# Are All Nondisclosures Created Equally?

## An Exploratory Factor Analysis of the Content of Supervisee Nondisclosure

by

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ABSTRACT

This study examined the factor structure of supervisee disclosure in clinical supervision. An original survey measure was created for this study, the Supervisee Disclosure Scale (SDS). Through exploratory factor analysis eight specific content areas of supervisee disclosure were identified. The eight specific content areas of supervisee disclosure include: Perceived Clinical Inadequacy, Transference Issues, Strengths of the Supervisory Relationship, Clinical Successes, Self, Weaknesses of the Supervisory Bond, Dissatisfaction with the Clinical Setting, and Own Clinical Voice. Furthermore, this study examined the potential relationship of clinical experience with the content areas of supervisee disclosure. The results of this study support a relationship between greater clinical experience and disclosure of items related to Self but not with the other content areas. Additionally, the bi-level factor structure of the Working Alliance Inventory/Supervision-Short (WAI-SS) was validated via confirmatory factor analysis. The bi-level factor structure of the WAI-SS identifies a hierarchical structure of general alliance in addition to the specific factors of task, bond, and goal. Lastly, this study preliminarily evaluated the relationship between WAI-SS factors of general alliance, task, bond, and goal and the preliminary specific content areas of supervisee disclosure. The hierarchical factor of general alliance was a statistically significant predictor for all specific content areas of supervisee disclosure. The preliminary findings of this study, highlight the important differences in the relationships among the specific factors of the supervisory working alliance and content areas of supervisee nondisclosure. The factor of task was not significantly correlated with content areas of supervisee disclosure and the factor of goal was only a significant predictor for two content areas of disclosure:

Strengths of the Supervisory Relationship and Dissatisfaction with Clinical Setting. The factor of bond was significantly correlated with six content areas of supervisee disclosure and significantly predicted five content areas: Strengths of the Supervisory Relationship, Clinical Successes, Self, Weaknesses of the Supervisory Bond, and Dissatisfaction with the Clinical Setting. This study contributes specificity to the supervision literature on supervisee disclosure and nondisclosure. The results of this study provide a psychometrically sound foundation for future research to identify aspects of the supervisory working alliance that may reduce supervisee nondisclosure.

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# CHAPTER 1

# INTRODUCTION

## The Problem in Perspective

Supervision of clinical work is an important part of training for psychotherapists because it involves an on-going relationship between an advanced and junior member of the field to develop clinical competency and thus improve client outcome (Bernard & Goodyear, 2014). Clinical supervision is a relation-based education and training to support, develop, and evaluate the supervisee's clinical competency (Milne, 2007). Clinical supervision provides accountability as psychotherapists-in-training apply the knowledge they have learned and work toward gaining clinical competency. Clinical supervision has three main purposes to ensure accountability and adequate clinical progression during a practicum, internship, or post-doctoral experience. Through supervision, the supervisor must foster professional development of the supervisee, ensure client welfare, and be a gatekeeper for entry into the profession (Bernard & Goodyear, 2014).

Theoretically, it is important that supervisors observe the supervisee's work with clients to adequately serve the three purposes of supervision. Despite the theoretical justification, due to logistical limitations and time constraints, observation of supervisee's clinical work does not always occur. Moreover, it seems that observation of supervisees' clinical work is more likely to not occur than it is to occur. In a study to investigate the supervision methods that are being implemented and how much the methods varied among supervisees, Amerikaner and Rose (2012) found that only 24% of participants indicated that their supervisors directly observed their clinical work on a regular basis.

Furthermore, 49.3% of participants confirmed that their supervisor had never directly observed their work (Amerikaner & Rose, 2012). Supervisors are often not able to directly observe supervisees' clinical work and therefore must rely on the information that the supervisees choose to disclose in supervision. Amerikaner and Rose (2012) found that almost 80% of participants confirmed that they, the supervisees, primarily or exclusively chose the case or cases to discuss in supervision. If the content of supervision is predicated on what the supervisee chooses to disclose in supervision then there is a necessity to examine the process of supervisee nondisclosure.

Supervision is a complicated process to study because of the relational aspect of the process. As part of the relationship, the content of conversation involves self-report by the supervisee and one of the most studied aspects of this process is supervisee nondisclosure. Supervisee nondisclosure can be defined as anything that the supervisee willingly decides not to bring into the conversation of supervision or discuss once the topic has been started (Farber, 2006; Hess et al., 2008; Ladany et al., 1996). Research has consistently found that supervisee nondisclosure occurs (Wallace & Alonso, 1994; Ladany, Hill, Corbett, & Nutt, 1996; Pisani, 2005; Mehr, Ladany, & Caskie, 2010; Mehr, Ladany, & Caskie, 2015; Hess, 2008; Yourman 2003; Yourman & Farber, 2006). Given the broad definition of supervisee nondisclosure, a variety of content areas of nondisclosure exist. To date, there have been qualitative inquiries of supervisees to uncover specific content that is not being disclosed in supervision. Qualitative studies have found that supervisees most often withheld information regarding: (1) negative perceptions of supervisor, (2) personal issues not directly related to supervision, (3) clinical mistakes, (4) evaluation concerns, (5) negative reactions to client, (6) attraction

issues, and (7) positive reactions to supervisor (Ladany et al., 1996; Mehr et al. 2010; Hess et al., 2008). Ladany and colleagues (1996) found that in addition to the aforementioned content areas of nondisclosure, supervisees also conceal disclosure of the following types: (1) countertransference, (2) client-counselor attraction issues, (3) supervision setting concerns, (4) supervisor appearance, (5) supervisee-supervisor attraction issues, and (6) positive reactions to clients. In a study to assess content areas of supervisee nondisclosure, Mehr and colleagues (2010) found these additional types of supervisee nondisclosure: (1) negative supervision experience, (2) concerns about supervisor's perception of supervisee, (3) therapeutic and theoretical difference with supervisor, (4) concerns about professional inadequacy, (5) professional and academic concerns, (6) clinical events, (7) clinical successes, and (8) other (Mehr et al., 2010). It is noteworthy that the content area of "attraction issues" in the Mehr and colleagues (2010) study included attraction issues among the triad of supervisor, supervisee/psychotherapist, and client, while this domain was separated into two distinct content areas in the Ladany and colleagues (1996) study. The studies conducted by Ladany and colleagues (1996) and Mehr and colleagues (2010) both assessed nondisclosure of supervisees at varying levels of training. Hess, Knox, Schultz, Hill, Sloan, Brandt, Kelley, and Hoffman (2008) engaged in consensual qualitative research to examine supervisee nondisclosure of more experienced clinicians, pre-doctoral interns. At the level of pre-doctoral interns, there were two content areas of supervisee nondisclosure: (1) clinical issues/intern mistakes and (2) problems in the supervisory relationship (Hess et al., 2008). Both content areas of nondisclosure found by Hess and colleagues (2008) were also identified in the Ladany and colleagues (1996) and Mehr and

colleagues (2010) studies. The richness of data from the qualitative inquiries of the content areas of supervisee nondisclosure provides a wide array of potential types of nondisclosure and introduces the possibility that types of nondisclosure may vary with clinical experience. The descriptive richness of these data seems to have been ignored in subsequent research regarding potential predictors of supervisee nondisclosure. Quantitative studies regarding supervisee nondisclosure use mean level occurrences of nondisclosure. In this approach, all nondisclosure is collapsed together into one variable without prior justification. Supervisee nondisclosure is treated as a unified troubling problem in supervision and the particular nuances of specific content areas of nondisclosure have been overlooked. There is an underlying assumption that all supervisee nondisclosure is equal and problematic for supervision; however, research on client nondisclosure in psychotherapy has demonstrated that this is not necessarily the case (Farber & Sohn, 2001; Kahn et al., 2001; Kelly 1998; Kelly, 2000; Kelly & Achter, 1995; Kelley, Kahn, & Coulter, 1996; Kelly & McKillop, 1996; McDaniel, Stiles, & McGaughey, 1981; Stiles, 1984; Stiles & Shapiro, 1994). Research on nondisclosure in psychotherapy provides support for the uniqueness of specific categories of nondisclosure.

**Categories of Nondisclosure in Psychotherapy**

Similar to the aforementioned research on supervisee nondisclosure, there has been research examining the content of client nondisclosure in psychotherapy; however, the literature on client nondisclosure goes beyond describing the content, it contextualizes the importance of specific categories of nondisclosure. The literature regarding the specific categories of nondisclosure will serve as a guide for this study to better

understand the broader concept of nondisclosure within a dynamic relationship. Hill, Thompson, Coger, and Denman (1993) differentiated client nondisclosure into three types: (1) reactions, (2) things left unsaid, and (3) secrets. The 'reactions' type of nondisclosure includes thoughts and feelings that clients may have in reaction to particular events in therapy (Hill et al., 1993). The 'things left unsaid' type of nondisclosure includes clients' thoughts and feelings that they do not voice to their therapists (Hill et al., 1993). The 'secrets' type of nondisclosure includes significant life experiences or feelings that clients conceal from their therapists (Hill et al., 1993). The overarching substance of these types of nondisclosure is the concealment of thoughts and feelings; however, the time frame of the concealment differentiates 'reactions,' 'things left unsaid,' and 'secrets.' 'Reactions' occur in response to a specific therapist intervention, whereas 'things left unsaid' happens within a session of psychotherapy, and 'secrets' involve a longer time frame that may not be spurred from events within psychotherapy (Hill et al., 1993). Research by Kelly and her colleagues have focused on the 'secret' type of client nondisclosure and found that the presence of this type of nondisclosure was a significant predictor of fewer symptoms at the end of therapy (Kelly 1998; Kelly & Yip, 2006). Perhaps counter intuitively, the research findings of Kelly and her colleagues (1998) suggest a self-presentational view of secret keeping such that clients may benefit from suppressing undesirable components of themselves from their therapists. Categories of client nondisclosure are important to consider because understanding the content and context of the nondisclosure can highlight specific aspects of the process of disclosure and nondisclosure that provide meaning for its occurrence.

