some of the anxiety that goes with supervision and opened a space to talk about this.

Did you register any particular emotional responses to this questionnaire? If so, what were these?
I remembered some of the anxiety and discomfort evoked by difficult aspects of the supervision process. I also recalled my emotional responses to my first patient and how powerful these were.

Participant 7

DEMOGRAPHIC DETAILS

Age: 25-35
Gender: Female
Supervisor/s Gender: 8 Female, 3 Male
Your Race: White
Supervisor/s Race: Black, White and Coloured

QUENSTIONNAIRE

I am interested in your answers and opinions, whether positive or negative. Please answer all of the questions as fully and as honestly as possible.

In the course of your psychology masters training, (including you internship year) did you ever find yourself withholding information from your psychotherapy supervisor/s pertaining to your psychotherapeutic work with one or more patients?

In the course of my training I was supervised by eleven supervisors in various contexts (this includes, for example, the trauma clinic, family therapy, long term and short term patient supervision both in M1 and at internship sites). There were certainly supervisors with whom one felt more comfortable and those with whom one felt more cautious or embarrassed. Although I am not immediately aware of any conscious withholding of information, I have no doubt that unconscious processes play out in supervision which as a beginning therapist I may not have been aware of at the time. I do think that perhaps I emphasized my empathic responses to my patients and found it harder to talk about my fascination, excitement and horror.

In the course of your training, did you ever find yourself intentionally misrepresenting your interaction or interventions with one or more patients to a psychotherapy supervisor?

I feel that I can answer no to this question for the most part. The content of sessions was not altered. In M1I would record sessions onto dvds and we would watch these in supervision, this meant that any tampering with actual material was not possible (much to my dismay at times). I also think my first supervisor strongly encouraged disclosure of all session material,

which set a precedent for future supervisions. I certainly rushed memory transcripts at times in the internship year, which may have led to omissions of session material.

In your psychotherapy transcripts and process notes submitted to your supervisor/s, did you ever edit your verbatim interventions to make them appear better in some way?
I think I sincerely tried to present sessions as they occurred. I am sure there were occasions though where I chose to present a patient with whom I thought I had a good session to appear competent or impress a supervisor over sessions with patients with whom I felt more lost. Frequency difficult to estimate – not often.

If you answered positively to any of the above questions, could you please provide your reasons for editing, withholding or misinterpreting the information concerned?
As above. Trying hard to get it right. Fear of evaluations. Fear of supervisors at times. Doubt of supervisor's personal integrity. Group supervision with difficult group members (not self-selected) can impose further anxiety and discomfort in supervision.

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about accurately reporting psychotherapy session material and your feelings about this material? [Yes/No]. If so, what?
Maintain strong professional boundaries
Avoid unnecessary self-disclosure (although of course when one works as colleagues in an institution this is not possible however the nature of disclosure in the supervision room can be considered)
Present feedback in manageable way
Encourage transparency verbally
Management of difficult group members

If you answered positively to any of the first three questions, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?
I suppose important themes are missed and learning is stunted. Subsequent supervision where evaluation is not a component of the relationship has been a freeing experience.

In the course of your training, did any fellow students acknowledge to you having engaged in the activities outlined in the first three questions.

I suspect a colleague made up a long-term client to appear competent when the actual client terminated. However this is a conjecture. Certain colleagues at two internship sites in particular seemed to really battle with their supervisors and reported having endured rather than benefited from supervision experiences.

In the course of your training, did you ever find yourself avoiding disclosure of particular thoughts and feelings related to your psychotherapy supervisor/s and your interaction with him/her/them? [Yes/No]. If so, what specific thoughts and feelings did you avoid disclosing?
Yes – where discomfort resulted from personal feelings about supervisor's character such as perceived emotional immaturity, aggression or questionable integrity.

If you answered positively to Question 8, what made you feel that you could/should not disclose those thoughts or feelings?
Fear, lack of trust or belief in a useful outcome. Not sure how appropriate it would be to bring personal opinions about supervisor's character into therapy. Didn't want to appear arrogant or unappreciative. It would take a very mature supervisor not to feel insulted or threatened. When one does not trust a supervisor's integrity, disclosure would be self defeating and unproductive.

If you answered positively to Question 8, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?
I was still able to benefit from theoretical information but uncomfortable emotions were left unaddressed. Parallel processes may have been missed.

In the course of your training, did any fellow students acknowledge to you that they avoided the disclosure of thoughts or feelings regarding their supervisory interaction to the supervisors concerned? If so, approximately how many students do you recall having done so?
Many

Did you feel that your relationship and interaction with your supervisor/s impacted upon your comfort/ease in openly disclosing information relevant to the supervision process? If so, in what way?

Yes. There were five supervisors with whom I felt very safe – this definitely had a positive impact on disclosure of anything that felt relevant to the patient and his or her therapeutic work.

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about disclosing thoughts or feelings relating to them and the supervisory process? If so, what?
As in question 5

Did you register any particular emotional responses to this questionnaire? If so, what were these?
Yes. I feel I have had some very positive experiences of supervision and some very difficult experiences. I think some censure of the internship supervisors in particular would be beneficial. I also think the fine line between what one takes to therapy and what one should take to supervision might have been a difficult negotiation at first. I feel a bit sad about some of the poor supervision I have seen that is not obvious to other more experienced supervisors. I feel I would want to do some supervision experiences differently and have some personal regrets about personal disclosures that I perceive were handled badly or led to retribution. I feel grateful to the supervisors who have instilled confidence on the therapeutic process and who have shared so much of their knowledge.