Related to specific categories of client nondisclosure is an issue of salience regarding the nondisclosure. Given the vast possibilities of client nondisclosure that occur, research has investigated which types of nondisclosure are most related to the client's perceived personal importance and extent of discussion in therapy. Farber and Sohn (1997) found that nondisclosure regarding feelings of inadequacy or failure, concerns about sexual performance, experience or feelings about masturbation, experiences of being sexually abused as a child, and the nature of my sexual experiences had high salience to clients. Client participants identify these types of disclosure as areas that they should be discussing in therapy, in more depth (Farber & Sohn, 1997). Given the research on different categories of client nondisclosure, it is a broad process that is comprised of a variety of different content areas and some types are more important to outcome. The categories of client nondisclosure are important and necessary to further the literature on the factors that are associated with the process and outcome of psychotherapy. While psychotherapy and supervision do not have exactly the same processes occurring within, there are similar and related processes that occur between the two.

**The Supervisory Working Alliance and Supervisee Nondisclosure**

The relationship between supervisory working alliance and supervisee nondisclosure has been well established in the literature. Ladany et al. (1996) argue that when the key components of the supervisory working alliance are not present, supervisees will engage in higher levels of nondisclosure. Moreover, supervisee nondisclosure appears to be related to a weak alliance, poor supervisory relationship, negative feelings about the supervisor, or concerns the supervisor would not be

supportive (Ladany et al., 1996; Ladany et al., 1997; Gray et al., 2001). Decisions regarding whether to disclose in supervision reflect the development of the supervisory alliance and the supervisees' level of comfort in that relationship (Yourman & Farber, 1996). Mehr, Ladany, and Caskie (2015) conducted a study to examine the overarching model of the interrelationships among trainee anxiety, supervisory working alliance, and counseling-self efficacy and their relation to supervisee willingness to disclose in supervision. Findings in this study support the relationship between higher counseling self-efficacy and less supervisee anxiety, a stronger supervisory working alliance and less supervisee anxiety, and a strong supervisory working alliance and higher willingness to disclose (Mehr et al., 2015). Support was not found for the relationship between supervisee anxiety and willingness to disclose or between counseling self-efficacy and willingness to disclose (Mehr et al., 2015). The findings of this study, which relate to willingness to disclose in supervision, seem to only support a positive relationship with supervisory working alliance. More specific personal characteristics of the supervisee (e.g., supervisee anxiety and counseling self-efficacy) do not seem to be related to willingness to disclose in supervision. These findings are important because it strengthens the literature on supervisory working alliance and supervisee disclosure in supervision; however, it assesses a self-reported willingness to disclose information rather than specifically inquiring about the content that one has chosen to conceal from his or her supervisor. This study will extend the literature by assessing supervisees' self-reported willingness to disclose specific content topics in supervision through a newly created survey measure, the Supervisee Disclosure Scale (SDS). After exploratory factor analysis and eventually confirmatory factor analysis, in a future research study, the SDS will

allow researchers to examine the relationship between supervisory working alliance and the specific content areas of nondisclosure in supervision.

In order to accurately examine the relationship between supervisory working alliance and the specific content areas of nondisclosure in supervision, the factor structure of the Working Alliance Inventory/Supervision-Short (WAI-SS) must be assessed. It is important to have a well-identified factor structure of a construct such as the supervisory working alliance prior to examining its relationship with other constructs. Researchers (Ladany & Caskie, 2015; Mehr et al., 2015) have used the Working Alliance Inventory/Supervision-Short (WAI-SS), which was adapted from the Working Alliance Inventory-Short Form, to apply to supervision, supervisees, supervisors, and supervisee issues rather than counseling, clients, therapists, and client problems. In a dissertation study, Bahrick (1989) was the first to adapt the Working Alliance Inventory to apply to supervision. Bahrick (1989) used seven advanced doctoral students to assess his newly adapted Working Alliance Inventory/Supervision and inter-rater agreement reached 97.6% for statements relevant to the bond factor. The inter-rater agreement reached 60% for statements relevant to the goals factor and 64% for the tasks factor and therefore Bahrick concluded that the adapted instrument consisted of two factors, (1) bond and (2) goals/tasks. To date, no factor analysis of the Working Alliance Inventory/Supervision has been conducted to formally evaluate the structure. Researchers (Tracey & Kokotovic, 1989) have found that the Working Alliance Inventory-Short Form has a bi-level factor structure with a hierarchical general alliance factor and three specific factors of (1) task, (2) bond, and (3) goals. The factor structure of the Working Alliance

Inventory/Supervision-Short will be evaluated in the current study to provide psychometric clarity for the working alliance construct, as it relates to supervision.

**Study Rationale**

Supervisee nondisclosure is prevalent despite the presumed necessity for disclosure in the self-report process of clinical supervision. Supervisee nondisclosure research has been descriptive of the content of nondisclosure and contains a wealth of information to help uncover the potential factors associated with nondisclosure. Unfortunately, the distinctiveness of the content of nondisclosure has subsided and instead all types of supervisee nondisclosure are treated equally when studying predictors of effective supervision. Further evaluation of specific categories of supervisee nondisclosure is necessary to be able to accurately assess potential differential relationships between types of supervisee nondisclosure and important aspects of effective supervision. Especially given the evaluative nature of supervision, it is plausible that certain categories of nondisclosure are problematic while other categories are tangential to effective supervision. The potential differential relationship of different types of supervisee nondisclosure would not be captured in mean level data regarding all nondisclosure. Moreover, once specific content areas of nondisclosure are identified, understanding the relationship with supervisee individual differences, such as clinical experience, could aid in the conceptualization of a potential developmental process of disclosure in clinical supervision. These ideas lead to the broad questions of this study: What are the unique factors or categories in supervisee nondisclosure? Does supervisees' clinical experience relate to the unique categories of supervisee nondisclosure? What is the factor structure of the Working Alliance Inventory/Supervision-Short (WAI-SS)? Do

the different types of nondisclosure, as identified through the Supervisee Disclosure Scale (SDS), differentially relate to the quality of the supervision relationship? It is expected that the SDS will reveal a clear factor structure, which will uncover specific types of supervisee nondisclosure. Identification of the factor structure of supervisee nondisclosure will allow the examination of the relationship between supervisee experience and the specific content areas. Similarly, identification of the factor structure of the WAI-SS will provide the foundation for future examination of the nuanced ways in which specific types of nondisclosure relate to specific factors of the supervisory working alliance.

The research on nondisclosure in supervision and the supervisory working alliance will be reviewed in the following chapter. The chapter will end with a full description of the research questions and hypotheses of this study. The methodology of the current study will be presented in Chapter 3.

# CHAPTER 2

# REVIEW OF THE LITERATURE

This chapter will review the relevant literature involving disclosure and nondisclosure in psychotherapy, disclosure and nondisclosure in supervision, and supervisory working alliance. The chapter will conclude with a thorough description of the current study, research questions, and hypotheses.

## Disclosure and Nondisclosure in Psychotherapy

Due to the interconnection between therapy and supervision, two change-oriented processes, a thorough understanding of the relevant literature involving disclosure and nondisclosure in psychotherapy will aid in conceptualization of supervisee nondisclosure, the primary aim of the current study. The extent of disclosure and nondisclosure in psychotherapy has been studied to elucidate a basic question of what features of clients' private worlds they will express to their therapists. Hill and colleagues proposed three separate categories of covert processes, which clients utilize during psychotherapy, including hidden reactions, things left unsaid, and secrets (1993). Results have supported that clients engage in more nondisclosure of negative reactions, in comparison to positive reactions (Hill et al., 1992, 1993; Thompson & Hill, 1991; Rennie, 1992, 1994). Approximately two-thirds of clients endorse nondisclosure of the 'things left unsaid' category and almost half of clients endorsed nondisclosure of 'secrets' (Hill et al., 1993). While findings from Hill and colleagues have provided classification of different categories of nondisclosure in psychotherapy and demonstrated the prevalence of its occurrence, the literature has extended into a more thorough understanding of types of topics most discussed and withheld from discussion in therapy.

Consideration of the content of issues most readily and least likely to be discussed in psychotherapy clarifies the process of nondisclosure. Hall and Farber (2001) used the Disclosure-to-Therapist Inventory-Revised (DTI-R) to assess the extent of clients' disclosure on a broad array of intimate topics in psychotherapy. The topics with the highest scores and therefore most thoroughly discussed in therapy are as follows: (1) "aspects of my personality that I dislike, worry about, or regard as a handicap," (2) "characteristics of my parents that I dislike," (3) "feelings of desperation, depression, or despair," (4) "my feelings of rage or anger toward my parents," (5) "my feelings of rage or anger toward my spouse/partner" (Hall & Farber, 2001). Overall scores for disclosure were around the mid-point of a 5-point scale, at 3.2, and therefore indicates moderate levels of disclosure of a broad array of 80 different topics (Farber & Hall 2002; Hall & Farber, 2001). Interestingly, patients may perceive themselves as highly disclosing when asked about their overall disclosure to their therapist, with mean scores ranging from 5.5-5.9 on a 7-point scale and between 79-82 on a 1-100 scale (Berano & Farber, 2006; Farber & Sohn, 1997; Pattee & Farber, 2004; Sohn & Farber, 2003). Clients seem comfortable in disclosing information of their personal lives to their therapists; however, there are content areas that are less often disclosed. The topics with the lowest score and therefore least discussed in psychotherapy are as follows: (1) "My sexual feelings toward or sexual fantasies about my therapist," (2) "my interest in pornographic books, magazines, movies, videos, etc.," (3) "bathroom habits: extreme fastidiousness, compulsive regularity or habitual irregularity, etc.," (4) "my experience of or feelings about masturbation," (5) "aspects of my body that I am most satisfied with" (Hall & Farber, 2001). Topics least discussed in psychotherapy, as determined in research by Hall

and Farber (2001) are interesting; however, the mere fact that these topics are not discussed does not necessarily have positive or negative implications. There is a critical distinction between nondisclosure of a topic of great significance to the client and nondisclosure of a topic of limited relevance (Farber, 2006). When conceptualizing significance regarding the process of psychotherapy, outcome is a meaningful way to measure it.

**Disclosure and Client Outcome in Psychotherapy.** There are three main schools of thought, and empirical support, regarding disclosure and its relationship to outcome: beneficial, problematic, and neutral. Pennebaker has found that writing about the traumatic events and situations that one has survived is related to reduction in distress, most related to physical symptomatology (1997; 2002). The process promoted by Pennebaker has widespread appeal; however, it was never originally studied with psychotherapy clients and therefore should only serve as indirect support for the usefulness of disclosure in a clinical setting (Farber, 2006). Writing about trauma can be viewed as a source of disclosure but it is substantially different than disclosure in psychotherapy because it does not involve an interpersonal aspect of sharing this disclosure with someone else and it does not require verbal discussion of this disclosure. The literature focused on the relationship between disclosure and client outcome in psychotherapy is much less consistent than Pennebaker's beneficial findings regarding health outcomes. Stiles and colleagues conducted a study to examine extent of client disclosure and outcome, as measured by depth of the session and a variety of outcome measures including: Minnesota Multiphasic Personality Inventory, the Psychiatric Status Schedule (Spitzer, Endicott, & Cohen, 1968), the Health-Sickness Rating Scale

(Luborsky, 1962), client rated level of happiness of a 9-point scale, clinical rating scales developed specifically for the Vanderbilt project, which included two scores, an overall intensity rating of current problems, and a distress score including the average of seven scales of anxiety, depression, guilt, enjoyment of life, self-esteem, optimism, and overall psychic distress (McDaniel, Stiles, McGaughey, 1981; Stiles, 1984). Stiles (1984) found no significant relationship between occurrence of disclosure and depth of session, as rated by the client, therapist, and outside. Additionally, client disclosure was not significantly related with any of the outcome measures (McDaniel, Stiles, McGaughey, 1981). While initially and perhaps intuitively, given the purpose and process of psychotherapy, touted as paramount within psychotherapy, it seems that the mere occurrence of client disclosure is not in itself associated with benefit in regards to therapeutic outcome. Furthermore, Regan and Hill (1992) discovered that the overall occurrence and valance of nondisclosure of the "things left unsaid" category was not related to client outcome; however, the content of these nondisclosures was significantly related to client outcome. Clients who endorsed nondisclosure of feelings-related 'things left unsaid' described sessions as less deep and continued to feel less satisfied with treatment (Regan & Hill, 1992). Moreover, research by Kelly and her colleagues have demonstrated no relationship between client disclosure and outcome and even that there may be positive benefit from nondisclosure (Kelly, 1998; 2000; Kelly & Achter, 1995; Kelly, Kahn, & Coulter, 1996; Kelly & McKillop, 1996). Kelly theorizes a self-presentational model of therapy and explains that concealment of certain undesirable aspects of one's private world is beneficial. In this model, the client reaps beneficial psychotherapy when he or she is able to present a more desirable image of oneself to the

therapist and therefore does not need to spend time or energy on anticipated or actual negative feedback from the therapist about shameful behavior, thoughts, or feelings (Kelly, 1998). In an attempt to justify the at best inconsistent and often non-existent findings between client disclosure and outcome, Kahn, Achter, and Shambaugh (2001) provided an important methodological distinction. Kahn and colleagues (2001) argue that throughout the literature on client disclosure and outcome both of these variables have been operationalized differently and this variety influences the varying results. Researchers have examined disclosure in various ways but have not consistently differentiated between disclosure of distressing and non-distressing content (Kahn et al., 2001). In essence Kahn and colleagues (2001) contend that the content of disclosure may be of more importance to study, in relation to outcome, than simply the occurrence because all disclosure or nondisclosure is not the same. There may be differing relationships between content areas of disclosure or nondisclosure and outcome. The literature on client disclosure in psychotherapy is helpful for understanding the process of effective psychotherapy and it is also beneficial in a translational manner to a related interpersonal process of clinical supervision. The structures present in psychotherapy can be viewed as isomorphic with the structures present in clinical supervision (Bernard & Goodyear, 2014). Given the isomorphic properties of the two similar domains of psychotherapy and supervision, the roles of therapist and client correspond to those of supervisor and supervisee and thus the two fields influence each other (White & Russell, 1997).

## Disclosure and Nondisclosure in Supervision

**Nature, Extent, and Importance of Nondisclosure.** All models of clinical supervision rely on supervisees to disclose information regarding the client, therapeutic interaction, supervisory interaction, and personal information about themselves (Yourman & Farber, 1996). Supervisors must have an adequate amount of information from their supervisees to promote development and assess competency (Yourman & Farber, 1996). Supervisors are not able to aid in supervisee growth with concerns that they are not aware of (Ladany, Hill, Corbett, & Nutt, 1996). Additionally, due to the responsibilities of the supervisor as respondeat superior it is imperative that supervisors are provided with accurate and honest information from their supervisees (Bernard & Goodyear, 2014). While the importance of supervisees' disclosure in supervision is paramount, there is a tendency for supervisees to omit or distort information (Wallace & Alonso, 1994; Ladany et al., 1996; Yourman & Farber, 1996; Webb & Wheeler, 1998; Hess et al., 2008; Mehr et al., 2010; Mehr et al., 2013; Mehr et al., 2015).

**Content of Supervisee Nondisclosure.** The phenomenon of nondisclosure in supervision is varied and widespread in its nature and extent. Five studies have been conducted that examine the content of what is not being disclosed by supervisees to their supervisors (Hess et al. 2008; Ladany et al., 1996; Mehr et al., 2010; Wallace and Alonso, 1994; Yourman and Farber, 1996). The findings from the qualitative studies of supervisee nondisclosure content, Ladany and colleagues (1996), Mehr and colleagues (2010), and Hess and colleagues (2008), have already been discussed in chapter 1 and will be reviewed in Table 1 below. Wallace and Alonso (1994) identified countertransference, breaking parameters of therapy, and deviations from theoretical

models as the most common areas for supervisee nondisclosure. Building on the findings of the landmark study by Ladany and colleagues (1996) previously discussed in chapter 1, Yourman and Farber (1996) found that 30-40% of supervisees choose to not disclose information at moderate to high (e.g., responses of 'sometimes' – 'always' on a Likert type scale) levels of frequency. Content areas that were concealed most often include: angry feelings toward clients (69.9% of participants endorsed at a high frequency; 23.7% endorsed at a moderate frequency; 6.5% endorsed at a low frequency), feelings of inadequacy as a clinician (51.6% endorsed at a high frequency; 43.0% endorsed at a moderate frequency; 5.4% endorsed at a low frequency), describing interactions with clients in which supervisees thought their supervisors might disapprove (47.3% endorsed at a high frequency; 48.4% endorsed at a moderate frequency; 3.2% endorsed at a low frequency), positive feelings about supervisor (33.3% endorsed at a high frequency; 53.8% endorsed at a moderate frequency; 12.9% endorsed at a low frequency), disagreement with supervisor (28.0% endorsed at a high frequency; 54.8% endorsed at a moderate frequency; 17.2% endorsed at a low frequency), negative feelings about supervisor (4.3% endorsed at a high frequency; 34.4% endorsed at a moderate frequency; 59.1% endorsed at a low frequency), clinical errors (2.2% endorsed at a high frequency; 37.6% endorsed at a moderate frequency; 60.2% endorsed at a low frequency), and theoretical or clinical views (4.3% endorsed at a high frequency; 20.4% endorsed at a moderate frequency; 75.3% endorsed at a low frequency) (Yourman & Farber, 1996).