Participant 8

DEMOGRAPHIC DETAILS

Age: 28
Gender: Female
Supervisor/s Gender: Female
Race: White
Supervisor/s Race: White

QUENSTIONNAIRE

I am interested in your answers and opinions, whether positive or negative. Please answer all of the questions as fully and as honestly as possible.

In the course of your psychology masters training, (including you internship year) did you ever find yourself withholding information from your psychotherapy supervisor/s pertaining to your psychotherapeutic work with one or more patients?

Yes. At the start of seeing my long term patient in M1, when concepts such as countertransference were new to me, I felt very exposed at disclosing information about my personal feelings towards my patient – in particular because at times I felt that I could personally identify with the issues my patient presented with. This caused anxiety as I wasn't sure if it was appropriate or not to feel this way and so thought that it would be better to keep it to myself. I experienced supervision as very intrusive and often felt vulnerable and inadequate. Another area where I felt the need to withhold information was around technique. What I was being trained in was different to how I had been trained before, and sometimes I would depart from technique for whatever reason and then feel terribly guilty and then feel like I needed to avoid my supervisor finding out. At first I didn't feel safe expressing anything that would risk me feeling more vulnerable and exposed. It took time to understand the usefulness of full disclosure through positive experiences in this supervision.

During my internship I would withhold my own responses to patients material if I thought that my supervisor would disapprove or comment negatively on the way that I had intervened as I had many experiences of my transcripts of sessions being criticized. Most of what I

would withhold would be interpretations or reflections that I judged to be inaccurate or wasn't sure of the usefulness of what I had said. I think the main problem was a difference in theoretical orientation and how this applied to the actual work. I would often disagree with suggestions for interventions because it didn't match my orientation but I didn't feel that I had the authority to challenge her on this. I remember feeling like I sounded so defensive in all interactions with her.

In the course of your training, did you ever find yourself intentionally misrepresenting your interaction or interventions with one or more patients to a psychotherapy supervisor?
Yes. During my internship I would "neaten" my reflections etc on transcripts as above.

In your psychotherapy transcripts and process notes submitted to your supervisor/s, did you ever edit your verbatim interventions to make them appear better in some way?
Yes. As in answer to Q 1 – I often felt attacked and so edited my transcripts to make them appear more like what my supervisor expected, to avoid criticism. My difficulties often were related to the length of my transcripts which I was told were far too long and so I would take out exchanges that I was unsure of – leaving only portions of the session remaining. I would hand in a transcript about every two weeks and I had to shorten them to make them more appropriate so they would be edited each time.

If you answered positively to any of the above questions, could you please provide your reasons for editing, withholding or misinterpreting the information concerned?
I think that my reasons were because I felt very insecure about myself as a therapist when I started with my first patient and felt vulnerable disclosing work that I wasn't sure of. I suppose that it was difficult to accept that I was ignorant and that certain knowledge and skills would only become available to me through experience, I felt under pressure to already know and already have well honed skills that were going to be evaluated. Secondly, during my internship I felt attacked and so tried to present material that I thought would avoid the most disapproval or criticism in order to protect myself. This made me feel more in control of our interactions. I also think that knowing that everything was being evaluated was really difficult to cope with and made me feel more pressure to do what was expected so I could get a favorable evaluation.

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about accurately reporting psychotherapy session material and your feelings about this material? [Yes/No]. If so, what?

Yes. During my internship I eventually sought alternate supervision from a M1 supervisor and the contrast between how my work was supervised was huge – this allowed my to be more honest to the supervisor I didn't get on with as I could be less defensive because I felt that there was someone who I trusted and respected that had validated the work. It was a difficult situation though because I also felt like a fraud, because I would then at times, especially when being evaluated, take material to supervision that I had already been supervised on because then I knew that if that was evaluated poorly there was something else going on – it wasn't just about me being an inadequate therapist. So I think that if supervisors are empathic, assist with developing insight into patients rather than pointing out that you don't know what's going on and offer praise for work that is done well then a more comfortable relationship can develop and for me, then honest self-disclosure comes more easily. I'm now in weekly supervision with someone of my choice and take the material, like countertransference, boundary violations and exchanges where I think I have misunderstood, as often it is most instructive, whereas during training this is what I would have left out. I think for me it has also just been time and more experience that has helped me to appreciate the different facets of the work and become more comfortable with myself as a therapist.

If you answered positively to any of the first three questions, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?

In retrospect, I don't think that I experienced my supervision (one rotation) during my internship as a learning experience at all. It was rather something that had to be endured each week and I knew that I had to show that I was seeing patients and thinking about them theoretically but I didn't experience it as a collaborative space where I gained insight into patients or myself as a therapist. I'm not sure what kind of an impact there was on the patients that I was seeing. I think that the anxiety that I felt also impeded any learning, and the learning that took place was more about trusting myself and finding alternate sources of support, like external supervision. It was such a relief to be able to take the same cases to another supervisor and be honest about what had happened in the session, I felt that this somehow redeemed the deceit in my other supervision.

In the course of your training, did any fellow students acknowledge to you having engaged in the activities outlined in the first three questions. [Yes/No].
Yes. Can remember speaking about this with at least the other 2 colleagues in my M1 supervision group. We would often discuss amongst ourselves in a more informal manner the things that we were afraid to disclose in supervision. I don't think that it was an uncommon feeling to feel insecure and worry about clinical material and I remember this being quite widely acknowledged.

In the course of your training, did you ever find yourself avoiding disclosure of particular thoughts and feelings related to your psychotherapy supervisor/s and your interaction with him/her/them? [Yes/No]. If so, what specific thoughts and feelings did you avoid disclosing?
Not sure if you mean avoiding disclosure to the specific supervisor…
I never discussed any thoughts or feelings I had about my supervisors with them during my training. Otherwise, was able to speak to others about my relationship with supervisors.

If you answered positively to Question 8, what made you feel that you could/should not disclose those thoughts or feelings?
I didn't feel that there was the space available to talk about our interactions – it wasn't initiated ever by a supervisor and I don't suppose that I ever had that kind of a relationship with one. Even if there was, I don't think that I would have shared anyway for fear of retaliation. I recall speaking to my M1 supervisor about my internship supervisor to ask for a referral for external supervision and she encouraged me to take the matter up but at the time I felt that I needed to get through it rather than deal with it. I thought that there would be a negative response to any complaint or confrontation. I think that I would now be able to talk to her about how intimidated I felt because I have more confidence and don't fear conflict as much.

If you answered positively to Question 8, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?
As previously stated, I don't think that any learning could take place within a relationship like the one I had with my internship supervisor anyway. Editing the transcripts made it worse because I felt angry that I did so much work and put so much effort into producing something that was at the end of the day valueless. It probably would have been more helpful

to be honest and try and speak about how difficult it felt to please her and the dilemma that put me in.

In the course of your training, did any fellow students acknowledge to you that they avoided the disclosure of thoughts or feelings regarding their supervisory interaction to the supervisors concerned? If so, approximately how many students do you recall having done so?
Yes. Colleagues had similar experiences with the same and other supervisors. Maybe discussed it with 5 or 6 other interns over the year.

Did you feel that your relationship and interaction with your supervisor/s impacted upon your comfort/ease in openly disclosing information relevant to the supervision process? If so, in what way?
Yes. When I was able to develop a good relationship with a supervisor based on the common purpose of the patients best interests and issues such as my own evaluation etc were not an issue it seemed that it was natural to be able to disclose as there was no fear of criticism and I knew that whatever had happened could be thought about in a meaningful way as a product of the work that I was doing rather than a more personal reproach that attacked my sense of myself as a therapist.

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about disclosing thoughts or feelings relating to them and the supervisory process? If so, what?
Yes. I think that if from the beginning the supervisor creates a thinking space and interact in a non-judgmental way towards the material brought, that sets up a relationship where anything can be spoken about. I think that if anxieties are acknowledged and the pressure to be deceitful is spoken about a more honest space can be created. At the same time, looking back, at the start of M1 I think that my supervisor had done that but my anxieties got in the way of perceiving it as such.

Did you register any particular emotional responses to this questionnaire? If so, what were these?

I started off feeling wary that I was expected to disclose so much about something that caused so much anxiety and guilt. I think mostly that it has been very useful to think about my experiences in supervision and how they have changed over time.

Participant 9

DEMOGRAPHIC DETAILS

Age: (*For confidentiality reasons I would prefer not to disclose my age)*
Gender: Female
Supervisor/s Gender: Female
Your Race: White
Supervisor/s Race: White and other

QUENSTIONNAIRE
I am interested in your answers and opinions, whether positive or negative. Please answer all of the questions as fully and as honestly as possible.

In the course of your psychology masters training, (including you internship year) did you ever find yourself withholding information from your psychotherapy supervisor/s pertaining to your psychotherapeutic work with one or more patients?
Not as far as I can remember now, I found that generally the best supervision was given when I reflected the sessions accurately and in detail.

In the course of your training, did you ever find yourself intentionally misrepresenting your interaction or interventions with one or more patients to a psychotherapy supervisor?
I had several different supervisors and some had not been trained at Wits. For these supervisors I found I would 'modify' sessions and I would focus less on psychodynamic aspects and would emphasize different aspects. For example, in order to get the best supervision, if the supervisor had a CBT/systemic training I would focus on these aspects rather than on psychodynamic aspects.

In your psychotherapy transcripts and process notes submitted to your supervisor/s, did you ever edit your verbatim interventions to make them appear better in some way?
I spent a great deal of time trying to get the sessions recorded as accurately as possible as this influenced the supervision (see #1).

If you answered positively to any of the above questions, could you please provide your reasons for editing, withholding or misinterpreting the information concerned?

_____

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about accurately reporting psychotherapy session material and your feelings about this material? [Yes/No]. If so, what?
No

If you answered positively to any of the first three questions, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?

_____

In the course of your training, did any fellow students acknowledge to you having engaged in the activities outlined in the first three questions.
No student spoke to me about engaging in the above mentioned activities.