The findings of the five studies regarding content of supervisee nondisclosure reveal the variety of topics that are not being discussed within supervision. It is important to empirically determine specific categories of supervisee nondisclosure so that the

literature can expand in meaningful ways about the significance of these categories rather than collapsing all nondisclosure together. Table 1 provides an overview of the different content areas of supervisee nondisclosure found in the literature.

Table 2.1

*Content Areas of Supervisee Nondisclosure Found in Previous Research*

| Content of Nondisclosure | Content present in research: |
|---|---|
| Negative perceptions of supervisor | L (1996); Y (1996); M (2010); H (2008) |
| Personal issues | L (1996); M (2010) |
| Clinical mistakes | W (1994); L (1996); Y (1996); M (2010); H (2008) |
| Evaluation concerns | L (1996); Y (1996); M (2010) |
| General client observations | L (1996); M (2010) |
| Negative reactions to client | L (1996); Y (1996); M (2010) |
| Countertransference | W (1994); L (1996); M (2010) |
| Client-counselor attraction issues | L (1996); M (2010) (combined intro attraction within the triad) |
| Positive reactions to supervisor | L (1996); Y (1996); M (2010) |
| Supervision setting concerns | L (1996) |
| Supervisor appearance | L (1996) |
| Supervisee-supervisor attraction issues | L (1996); M (2010) (combined intro attraction within the triad) |
| Positive reactions to client | L (1996) |
| Negative supervision experience | M (2010); H (2008) |
| Concerns about supervisor's perception of supervisee | M (2010) |
| Therapeutic and theoretical difference with supervisor | W (1994); Y (1996); M (2010) |
| Concerns about professional inadequacy | Y (1996); M (2010) |
| Professional and academic concerns | M (2010) |
| Other | M (2010) |
| Clinical successes | M (2010) |

*Note*: W = Wallace & Alonso, 1994; L = Ladany et al., 1996; Y = Yourman & Farber, 1996; M = Mehr et al., 2010; H = Hess et al., 2008.

**Supervisee Experience and Nondisclosure.** In all five of the previously mentioned studies on supervisee nondisclosure (Wallace & Alonso, 1994; Ladany et al., 1996; Yourman & Farber; Mehr et al., 2010; Hess et al., 2008) supervisee clinical experience was a demographic variable collected in the studies. Four out of the five studies (Wallace & Alonso, 1994; Ladany et al., 1996; Yourman & Farber 1996, and Mehr et al., 2010) had samples with a range of clinical experience and found a variety of different content areas of supervisee nondisclosure.

Wallace and Alonso (1994) used trainees with 'various levels of experience.' Ladany and colleagues (1996) had a sample of 65% doctoral students and 33% master's students with 39% reporting experience level at 'beginning practicum,' 32% at 'advanced practicum,' and 26% at 'internship.' The sample in Ladany and colleagues' study (1996) had a median of 12 months of prior counseling experience and a median total of working with 15 clients in their lifetime. Yourman and Farber used a sample of all doctoral students with a mean "number of years in their program" of 3.3 years (*SD* = 1.1) and 59.8% of the sample in their third or fourth year in their program. The sample in Yourman and Farber's study (1996) had an average of 11.2 months of supervision with their current supervisor. Mehr and colleagues (2010) had a sample of counseling and clinical psychology students with 26% in a 'beginning practicum,' 36% in an 'advanced practicum,' and 31% on 'internship." The sample in Mehr and colleagues' study (2010) had a median of 16 months of counseling experience (*M* = 24.24), a median number of 25 clients that they have worked with in their lifetime (*M* = 109.92), and attended an average of 20.62 supervision sessions with their current supervisor. Yourman and Farber (1996) and Mehr and colleagues (2010) conducted analyses to examine the relationship between

clinical experience and supervisee nondisclosure. Findings of these studies did not support experience (as defined in each study) to be significantly related to mean levels of supervisee total disclosure (Yourman & Farber, 1996; Mehr et al., 2010). The relationship between clinical experience and total level of disclosure or nondisclosure was evaluated in previous studies but not for each specific content area (Yourman & Farber, 1996; Mehr et al., 2010). Supervisees' previous clinical experience may be an important predictor for specific content areas of nondisclosure in clinical supervision.

Furthermore, Hess and colleagues (2008) specifically used a less diverse sample in terms of clinical experience. Only participants with more clinical experience, pre-doctoral interns, were included in the study by Hess and colleagues (2008) and these participants identified fewer content areas of supervisee nondisclosure. The findings of Hess and colleague (2008) encouraged the continued examination of clinical experience and its relationship with specific content areas of supervisee nondisclosure. Evaluation of previous clinical experience as it relates to specific content area of supervisee nondisclosure has not been conducted, to date. Uncovering the potential relationship would be informative for supervisors. Individual differences in clinical experience are important in understanding supervisee nondisclosure.

**Motivation for Supervisee Nondisclosure.** While understanding what is being hidden from the supervisor is important, the motivation behind the concealment is also a factor of interest in the literature. In addition to examining the content of nondisclosure, Ladany and colleagues (1996) explored the reasons for the nondisclosure. The most common reasons for nondisclosure were perceived unimportance, the personal nature of nondisclosure, negative feelings about the nondisclosure, a poor alliance with the

supervisor, deference to the supervisor, and impression management (Ladany et al., 1996; Mehr et al., 2010). Less typical reasons for supervisee nondisclosure included: the supervisor's agenda, political suicide, pointlessness, and a belief that the supervisor was not competent (Ladany et al., 1996). Typically, information was passively withheld such that neither the supervisee nor the supervisor brought up the content (Ladany et al., 1996). In addition to the aforementioned reasons, Mehr and colleagues (2010) also found that supervisees provided the following for nondisclosure, a poor alliance with supervisor, worry about impact on supervisory relationship, thinking that the supervisor was already aware, and uncertainty regarding how to approach the discussion. The assortment of reasons for nondisclosure reported by Ladany and colleagues (1996) and Mehr and colleagues (2010) provide further support for the need to empirically validate categories of supervisee nondisclosure. Nondisclosure of information because the supervisee perceives it as unimportant or is too personal may not warrant continued research or clinical implications for supervision. Again, not all nondisclosure is equal; however, nondisclosure that is motivated by deference to the supervisor, impression management, worry about the impact on the supervisory working alliance, and a poor alliance with the supervisor may be related to specific categories of supervisee nondisclosure. While many reasons factor into a supervisee's decision not to disclose information, the strength of the supervisory working alliance has consistently been a significant predictor in supervisee nondisclosure.

## The Supervisory Relationship

The relationship between the supervisor and supervisee in clinical supervision seems to be the most foundational aspect of supervision because of its ability to enable or inhibit supervisee growth. Among the numerous models of supervision that have been developed and implemented over the years, the supervisory relationship is one of the key factors in confirming effectiveness of supervision (Ladany, Ellis, & Friedlander, 1999) and quality of supervision (Worthen & McNeill, 1996). Given the importance of the supervisory relationship, there are various models that have defined the essential components.

**Supervisory Relationship Models.** Bordin (1979) postulated that the working alliance between a therapist and client has three essential elements: the bond, tasks, and goals. While the three aspects of bond, tasks, and goals are present in the supervisory working alliance, as they are in the therapeutic working alliance, there are different components that play into the supervisory working alliance in Bordin's (1983) conceptualization of it (Angus & Kagan, 2007). In the supervisory working alliance, the bond encompasses the amount of trust and caring that is present in the relationship through working together (Bordin, 1983). In the supervisory working alliance, the tasks relate directly to the goals and are derived from didactic experiences and therapeutic orientations to supervision (Bordin, 1983). Goals are to be mutually set in the supervisory working alliance and may include the following, depending on the needs of the supervisee: proficiency of a specific skill, increasing the supervisee's conceptualization of the client and process issues, growing awareness of self and influence on the process, surmounting personal and logical obstacles toward learning and attainment of therapeutic

skills and processes, and intensifying one's knowledge and utilization of concepts and theories (Bordin, 1983). The strength of the supervisory working alliance extends beyond mutually agreed upon goals and includes the necessity for mutual understanding about the tasks, which accompany the shared goals of supervision (Bordin, 1983). The supervisor usually assigns tasks of the supervisory working alliance and the strength of the supervisory working alliance will influence how well the supervisee understands the connection between the tasks and goals (Bordin, 1983). Conversely, in a strong supervisory working alliance, the supervisor would adapt to the supervisee if he or she were unable to participate in the tasks set forth. Key components of the supervisory working alliance include mutual trust, liking, and caring between the supervisor and supervisee and these feelings encompass the bond of the supervisory working alliance (Bordin, 1983). The supervisory working alliance, as conceptualized by Bordin, has many similarities with the therapeutic working alliance present in psychotherapy because of the relational basis of both domains. The Working Alliance Inventory (WAI; Horvath & Greenberg, 1986) is a quantitative measure that has an empirically validated bi-level factor structure with a general alliance as its primary factor and 3 secondary specific factors of task, bond, and goal (Tracey & Kokotovic, 1989). The factor structure of the WAI and WAI-Short (Tracey & Kokotovic, 1989) aids researchers in examining and deciphering scores on the WAI because the primary construct measured is the general alliance and not the individual three factors. Specifically, items on the WAI have separate and independent variance associated with the general alliance factor, in addition to, the specific unique subscales of tasks, bond, and goal (Reise, 2012). While the general alliance, tasks, bond, and goals of the working alliance have been validated there are

other conceptualizations of the relationship that include specific features that should be taken into consideration.