In the course of your training, did you ever find yourself avoiding disclosure of particular thoughts and feelings related to your psychotherapy supervisor/s and your interaction with him/her/them? [Yes/No]. If so, what specific thoughts and feelings did you avoid disclosing?
Not that I can remember at this stage, except perhaps for some of the supervisors who were not psychodynamically trained and who therefore were unable to provide psychodynamic supervision. When one of my supervisors who was not psychodynamically trained asked me for my therapy notes I withheld from her that I felt her psychodynamic supervision was limited.

If you answered positively to Question 8, what made you feel that you could/should not disclose those thoughts or feelings?
See above

If you answered positively to Question 8, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?
With these supervisors I would focus on their field of expertise, for example CBT/systemic and thus would get supervision in these areas/modalities.

In the course of your training, did any fellow students acknowledge to you that they avoided the disclosure of thoughts or feelings regarding their supervisory interaction to the supervisors concerned? If so, approximately how many students do you recall having done so?
No

Did you feel that your relationship and interaction with your supervisor/s impacted upon your comfort/ease in openly disclosing information relevant to the supervision process? If so, in what way?
Yes. If I had a good relationship with the supervisor and s/he was empathic I would feel more comfortable disclosing information.

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about disclosing thoughts or feelings relating to them and the supervisory process? If so, what?
Not that I can think of now.

Did you register any particular emotional responses to this questionnaire? If so, what were these?
It made me realize how quickly I have forgotten much about by supervision which I received 2 years ago

Participant 10

DEMOGRAPHIC DETAILS

Age: 24
Gender: Male
Supervisor/s Gender: Female
Race: Black
Supervisor/s Race: White

QUENSTIONNAIRE

I am interested in your answers and opinions, whether positive or negative. Please answer all of the questions as fully and as honestly as possible.

In the course of your psychology masters training, (including you internship year) did you ever find yourself withholding information from your psychotherapy supervisor/s pertaining to your psychotherapeutic work with one or more patients?
No

In the course of your training, did you ever find yourself intentionally misrepresenting your interaction or interventions with one or more patients to a psychotherapy supervisor?
No

In your psychotherapy transcripts and process notes submitted to your supervisor/s, did you ever edit your verbatim interventions to make them appear better in some way?
No, it was almost impossible because I had to video record my sessions and watch it with my supervisor.

If you answered positively to any of the above questions, could you please provide your reasons for editing, withholding or misinterpreting the information concerned?

_____

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about accurately reporting psychotherapy session material and your feelings about this material? [Yes/No]. If so, what?

_____

If you answered positively to any of the first three questions, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?

_____

In the course of your training, did any fellow students acknowledge to you having engaged in the activities outlined in the first three questions.

No

In the course of your training, did you ever find yourself avoiding disclosure of particular thoughts and feelings related to your psychotherapy supervisor/s and your interaction with him/her/them? [Yes/No]. If so, what specific thoughts and feelings did you avoid disclosing?

No

If you answered positively to Question 8, what made you feel that you could/should not disclose those thoughts or feelings?

_____

If you answered positively to Question 8, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?

_____

In the course of your training, did any fellow students acknowledge to you that they avoided the disclosure of thoughts or feelings regarding their supervisory interaction to the supervisors concerned? If so, approximately how many students do you recall having done so?

_____

Did you feel that your relationship and interaction with your supervisor/s impacted upon your comfort/ease in openly disclosing information relevant to the supervision process? If so, in what way?

Yes, I was able to share my thoughts without fear of being judged. It helped to understand that I was just a learner and would make mistakes.

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about disclosing thoughts or feelings relating to them and the supervisory process? If so, what?

_____

Did you register any particular emotional responses to this questionnaire? If so, what were these?

_____

Participant 11

DEMOGRAPHIC DETAILS

Age: 23
Gender: Female
Supervisor/s Gender: Male
Race: Coloured
Supervisor/s Race: White

QUENSTIONNAIRE

I am interested in your answers and opinions, whether positive or negative. Please answer all of the questions as fully and as honestly as possible.

In the course of your psychology masters training, (including you internship year) did you ever find yourself withholding information from your psychotherapy supervisor/s pertaining to your psychotherapeutic work with one or more patients?
Yes, The information that was withheld would depend on whether or not I felt comfortable with my supervisor and it was more prominent at the beginning of the year as opposed to the rest of the year, as I felt more comfortable with my supervisor and became more comfortable with myself as a therapist. The information that was withheld was usually my responses to questions that was asked by a patient and I wasn't sure how I should have answered it or dealt with it at that moment, so in supervision I would raise it as a hypothetical question, that way I still got the answer I needed.

In the course of your training, did you ever find yourself intentionally misrepresenting your interaction or interventions with one or more patients to a psychotherapy supervisor?
Yes, particularly when the tape recorder failed and I could not remember exactly how the session actually went. Or when I knew that my intervention was not going to go down well with my supervisor as it was not an intervention that should have been used. For example, giving into countertransference and being very directive or overtly frustrated with the patient.

In your psychotherapy transcripts and process notes submitted to your supervisor/s, did you ever edit your verbatim interventions to make them appear better in some way?
No, I usually gave a verbatim account of what was said, unless I could not hear what my patient was saying which was very often because she spoke so softly.

If you answered positively to any of the above questions, could you please provide your reasons for editing, withholding or misinterpreting the information concerned?
Already answered under the questions concerned.

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about accurately reporting psychotherapy session material and your feelings about this material? [Yes/No]. If so, what?
No, he was very specific about things and one did not feel like they could disappoint him so it would not have mattered what he said because I would still have like to produce the work that he would have approved of.

If you answered positively to any of the first three questions, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?
I don't think it impacted that much because I would still pose the question to him or try and get information from him on how to specifically deal with the situation but would present it in a hypothetical scenario. So I still benefited from supervision.

In the course of your training, did any fellow students acknowledge to you having engaged in the activities outlined in the first three questions. [Yes/No].
We never actually spoke about it. But I think most students did.

In the course of your training, did you ever find yourself avoiding disclosure of particular thoughts and feelings related to your psychotherapy supervisor/s and your interaction with him/her/them? [Yes/No]. If so, what specific thoughts and feelings did you avoid disclosing?
No not really, I was very talkative and often felt like I asked too many questions and was a bit too honest sometimes.

If you answered positively to Question 8, what made you feel that you could/should not disclose those thoughts or feelings?

N/A

If you answered positively to Question 8, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?
N/A

In the course of your training, did any fellow students acknowledge to you that they avoided the disclosure of thoughts or feelings regarding their supervisory interaction to the supervisors concerned? If so, approximately how many students do you recall having done so?
Yes, almost all but about 9 maybe.

Did you feel that your relationship and interaction with your supervisor/s impacted upon your comfort/ease in openly disclosing information relevant to the supervision process? If so, in what way?
Yes, he was a very paternal figure for me and he is also very good at what he does so one did not feel like making mistakes was allowed but this was the feeling I initially had with him, but it did subside with a lot of therapy and growth in my self-confidence.

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about disclosing thoughts or feelings relating to them and the supervisory process? If so, what?
Yes, Even I make mistakes and that it was okay and that he was a student once. Which he did and it made a huge difference in my comfort level.

Did you register any particular emotional responses to this questionnaire? If so, what were these?
No I think I'm far to tired to even feel anything these days. But it was a really good questionnaire in terms of thinking about how we relate to those who train and evaluate us.
Well done and good luck!

Participant 12

DEMOGRAPHIC DETAILS

Age: 45
Gender: Female
Supervisor/s Gender: Female
Race: White
Supervisor/s Race: White

QUENSTIONNAIRE

I am interested in your answers and opinions, whether positive or negative. Please answer all of the questions as fully and as honestly as possible.

In the course of your psychology masters training, (including you internship year) did you ever find yourself withholding information from your psychotherapy supervisor/s pertaining to your psychotherapeutic work with one or more patients?
Not for long! There was an instance when I had made a brief comment about a patient while walking up the steps near the canteen. It was very early and very cold and when I turned around and looked back there had been a guy standing near the steps wearing a hat similar to my patient's. I became paranoid that he had heard my comment, that it was him standing there. I began to see this evidenced in my therapies with him until I brought it to supervision (a few weeks later) where my supervisor felt it was highly unlikely that it was him and that she saw evidence of my comment in my transcripts – it had been a good learning experience for me.

In the course of your training, did you ever find yourself intentionally misrepresenting your interaction or interventions with one or more patients to a psychotherapy supervisor?
No

In your psychotherapy transcripts and process notes submitted to your supervisor/s, did you ever edit your verbatim interventions to make them appear better in some way?

I do remember a specific instance of cutting out a whole lot of waffle at the end of a transcript ie: I sort of made or kept making some long winded summaries at the end of one particular session and I cut one or two of them back (from transcripts). I did not generally modify recordings as I tend to have an overly developed superego. There were one or two occasions where things were modified on memory transcripts while working with a particular supervisor. It happened but not frequently – possibly twice.

If you answered positively to any of the above questions, could you please provide your reasons for editing, withholding or misinterpreting the information concerned?
Qu1 – I felt that I may have violated confidentiality and be in big trouble. Also that I may have hurt my patient in someway.
Qu3 – I was embarrassed by the extent of my waffle more than the content (recorded transcript). Memory transcript fudge was due to the supervisor having made the supervision quite personal. She began reflecting on me as a person after only knowing me about 3-4weeks which made me feel extremely vulnerable to the extent that I didn't want to give her much room to comment on me which at the time I experienced as quite attacking. She wasn't around for long and I never experienced this again.

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about accurately reporting psychotherapy session material and your feelings about this material? [Yes/No]. If so, what?
Supervision can be so holding and containing but also so damaging especially when one is a new therapist, very uncertain of one's ability and also in one's own process of change which adds to the sense of vulnerability. I think that it is very important to help a therapist (student) reflect on herself in relation to the process of therapy, in particular around things like countertransference, so it wasn't necessary that the supervisors shouldn't have done it, it was the way it was done. She sat in the supervision giving me one reflection after another about myself – not woven into the fabric of the therapy. It was almost as though she needed to show me how clever she was or maybe even put me in my place. One needs to be able to trust one's supervisor who will not be overtly judgmental and personal.

If you answered positively to any of the first three questions, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?