Holloway (1995) posits that the supervisory relationship has three main elements including (1) the interpersonal relationship between supervisor and supervisee, (2) the phase of the relationship, and (3) the supervisory contract. Furthermore, Holloway offers that the supervisory relationship is a formal, hierarchical relationship, involving power and involvement as important elements, which evolve over time. The elements highlighted by Holloway (1995) are all components of supervision that could be taken into consideration when assessing the supervisory relationship; however, this model of the supervisory relationship has not been empirically tested with validated measures of its constructs (Cliffe, Beinart, & Cooper, 2014). It is important that validated measures of the essential constructs of the supervisory relationship are created and utilized to gain a deeper literature base on this important process. Without empirical testing with validated measures, this conceptualization of the essential components of the supervisory relationship stands as a theoretical position and will not be utilized in this study.

Beinart (2002; 2012) developed another model of the supervisory relationship to explain the effectiveness of the supervisory relationship. In this model the relational elements, such as developing boundaries and trust, must be facilitated before the tasks of supervision can be effective. Within Beinart's model, the elements of support, respect, commitment, sensitivity to needs, and collaboration are also important to the supervisory working alliance (Cliffe et al., 2014). Palomo et al. (2010) extended Beinart's model and conceptualized the supervisory relationship, through qualitative methodology, as including three facilitative components (i.e., safe base, commitment, and structure) and

three educative components (i.e., supervisor acting as a role model, initiating reflective education, and delivering formative feedback). Palomo and colleagues (2010) found that the facilitative and educative components of the supervisory relationship were supportive for supervisee development. Understanding the theoretical models of the supervisory relationship gives rise to the different assessment measures of the supervisory relationship.

**Assessment of the Supervisory Working Alliance**

There have been two research groups to develop an alliance measure specific to supervision (Efstation, Patton, & Kardash, 1990; Cliffe et al., 2014) and one approach to modify a valid measurement of working alliance to be appropriate for supervision (Bahrick, 1990; Baker, 1990). The Supervisory Working Alliance Inventory (SWAI; Efstation et al., 1990) was created to assess the set of actions used by supervisors and supervisees to facilitate the learning of the supervisee. This measure utilized a top-down approach, through which experts created a list of activities that they considered representative of what a supervisor and supervisee actually do in supervision (Efstation et al., 1990). The SWAI consists of 23 items for the supervisor and 19 items for the supervisee and responses are given on a 7-point Likert scale ranging from 1 (never) to 7 (almost always). The SWAI has a three-factor structure for the supervisors: (1) client focus ($\alpha = 0.71$), (2) rapport, ($\alpha = 0.73$) and (3) identification ($\alpha = 0.77$). The SWAI has a two-factor structure for the supervisees: (1) rapport ($\alpha = 0.90$) and (2) client focus ($\alpha = 0.77$). Results of analyses using principal-factors, maximum-likelihood, and alpha-extraction methods found the three-factor solution for supervisors and the two-factor solution for supervisees to be stable across all extraction methods (Efstation et al., 1990).

The SWAI evaluates the pragmatic aspects of supervisory relationship and was developed by careful consideration of the specific processes occurring in supervision and not necessarily based on a theoretical conceptualization of the relationship.

The Supervisory Relationship Questionnaire (SRQ; Palomo, Beinart, & Cooper, 2010) measures the supervisory relationship strictly from the perspective of the supervisee and is derived from Beinart's (2004) themes of the supervisory relationship and consists of six components (1) safe base, (2) structure, (3) commitment, (4) reflective education, (5) role model, and (6) formative feedback, as extracted through the principal components method of factor extraction. The six factors were extracted and rotated using the direct oblimin method and accounted for 65.3 percent of the variance in SRQ scores (Palomo et al., 2010). The six-factor solution was found to be stable across methods of factor extraction. The SRQ consists of 67 items with responses on a 7-point Likert scale, ranging from 1 (strongly disagree) to 7 (strongly agree. Internal consistency estimates have been excellent ($\alpha = 0.98$) with alpha coefficients for the subscales ranging from good to excellent ($\alpha = 0.97$ [safe base], 0.87 [structure], 0.95 [commitment], 0.93 [reflective education], 0.95 [role model], and 0.93 [formative feedback]). Despite the strong psychometric properties of the SRQ, this measure was developed and based on a model of supervisory relationship from a British conceptualization and sample. There are cultural and professional differences between clinical supervision processes and standards in the United Kingdom and the United States. For example, supervision is a process that is inherent in the clinical process of mental health professionals and is not merely required during training and licensure obtainment and therefore the supervisory relationship may greatly differ between the two cultures.

Working Alliance Inventory-Supervision-Short Form is a modified version of a widely-utilized assessment of the working alliance, WAI-Short (Tracey & Kotovic, 1989). The WAI-Short has been described previously in this chapter, regarding its bi-level factor structure of a general alliance as the primary factor and three specific factors of task, bond, and goal as secondary factors (Tracey & Kotovic, 1989). The WAI-Supervision-Short Form (Bahrick, 1989) substituted the words supervision and supervisor in place of the original items using therapy and therapist. The factor structure of the WAI-Supervision-Short Form has not been empirically evaluated. When the WAI was first modified to use with supervision, Bahrick (1989) used seven raters to evaluate the extent to which the three aspects of the working alliance, as defined by Bordin (183), were reflected in the items of the WAI-Supervision. Inter-rater agreement reached 97.6% for statements relating to the bond aspect of the working alliance. Raters were unable to make reliable distinctions between statements relevant to supervisory goals and tasks; agreement reached 64% for tasks and 60% for goals. Given the qualitative evaluation of seven raters, Bahrick (1989) posited that the WAI-Supervision consisted of two factors: (1) bond and (2) task/goals; however, this factor structure has not been empirically evaluated. Given the literature on the processes of working alliance in psychotherapy and the isomorphic structures in supervision, the WAI-Supervision-Short Form is beneficial in extending findings from the psychotherapy field into the supervision realm; however, a confirmatory factor analysis of the measure is necessary for empirical support prior to investigating the relationship between supervisory working alliance and supervisee nondisclosure.

**The Supervisory Working Alliance and Supervisee Nondisclosure**

The relationship between supervisory working alliance and supervisee nondisclosure has been well established in the literature. As presented in Chapter 1, research has been conducted and results have found supervisee nondisclosure to be related to a weak alliance, poor supervisory relationship, negative feelings about the supervisor, or concerns the supervisor would not be supportive (Ladany et al., 1996; Ladany et al., 1997; Gray et al., 2001). Decisions regarding whether to disclose in supervision reflect the development of the supervisory alliance and the supervisees' level of comfort in that relationship (Yourman & Farber, 1996). Significant relationships between higher counseling self-efficacy and less supervisee anxiety, a stronger supervisory working alliance, and less trainee anxiety, and a strong supervisory working alliance and higher willingness to disclose have been established in the literature (Mehr et al., 2015). The literature on the supervisory working alliance and supervisee nondisclosure, measured as mean level occurrence, seems to consistently support the positive relationship between the strength of the supervisory working alliance and supervisees' willingness to disclose information in supervision. While understanding the relationship between these two variables is foundational, there is a need to better assess this relationship in regards to the specific content areas of supervisee disclosure; however, this cannot be done until the factor structure of the measurement of supervisory working alliance is tested empirically.

Exploration of the relationship between supervisory working alliance and specific content areas of disclosure in supervision has been limited. Webb and Wheeler (1998) conducted a study of 96 British counselors (20 males and 75 females) regarding

disclosure in supervision and found a positive correlation between the quality of the supervisory working alliance and the extent of disclosure in supervision. This is the first study to examine the correlations between supervisory working alliance and specific content areas of disclosure, (1) sensitive topics regarding the client and the counseling process, and (2) sensitive subjects about the supervisor and supervision process. The authors used the Supervisory Working Alliance Inventory (SWAI; Efstation et al., 1990), only assessing the supervisee's perception of the supervisory working alliance. The SWAI has two major factors: (1) supervisor's attempts to build rapport (e.g., "my supervisor makes the effort to understand me") and (2) focus on the trainee's understanding of the client (e.g., "when correcting my errors with a client, my supervisor offers alternative ways of intervening with the client") (Efstation et al., 1990). The authors found a positive correlation between supervisees' perceived level of rapport between self and supervisor and ability to disclose sensitive issues relating to clients ($r = 0.43$), ability to discuss issues relating to supervision ($r = 0.44$) (Webb & Wheeler, 1998). There were no significant correlations with the second factor of the SWAI, trainee's understanding of the client, and content of disclosure. The factors of the SWAI are related to the three factors of Bordin's supervisory working alliance; however, tasks and goals are combined into one factor (i.e., focus on trainee's understanding of the client) rather than viewed as distinct. The use of the SWAI is a limitation of this study, which will be strengthened in the current study. While the SWAI does measure aspects of the supervisory relationship, it does not empirically support the theory of the supervisory working alliance, as proposed by Bordin (1983). Therefore, a more thorough examination of the supervisory relationship will be conducted using an empirically validated measure

of the general alliance and specific factors of goal, tasks, and bond, the Working Alliance Inventory (WAI). The WAI measure has been empirically validated as a measure of the working alliance in a therapy context but the Working Alliance Inventory/Supervision-Short (WAI-SS) has not been empirically validated to date. The results of Webb and Wheeler's study (1998) seem to add merit to the importance of examining the differential relationship of the supervisory working alliance and the specific content areas of supervisee nondisclosure. Confirming the factor structure of the WAI-SS will allow future research to better understand the general and specific factors of the supervisory working alliance, as they relate to supervisee nondisclosure.

The strength of the supervisory working alliance may foster different content areas of supervisee nondisclosure. Hess and colleagues (2008) interviewed pre-doctoral interns about a significant nondisclosure event that had occurred in supervision. Eight pre-doctoral interns were classified as having a 'good supervisory relationship' and six were classified as having a 'problematic supervisory relationship,' as determined by satisfaction of supervision, and higher ratings of supervisor attractiveness and interpersonal sensitivity on the Supervisory Styles Inventory (SSI; Friedlander & Ward, 1994). For the pre-doctoral interns in 'good supervisory relationships' the content of their nondisclosure was about personal reactions to clients (e.g., countertransference, issues regarding the therapeutic relationship, and perceived clinical mistakes). Pre-doctoral interns in 'problematic supervisory relationships' chose not to disclose global dissatisfaction with the supervisory relationship (e.g., issues related to the supervisor's theoretical orientation and the supervisor's mixed messages or expectations) (Hess et al., 2008). Hess and colleagues (2008) found that content of supervisee nondisclosure varies

as a function of the supervisory relationship. The classification of the supervisory relationship, as either 'good' or 'problematic' in this study was dependent on three components: (1) supervisee satisfaction with supervision, (2) supervisees' perceptions of their supervisor's attractiveness (e.g., trusting and flexible), and (3) supervisees' perception of their supervisor's interpersonal sensitivity (e.g., perceptive and invested). Supervisee satisfaction with supervision is a broad concept and relates to the general factor of the alliance in the supervisory working alliance, the sum of all three specific factors of goals, tasks, and bond. Theoretically, a supervisee would not report satisfaction if any of these specific factors were less than favorable. Items two and three of the aforementioned components of a 'good supervisory relationship' reflect one aspect of Bordin's supervisory working alliance, the bond. Taken together, the supervisee nondisclosure content area of client concerns may be related to a higher level of the supervisory bond of the supervisory working alliance and the lower level of the bond subscale on the supervisory working alliance may be related to the supervisee nondisclosure content area of supervision concerns. Hess and colleagues only examined the relationship of two content areas of supervisee nondisclosure; however, it provides empirical support for some of the potential theoretical hypotheses regarding the relationship between the general alliance, specific factors of the supervisory working alliance, and the specific content areas of supervisee nondisclosure. These theoretical hypotheses cannot be evaluated until psychometrically sound measures have validated the content areas of supervisee disclosure and the factor structure of the supervisory working alliance.

## The Current Study

The purpose of the current study is to examine the factor structure of supervisee nondisclosure to identify nondisclosure categories. Furthermore, this study will specifically examine the potential relationship of clinical experience with the content areas of supervisee nondisclosure. Lastly, this study will evaluate the factor structure of measurement of the supervisory working alliance and evaluate its relationship with the preliminary content areas of supervisee disclosure. This study will add specificity to the nondisclosure in supervision literature. The results of this study will lay a psychometrically sound foundation for future research to identify aspects of the supervisory working alliance that may reduce supervisee nondisclosure. The research questions of this study are as follows:

R1: What is the factor structure of supervisee nondisclosure content areas, as measured through the Supervisee Disclosure Scale (SDS)?

R2: What are the relationships among clinical experience variables and the content areas of supervisee disclosure?

R3: Does the factor structure of WAI-Supervision-Short Form fit the bi-level factor structure of the WAI-Short Form?

R4: Do the content areas of supervisee disclosure differentially relate to the factors of the supervisory working alliance?

The hypotheses of this study are as follows:

H1: The SDS will demonstrate a clear and systematic factor structure, which will capture relevant content areas of supervisee nondisclosure.

H2: Greater clinical experience will be related to an increase in disclosure of the factors of the SDS.

H3: The factor structure of the WAI-Supervision-Short Form will be similar to the factor structure of the WAI-Short Form from which the measure is adapted. There may be a bi-level factor structure with a *general alliance* factor at the primary level and three secondary factors: *bond*, *task*, and *goal*.

H4: The factors of the supervisory working alliance will differentially relate to the specific areas of supervisee disclosure. Specifically, a strong *general alliance* will be related to more disclosure; however, the specific factors of *bond*, *task*, and *goal* may differentially relate to specific content areas.

# CHAPTER 3

# METHODS

## Participants

Since there is no null hypothesis to test when conducting an exploratory factor analyses, a power analysis cannot be determined. There are general guidelines when assessing sample size for an exploratory factor analysis such as 5:1 or 10:1; however, these guidelines are not supported empirically (Guadagnoli & Velicer, 1988; MacCallum, Widaman, Xhang, & Hong, 1999). Rather than using the number of variables as the deciding factor in sample size estimations, assessing the degree to which factors are overdetermined and communalities is best (Kahn, 2006). Given that there have not yet been empirical studies to help in prediction of the magnitude of structure coefficients and the communalities for supervisee nondisclosure, these aspects cannot assist in determining sample size a priori. The prospective sample size for this study was 200 participants. Eligibility for this study required participants to currently be providing counseling through a practicum or internship experience and obtaining supervision of their clinical work. Potential participants were recruited through participation requests to training directors at doctoral training programs of Counseling Psychology and Clinical Psychology and CACREP accredited programs of Clinical Mental Health Counseling throughout the United States. Additionally, participation requests were sent out through listservs through the applicable divisions in the American Psychological Association, American Counseling Association, and student groups and organizations of Counseling, Counseling Psychology, and Clinical Psychology.

Participant demographics. Initially, 271 participants responded to the participant request and opened the survey link. Two individuals chose not to participate after reading the informed consent. Twenty-nine individuals agreed to the informed consent but then did not complete any information after "I agree to participate." Together, 29 individuals did not provide demographic information or complete the WAI-SS or SDS measures. After cleaning the data, 223 participants completed the majority of all measures (i.e., demographic information, WAI-SS, and SDS measures). Using pairwise deletion missing data analysis, a total of 221 responses for the WAI-SS measure and a total of 203 responses for the SDS measure were used in analyses for this study.

Demographic Information. Demographic information about each participant and his or her experiences with supervision was collected. Specifically, information about supervisee age, gender, race, ethnicity, sexual orientation, degree program, field of study, level of training, months of counseling experience, number of previous practica or supervised fieldwork experiences completed, number of past supervisors, total number of clients, supervision sessions to date with current supervisor, hours of individual supervision received per week was collected. Demographic information about each participant's supervisor, as reported by the supervisee, was also collected. Specifically, supervisor age range, gender, race, ethnicity, sexual orientation, length of supervised counseling experience, length of supervision experience, and total number of current supervisees was collected. Previous research has not supported the following demographic variables as significant predictors of aggregate non-disclosure scores: supervisee age, supervisee gender, supervisor gender, ethnicity, theoretical orientation, supervisee's number of years in the training program (Yourman & Farber, 1996), months

of counseling experience, and total number of clients seen (Mehr et al., 2010). In this study, clinical experience variables were used to examine the relationship with specific content areas of supervisee nondisclosure. Participants' clinical experience was captured in four separate variables: (1) months of supervised counseling experience, (2) number of clients worked with clinically, (3) weeks completed at current site, and (4) number of individual supervision sessions. The median months of counseling experience for the sample of this study was 11.00 ($M$ = 18.13, $SD$ = 16.88 with a range from 0-72). The median number of previous clients for the sample of this study was 25.00 ($M$ = 46.06, $SD$ = 67.00 with a range from 0-350). The median number weeks completed at current site for the sample of this study was 18.00 ($M$ = 19.33, $SD$ = 13.39 with a range from 0-66). The median number of individual supervision sessions with current supervisor for the sample of this study was 13.00 ($M$ = 16.32, $SD$ = 14.21 with a range from 0-80).