I feel that selective reporting would certainly affect learning and am therefore very grateful I'm not having to protect myself much at all through fudging it in supervision. It has therefore been quite embarrassing at times, certainly in case presentations where transcripts have been required, but the learning has been good.

In the course of your training, did any fellow students acknowledge to you having engaged in the activities outlined in the first three questions.
No

In the course of your training, did you ever find yourself avoiding disclosure of particular thoughts and feelings related to your psychotherapy supervisor/s and your interaction with him/her/them? [Yes/No]. If so, what specific thoughts and feelings did you avoid disclosing?
I think my supervisors couldn't believe that I could love my patients so much and so consciously. I didn't suppress stuff but unconsciously I probably did as later on I did express more my irritation and anger in relation to them and became less defended in a sense in being able to express those emotions in supervision.

If you answered positively to Question 8, what made you feel that you could/should not disclose those thoughts or feelings?
It was probably about both the supervisor and myself but mainly myself. It was about me through my own growth, development, needing to be less pleasing and also about the supervisor that was able to hold the expression of those in a less judgmental way.

If you answered positively to Question 8, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?
My apparently not reporting feelings was stressed by supervisors which made me constantly look at myself and ask if that was true, ie work was continually being done on myself in being able to express. Negative emotion or what I perceived to be so.

In the course of your training, did any fellow students acknowledge to you that they avoided the disclosure of thoughts or feelings regarding their supervisory interaction to the supervisors concerned? If so, approximately how many students do you recall having done so?
No

Did you feel that your relationship and interaction with your supervisor/s impacted upon your comfort/ease in openly disclosing information relevant to the supervision process? If so, in what way?

She was perceived by me to be quite a punitive person which would affected my going to her.

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about disclosing thoughts or feelings relating to them and the supervisory process? If so, what?

I felt far too vulnerable with the one supervisor to address the personal nature that she conducted supervision. I may have done something about it over time, but she wasn't there long enough. If she had noticed a change in me (ie my becoming more closed) I would have welcomed her bringing it up – I felt I had to protect myself otherwise. She kept on saying she shouldn't be doing it, so perhaps should have checked the effect it had on me.

Did you register any particular emotional responses to this questionnaire? If so, what were these?

I did register some anger during this process towards the one supervisor despite my understanding why she is the way she is in the world. This has possibly helped in a sense that it has given me a voice where before I didn't have one.

Participant 13

DEMOGRAPHIC DETAILS

Age: 27
Gender: Female
Supervisor/s Gender: Female
Race: White
Supervisor/s Race: White

QUENSTIONNAIRE

I am interested in your answers and opinions, whether positive or negative. Please answer all of the questions as fully and as honestly as possible.

In the course of your psychology masters training, (including you internship year) did you ever find yourself withholding information from your psychotherapy supervisor/s pertaining to your psychotherapeutic work with one or more patients?
Yes – towards the beginning of training it was generally when I felt I had done something 'wrong', such as said something inappropriate. I found it difficult to take dreams to supervision – also specifically at the beginning of training. Sexual countertransference, although I only remember one instance of this, I did not share in supervision.

In the course of your training, did you ever find yourself intentionally misrepresenting your interaction or interventions with one or more patients to a psychotherapy supervisor?
No – I would try and represent events as accurately as possible but may have left out some information – which I guess could be misrepresenting in a way as it may have been to present myself in a more positive way.

In your psychotherapy transcripts and process notes submitted to your supervisor/s, did you ever edit your verbatim interventions to make them appear better in some way?
No I was always very strict about transcribing exactly.

If you answered positively to any of the above questions, could you please provide your reasons for editing, withholding or misinterpreting the information concerned?
Personally, I generally take a while to trust someone and found it difficult at first to be completely open with someone I hardly knew. I think it may also have been about wanting to get it 'right' and fearing of getting it 'wrong' especially in the beginning when I did not understand therapy properly. Also a personal fear of authority that I have and not wanting to 'get into trouble'.

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about accurately reporting psychotherapy session material and your feelings about this material? [Yes/No]. If so, what?
No

If you answered positively to any of the first three questions, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?
I think it did influence my learning in that I missed some very useful opportunities to learn about therapy and myself as a therapist – once I was completely comfortable with my supervisors I shared everything and found I learnt so much more and felt much more capable. Having the supervisor encourage this and seeing that I didn't 'get into trouble' helped me to be more open and share more.

In the course of your training, did any fellow students acknowledge to you having engaged in the activities outlined in the first three questions. [Yes/No].
Yes - 3

In the course of your training, did you ever find yourself avoiding disclosure of particular thoughts and feelings related to your psychotherapy supervisor/s and your interaction with him/her/them? [Yes/No]. If so, what specific thoughts and feelings did you avoid disclosing?
Yes – there was one supervisor I did not get on with and found very difficult but was never able to share these feelings.

If you answered positively to Question 8, what made you feel that you could/should not disclose those thoughts or feelings?
I was unsure how she would react and was concerned it would count against me.

If you answered positively to Question 8, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?
I don't feel it did.

In the course of your training, did any fellow students acknowledge to you that they avoided the disclosure of thoughts or feelings regarding their supervisory interaction to the supervisors concerned? If so, approximately how many students do you recall having done so?
Yes 4

Did you feel that your relationship and interaction with your supervisor/s impacted upon your comfort/ease in openly disclosing information relevant to the supervision process? If so, in what way?
Absolutely! The supervisors with whom I had good relationships and who made me feel comfortable, were the supervisors who I was most open with regarding disclosure of information.

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about disclosing thoughts or feelings relating to them and the supervisory process? If so, what?
Not being punitive or judgmental helps in disclosure. Also building a relationship and being aware of how uncomfortable it is to share thoughts and feelings with someone one doesn't know – a lot like therapy really. When supervisors play into power dynamics this makes things difficult as well.

Did you register any particular emotional responses to this questionnaire? If so, what were these?
A sense of anger at the supervisor whom I found particularly punitive and who I felt played with her position of power in an unfair and unhelpful way.

Participant 14

DEMOGRAPHIC DETAILS

Age: 31
Gender: Female
Supervisor/s Gender: Female
Race: White
Supervisor/s Race: White

QUENSTIONNAIRE

I am interested in your answers and opinions, whether positive or negative. Please answer all of the questions as fully and as honestly as possible.

In the course of your psychology masters training, (including you internship year) did you ever find yourself withholding information from your psychotherapy supervisor/s pertaining to your psychotherapeutic work with one or more patients?

Not that I can recall really. I felt very comfortable with my supervisor and not judged. I was committed to learn and look at my own countertransference issues. It felt like a safe space. Of course this might be want I projected onto the space and really wished for, and therefore created quite an idealized space. I managed to maintain that idealization then until the end of M2. Although the supervision space did change from that of 'therapeutic supervision' to research supervision. In M2 I had an external supervisor for my long term case. With her I did feel more scrutinized and more tempted to omit bits of my session. I would try and bring all the messy bits as I found that that was most useful to me and my patient. In the beginning of M2 although I did have the same long term patient I had changed supervisors who both worked quite differently in terms of the pathology my client presented with. For this reason I did feel that in the beginning I would omit details around what I would do for example read my clients journal entries, which we had been doing together as part of a therapy plan, which the 2nd supervisor did not agree with. Once I had weaned myself from one mode of therapy to another it was easier to be more honest. So it was more tempting to omit information when I felt less safe, and was not sure that I was a 'good enough' intern psychologist.

PS> We also had different supervisors for each half year supporting us at our internship placements. I have omitted my experience with them, as I think you must be making reference to my Wits supervisor?

In the course of your training, did you ever find yourself intentionally misrepresenting your interaction or interventions with one or more patients to a psychotherapy supervisor?
No

In your psychotherapy transcripts and process notes submitted to your supervisor/s, did you ever edit your verbatim interventions to make them appear better in some way?
No

If you answered positively to any of the above questions, could you please provide your reasons for editing, withholding or misinterpreting the information concerned?
Please see question one for details

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about accurately reporting psychotherapy session material and your feelings about this material? [Yes/No]. If so, what?
For my primary supervisor no. For my M2 external supervisor I think there were times when it was easy to feel judged as there seemed to be a clear sense of what was appropriate therapy i.e. purely psychodynamic rather than more CBT orientated or behavioural orientated therapy which others might have regarded useful in terms of the pathology I was working with… Perhaps something around being more open to the possibility of the use of other therapeutic works and being clear but kind that that was not the mode that we were learning. Although my supervisor did mention that initially it did feel very scary to disagree with this supervisors at times.

If you answered positively to any of the first three questions, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?
I don't think it did really, although could have gained more insight on the different modes and appropriateness of each? I did however reflect on this myself.

In the course of your training, did any fellow students acknowledge to you having engaged in the activities outlined in the first three questions.
No

In the course of your training, did you ever find yourself avoiding disclosure of particular thoughts and feelings related to your psychotherapy supervisor/s and your interaction with him/her/them? [Yes/No]. If so, what specific thoughts and feelings did you avoid disclosing?
Disclosure to who? My supervisor? If so, no I don't think I did avoid that. Maybe to fellow students who had different experiences or opinions of that same supervisor.

If you answered positively to Question 8, what made you feel that you could/should not disclose those thoughts or feelings?
In terms of my peers, I didn't think it was useful to compare or argue about the integrity of my supervisor. Each persons' experiences were for themselves to understand, I didn't feel my understanding or experience had anything useful to add. Also I did not want to taint my positive experience by having my peers scrutinize my experience. I felt it was quite a personal subject that I wanted to protect and hold safe.

If you answered positively to Question 8, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?
Not relevant to me.

In the course of your training, did any fellow students acknowledge to you that they avoided the disclosure of thoughts or feelings regarding their supervisory interaction to the supervisors concerned? If so, approximately how many students do you recall having done so?
Yes, approximately 5 different fellow students.

Did you feel that your relationship and interaction with your supervisor/s impacted upon your comfort/ease in openly disclosing information relevant to the supervision process? If so, in what way?
Yes absolutely. As I did feel comfortable, safe and not judged in my interaction with my supervisor it was easy for me to disclose and interact with integrity. I think if I felt

scrutinized, judged, criticized I would find it less constructive, useful or productive to disclose fully.

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about disclosing thoughts or feelings relating to them and the supervisory process? If so, what?