Table 3.1

*Demographic Characteristics of the Sample (N = 223)*

| Characteristics | N | % |
|---|---|---|
| Gender | | |
| Male | 41 | 18.4 |
| Female | 181 | 81.2 |
| Transgender | 1 | 0.4 |
| Age Category | | |
| 20-24 | 60 | 26.9 |
| 25-29 | 96 | 43.0 |
| 30-34 | 36 | 16.1 |
| 35-39 | 14 | 6.3 |
| 40-44 | 8 | 3.6 |
| 45-49 | 4 | 1.8 |
| 50-54 | 3 | 1.3 |
| 55-59 | 1 | 0.4 |
| 60+ | 1 | 0.4 |
| Race/Ethnicity | | |
| African American/Black | 9 | 4.0 |

| | | |
|---|---|---|
| Asian/Asian American | 21 | 9.4 |
| Caucasian/White | 158 | 70.9 |
| Latino/a/Hispanic | 22 | 9.9 |
| Native American or Alaska Native | 2 | 0.9 |
| Biracial/Multiracial | 8 | 3.6 |
| Other | 3 | 1.3 |
| Sexual Orientation | | |
| Bisexual | 17 | 7.6 |
| Pansexual | 5 | 2.2 |
| Straight | 179 | 80.3 |
| Gay/Lesbian | 15 | 6.3 |
| Other | 5 | 2.2 |
| Missing | 3 | 1.3 |
| Degree Program | | |
| Clinical Psychology | 17 | 7.6 |
| Counseling Psychology | 99 | 44.4 |
| Clinical Mental Health Counseling | 84 | 37.7 |
| Other | 22 | 9.9 |
| Missing | 1 | 0.4 |
| Degree Seeking | | |
| Ph.D. | 84 | 37.8 |
| Psy.D. | 22 | 9.9 |
| Masters | 116 | 52.3 |
| Missing | 1 | 0.4 |
| Completed Semesters in Program | | |
| 0 | 1 | 0.4 |
| 1 | 19 | 8.5 |
| 2 | 13 | 5.8 |
| 3 | 33 | 14.8 |
| 4 | 43 | 19.2 |
| 5 | 23 | 10.3 |
| 6 | 18 | 8.1 |
| 7 | 26 | 11.7 |
| 8 | 17 | 7.6 |
| 9 | 14 | 6.3 |
| 10 | 5 | 2.2 |
| 11 | 3 | 1.3 |
| 12 | 4 | 1.8 |
| 13 | 1 | 0.4 |
| 14 | 1 | 0.4 |
| 15 | 1 | 0.4 |
| Prior Clinical or Counseling Graduate Program | | |
| No | 161 | 72.2 |
| Yes | 62 | 27.8 |
| Clinical Setting | | |

| | | |
|---|---|---|
| Private Practice | 13 | 5.8 |
| Hospital/Medical Center | 30 | 13.5 |
| University Counseling Center | 77 | 34.5 |
| Community Mental Health Agency | 63 | 28.3 |
| Other | 40 | 17.9 |
| Supervisor Status | | |
| Student Peer | 1 | 0.4 |
| Doctoral Student | 13 | 5.8 |
| Pre-Doctoral Intern | 8 | 3.6 |
| Post-Doc | 8 | 3.6 |
| Licensed Professional | 187 | 83.9 |
| Other | 6 | 2.7 |
| Supervisor's Gender | | |
| Male | 65 | 39.1 |
| Female | 156 | 70.0 |
| Other | 2 | 0.9 |
| Supervisor's Race/Ethnicity | | |
| African American/Black | 19 | 8.5 |
| Asian/Asian American | 10 | 4.5 |
| Caucasian/White | 168 | 75.3 |
| Latino/a/Hispanic | 14 | 6.3 |
| Biracial/Multiracial | 3 | 1.3 |
| Other | 3 | 1.3 |
| Missing | 6 | 2.6 |
| Supervisor's Sexual Orientation | | |
| Straight | 149 | 66.8 |
| Gay/Lesbian | 12 | 5.4 |
| Don't know | 62 | 27.8 |

## Measures

**Working Alliance Inventory/Supervision-Short (WAI-SS; trainee version).** The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) and the Working Alliance Inventory-Short (WAI-Short; Tracey & Kotovic, 1989) are widely used measures of the therapeutic working alliance. The WAI/S-Short (Ladany et al., 2013) is a modified version for supervision of the WAI-Short. The Working Alliance Inventory/Supervision-Short (WAI/S-Short; Ladany et al., 2013) is a 12-item self-report questionnaire used to assess supervisees' perceptions of the supervisory working alliance.

Participants respond to items on a seven-point Likert scale ranging from 1 (never) to 7 (always). In terms of validity, the WAI-SS was found to be positively related to effective supervisor behaviors, such as strengthening the supervisory relationship, promoting open discussion, and demonstrating positive personal and professional characteristics (Ladany et al., 2013). In terms of reliability, previous internal consistency estimates of the WAI/S-Short exceeded .80 (Ladany et al., 2013) and .96 (Mehr et al., 2010). The internal consistency estimate of the WAI/S-Short for this current study was .83. The WAI-Supervision-Short Form is adapted from the WAI-Short Form (Tracey & Kokotovic, 1989) and this measure has a bi-level factor structure. Four scores were calculated: one for the *general alliance* factor and three for the specific factors of *task*, *bond*, and *goal*. The process of ipsatizing scores was necessary to accurately calculate the four scores, given the bi-level factor structure of the measure. First, the *general alliance* score was created by taking the average of all items of the WAI-SS. Next, the variance of the *general alliance* score was removed to create the specific factor scores by subtracting each participant's total mean from each item response and then these scores were averaged to generate accurate subscale scores (Reise, 2012).

**Supervisee Disclosure Scale (SDS).** The measures of supervision nondisclosure that have been developed and used in literature, to date, do not adequately meet the needs for this study and therefore a discussion of survey selection will follow. The Self-Disclosure Inventory (Mehr et al., 2015) is the only measure that has been used to assess the supervisee's self-reported perception of his or her disclosure or nondisclosure in supervision; however, this survey does not assess the specific content areas of supervisee non-disclosure. All other quantitative measures in the literature assess supervisee

nondisclosure through self-reported perception of the supervisee's willingness or tendency to engage in non-disclosure, such as the Trainee Disclosure Scale (TDS; Walker, Ladany, & Pate-Carolan, 2007). In the current study, the TDS was modified to include the seven content areas of non-disclosure that were found by Mehr and colleagues (2010) because these content areas represent additional topics of disclosure for supervisees and need to be included in the creation of a measure of supervisee disclosure. The SDS is a 78-item self-report questionnaire that was developed based on the findings in the Ladany et al. (1996) and Mehr et al. (2010) studies regarding content of supervisee non-disclosure. Additionally, five counseling psychology doctoral students were queried regarding instances of nondisclosure in their experiences of clinical supervision to aid in item generation and creation. The measure assesses supervisees' propensity for disclosure in supervision. Participants responded to items on a five-point Likert scale ranging from 1 (not at all likely) to 5 (very likely). The internal consistency estimate of the 78-item SDS for this current study was .97. Reliability information will be presented in Chapter 4 regarding item deletion and final selection for the SDS. Factor-based scales were created in SPSS for each of the eight factors of the SDS. Factor-based scales were a composite measure of scores of all items of each factor (Pett, Lackey, Sullivan, 2003). A participant's score on a specific factor scale was calculated by adding up the participant's responses to all the items of that particular factor.

**Procedure**

Data was collected during the summer and fall semesters of 2016 and spring semester of 2017. A cover letter explained that participation was completely voluntary, affirmed the anonymity of responses, and outlined any potential risks from participation.

After the participant granted informed consent, participants were prompted to complete the questionnaire as it related to their most recent supervision session with their current supervisor. All questionnaires were completed electronically.

**Data Analysis**

Given the creation of items for the SDS, an exploratory factor analysis using principal axis with oblique rotation (oblimin) was performed to determine the specific loadings and factor structure of the content areas of nondisclosure. Statistical Package for the Social Science (SPSS), a computer-based software program, was utilized for the exploratory factor analysis, parallel analyses, MAP test, and maximum likelihood tests.

Confirmatory factor analysis of the Working Alliance Inventory-Supervision-short (WAI-SS) measure was conducted using Mplus software version 7.4 (Muthén & Muthén, 1998-2015). Analyses were conducted using mean-and variance-adjusted weighted least squares (WLSMV) estimation due to the ordered nature of the data (i.e., categorical Likert responses). Originally, 221 students enrolled in the survey; however, two participants did not complete any of the 12 items of the WAI-SS and one participant did not complete one of the 12 items. Prior to CFA, descriptive statistics including correlations, means, and standard deviations for the 12 items were examined. Model fit was assessed using goodness of fit indices provided by the WLSMV estimator: Satorra Bentler scaled chi-square (SB $\chi^2$), root mean square error of approximation (RMSEA) 90% confidence interval, weighted root mean square residual (SRMR), Tucker-Lewis index (TLI), and the comparative fit index (CFI) were implemented to evaluate comparative fit between the models. Model misspecification was detected by a statistically significant p value less than .05 on the SB $\chi^2$ test, RMSEA values greater than

.06, WRMR values greater than .90, and CFI and TLI values lower than .95, in line with Muthén & Muthén (1998–2015) and Hu & Bentler's (1999) suggestions. The change in SB $\chi^2$ was used to compare the fit of nested models. If the decline in fit was statistically significant, the less restrictive model was retained (Kline, 2005). The SB $\chi^2$ comparison tests were calculated by the Mplus DIFFTEST program with WLSMV (Muthén & Muthén, 1998–2015).