I think what was useful i.t.o. me feeling comfortable with my supervisor was the authenticity in which she interacted with me. Her willingness to self disclose about her own experiences or her own mishaps as a way to portray a process to me made me feel that our interaction was one of integrity, honesty and not judgemental. Her standpoint was not that of saying what was wrong or right but thinking around what was most useful i.t.o appropriate therapeutic work with a particular patient with particular pathology. She really provided a space of mentalization, rather than right, wrong etc…

Did you register any particular emotional responses to this questionnaire? If so, what were these?

Well, I think it feels like it was quite long ago and difficult to really get in touch with the details required by your questionnaire. I guess I was present to my need to protect my memory of that space and what it had meant to me. I realized how idealized it might come across. I was also present to a sense that me protecting that space might be thought about and analyzed which was quite disconcerting on some level. It left me wondering whether it would be believed that I felt so comfortable with this particular supervisor that I could disclose to the fullest of my abilities etc etc.

Participant 15

DEMOGRAPHIC DETAILS

Age: 28
Gender: Male
Supervisor/s Gender: Female
Your Race: White
Supervisor/s Race: White

QUENSTIONNAIRE

I am interested in your answers and opinions, whether positive or negative. Please answer all of the questions as fully and as honestly as possible.

In the course of your psychology masters training, (including you internship year) did you ever find yourself withholding information from your psychotherapy supervisor/s pertaining to your psychotherapeutic work with one or more patients?
Yes I have withheld information about some counter-transference experiences, mostly due to the perception of being evaluated by my supervisor(s) and at times also due to my inexperience. I have also withheld some verbal expressions and interventions, for feeling that they may have not been useful or may be interpreted incorrectly or judged to be inappropriate by my supervisor.

In the course of your training, did you ever find yourself intentionally misrepresenting your interaction or interventions with one or more patients to a psychotherapy supervisor?
No, tried to report everything as accurately as possible.

In your psychotherapy transcripts and process notes submitted to your supervisor/s, did you ever edit your verbatim interventions to make them appear better in some way?

No. (Have not altered transcripts and tried to keep notes as accurate as possible)

If you answered positively to any of the above questions, could you please provide your reasons for editing, withholding or misinterpreting the information concerned?

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about accurately reporting psychotherapy session material and your feelings about this material? [Yes/No]. If so, what?
Yes, if there was less of an evaluative element to the supervisory process. Supervisors would have created a more comfortable environment, by perhaps being more transparent and clear about their evaluations and the effect this may have on disclosing fully perceived blunders or difficulties.

If you answered positively to any of the first three questions, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?
Minimally influenced my learning. I felt that I learnt a lot from the supervision process. Where I did withhold information, I feel that it did not affect my learning very much. I feel that I may have influenced being able to learn more about authentically confronting particular personal issues or challenging idea that were misunderstood, either by myself or my supervisor.

In the course of your training, did any fellow students acknowledge to you having engaged in the activities outlined in the first three questions.
Yes, I heard directly from 1 other student and indirectly of about 4 students.

In the course of your training, did you ever find yourself avoiding disclosure of particular thoughts and feelings related to your psychotherapy supervisor/s and your interaction with him/her/them? [Yes/No]. If so, what specific thoughts and feelings did you avoid disclosing?
Yes, but seldom. Thoughts that the supervisor is misunderstanding something, or that I am confused about something they are saying. Occasionally feelings of frustration and at times agitation, this may relate to the above thoughts.

If you answered positively to Question 8, what made you feel that you could/should not disclose those thoughts or feelings?
I wanted the supervisor to know that I understood her. Felt that it may be inappropriate or I may be judged if I disclose negative feelings about her and the process. Also the thought of

'challenging authority', which I felt the supervisor may think, also prevented me from disclosing.

If you answered positively to Question 8, how do you feel your selective reporting influenced (if at all) your learning in the supervision context?
Somewhat, may have been more useful to challenge and discover more about myself and the patient through the supervisory relationship. I feel that I may have missed out on properly unpacking particular transference and counter transference themes. It may have also been a learning experience in terms of having more of my ideas heard and getting better clarity about the supervisors perspective or point of view.

In the course of your training, did any fellow students acknowledge to you that they avoided the disclosure of thoughts or feelings regarding their supervisory interaction to the supervisors concerned? If so, approximately how many students do you recall having done so?
I do not recall any fellow students acknowledging this.

Did you feel that your relationship and interaction with your supervisor/s impacted upon your comfort/ease in openly disclosing information relevant to the supervision process? If so, in what way?
Yes. The supportive and open the supervisor was to my experience of therapy, the more at ease I felt. I also feel that when the supervisor displayed warmth and compassion to both my self and the patient, this helped a lot as well.

Is there anything that your supervisor/s could have said or done that might have made you feel more comfortable about disclosing thoughts or feelings relating to them and the supervisory process? If so, what?
There where only few occasions, where my supervisor(s) may have been more curious about my feelings toward them or the supervisory process. To also maybe invite more open reflection and discussion about supervision and the supervisory relationship. They may also have asked more direct questions about it and to reassure with an accepting and non-judgmental attitude towards such inquiry.

Did you register any particular emotional responses to this questionnaire? If so, what were these?

Not really.