# CHAPTER 4

# RESULTS

This study was conducted to gain an empirical understanding of supervisee nondisclosure in clinical supervision. There were four aims of this study; (1) create a psychometrically sound measure of types of supervisee disclosure (SDS) through exploratory factor analysis, (2) evaluate the relationship between supervisees' clinical experience and the specific content areas of supervisee disclosure, (3) evaluate the factor structure of the Working Alliance Inventory-Supervision Short (WAI-SS) through confirmatory factor analysis, as this has not been conducted since it was revised from the Working Alliance Inventory-Short Form to be applicable to clinical supervision, and (4) evaluate the relationship between the factors of the WAI-SS and the preliminary content areas of supervisee disclosure. This chapter will explore the statistical analyses and procedures that were conducted to test the proposed hypotheses. Results from the statistical analyses are displayed within this chapter.

## Exploratory Factor Analysis of Supervisee Disclosure Scale

The item means, standard deviations, and inter-item correlation were evaluated. On a 5-point scale, where 1 = not at all likely to bring up issues of _____ with your supervisor and 5 = very likely to bring up issues of _____ with your supervisor, the means ranged from 1.61 (Item 58: Your negative thoughts or feelings about your supervisor's external image (e.g., dress/fashion habits, visible anxiety/stress) to 4.5 (Item 14: Instances when you feel at a loss regarding treatment for your client(s)). No inter-item correlation exceeded $r = .80$. Barlett's test of sphericity and the Kaiser-Meyer-Olkin (KMO) measures of sampling adequacy were used to evaluate the strength of the linear

association among the 78 items in the correlation matrix. Barlett's test of sphericity was significant ($\chi^2$ = 11287.802, $p$ <.000); thus, the correlation matrix is not an identity matrix. The KMO statistic, an index that compares the magnitude of observed correlations with the magnitude of the partial correlation coefficients was .92 and suggestive that factor analysis is appropriate and could be expected to yield some common factors. Given the correlated nature of the constructs of supervisee disclosure, an oblique rotation (Oblimin) was used for all following analyses.

Exploratory factor analysis provided information on the number of latent factors underlying items within the Supervisee Disclosure Scale (SDS). Initially, an exploratory factor analysis (EFA) with principal axis factoring (PAF) with an oblimin oblique rotation was conducted to extract a scree plot and eigenvalues greater than one (Kaiser criterion) to assess dimensions of supervisee disclosure. The scree plot indicated three factors while the eigenvalues greater than one indicated 14 factors. The first factor accounted for 33.52% of the total shared variance among measures, the second factor accounted for an additional 8.21% of the total shared variance among measures, while the third factor accounted for an additional 3.87% of the total shared variance among measures. The amount of common variance among measures of each additional factor was 2.71%, 2.32%, 2.14%, 1,66%, 1.48%, 1.19%, 1.08%, 1.02%, .97%, .87%, and .82% respectively. The cumulative percentage total shared variance among measures for the first three factors was 45.59% and the first fourteen factors was 61.85%. The scree plot and Kaiser criterion are commonly used methods to aid in factor determination; however, there are additional empirical methods that assist in better specifying the number of factors.

To aid in factor selection, the O'Connor's (2000) SPSS program was used to conduct parallel analysis, a simulated statistical technique. Based on a parallel analysis conducted using principal axis factoring (PAF), the mean and 95% eigenvalue criterion suggested extracting six factors. Alternatively, O'Connor's (2000) SPSS program was used to conduct the minimum average partial test (MAP) (Velicer, 1976) and both the original and revised versions of the MAP test suggested that eight factors underlie the items. Finally, maximum likelihood estimation was conducted to assess whether the number of specific factors accounted for the correlation among the measures. The aforementioned empirical aids were evaluated for interpretability of factors. After evaluating the interpretability of the proposed factor structures (i.e., how the items "hung" together for factors structures of 3, 6, 8, 14, and 18), the six and eight-factor structures were identified as having the most conceptual clarity and parsimony. Additionally, a seven-factor structure was evaluated due to theoretical findings of previous qualitative studies (Ladany et al., 1996; Mehr et al. 2010; Hess et al., 2008). An overview of the initial six-factor structure is provided in Table 4.1, an overview of the initial seven-factor structure is provided in Table 4.4, and an overview of the initial eight-factor structure is provided in Table 4.5.

Table 4.1

*Factor Loadings from the Rotated Initial Six-Factor Pattern Matrix for the SDS: Principal Axis Factoring with Oblimin Rotation*

| | Factors | | | | | |
|---|---|---|---|---|---|---|
| SDS Item | 1 | 2 | 3 | 4 | 5 | 6 |
| 75. Instances when you felt you made a clinical mistake in implementing specific intervention(s) with a client. | .86 | -.05 | .11 | -.10 | .06 | .01 |
| 49. Instances when you felt you made a clinical mistake in your conceptualization of your | .83 | -.01 | .09 | -.10 | -.03 | .02 |

| | | | | | | |
|---|---|---|---|---|---|---|
| client(s). | | | | | | |
| 66. Instances when you felt you made a clinical mistake regarding your diagnosis for your client(s). | .82 | .06 | -.06 | -.03 | .06 | .11 |
| 68. Instances when you have felt that your clinical decision making may not have been the most appropriate. | .81 | .05 | .07 | -.12 | -.05 | .08 |
| 44. Instances when you felt you made a clinical mistake in your treatment planning and implementation (e.g., sequencing of issues and interventions). | .79 | -.03 | .15 | -.12 | -.01 | -.02 |
| 39. Instances when you felt you made a clinical mistake in your psychological assessment administration. | .75 | -.02 | .05 | -.07 | -.05 | -.07 |
| 36. Instances when you are having a difficult time feeling empathetic toward your client(s). | .71 | -.06 | -.05 | -.10 | .12 | .06 |
| 14. Instances when you feel at a loss regarding treatment for your client(s). | .70 | -.23 | -.05 | -.06 | .05 | -.15 |
| 30. Instances when you expressed resentment toward or about your client(s). | .68 | .14 | -.10 | -.07 | .07 | .04 |
| 59. Instances when your feelings, in response to the dynamics occurring in the counseling relationship, are interfering with your clinical work with your client(s) (e.g., hostility, love, protectiveness, guilt, envy, apathy, etc.). | .68 | -.02 | -.02 | -.06 | .19 | .01 |
| 4. Instances when your thoughts, in response to the dynamics occurring in the counseling relationship, are interfering with your clinical work with your client(s) (e.g., reflecting on areas not central to a client's concern, your own opinion on topics, etc.). | .67 | -.05 | .06 | .17 | .16 | -.13 |
| 69. Instances when you lose neutrality and side with your client(s). | .66 | .01 | .01 | -.22 | .10 | .04 |
| 6. Instances when your behaviors, in response to the dynamics occurring in the counseling relationship, are interfering with your clinical work with your client(s) (e.g., acting in a submissive manner, significant discrepancies between case note and what actually occurred, avoiding eye contact in session, making more suggestions to a client than usual, etc.). | .64 | -.08 | .07 | .08 | .07 | -.27 |
| 29. Instances when you engaged in too much self-disclosure with your client(s). | .64 | .09 | -.08 | -.11 | .01 | -.04 |
| 28. Instances when you treat your client(s) in a disciplinary manner during session(s). | .64 | .19 | -.11 | -.02 | -.03 | .04 |

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|---|---|---|---|---|---|---|
| 2. Instances when you felt you made a clinical mistake in your interpersonal assessment of a client within or across sessions. | .61 | -.01 | .07 | -.05 | -.04 | -.15 |
| 71. Instances when you feel your personal issues are interfering with your clinical work with your client(s). | .60 | .08 | -.04 | -.03 | .21 | -.01 |
| 9. Issues regarding client-counselor attraction (e.g., bringing up perceived or vocalized client attraction toward you). | .60 | .12 | -.05 | .01 | -.02 | -.16 |
| 77. Instances when you are frustrated by your client(s) (e.g., perceived lack of progress or motivation). | .55 | -.06 | -.20 | -.31 | .06 | .10 |
| 13. Instances when you are irritated by behaviors, physical appearance, beliefs, or interpersonal characteristics of your client(s). | .45 | -.18 | -.18 | -.14 | .21 | -.23 |
| 50. Issues regarding counselor-client attraction [e.g., bringing up attraction that you feel toward your client(s)]. | .45 | .29 | -.15 | .02 | .12 | -.07 |
| 74. Instances when your conceptualization of your client(s) differs from your supervisor's conceptualization. | .42 | .04 | -.14 | -.41 | .01 | -.03 |
| 56. Negative thoughts, feelings, or descriptions of the professional characteristics of your supervisor. | -.13 | .62 | -.12 | -.09 | .03 | -.30 |
| 60. Your thoughts or feelings about perceived or vocalized supervisor attraction toward you. | .22 | .62 | -.07 | .10 | -.09 | -.12 |
| 63. Instances when you acted flirtatious with your client(s). | .54 | .59 | -.14 | .06 | -.14 | .05 |
| 40. Your idolization of your supervisor. | .00 | .57 | .57 | .29 | .00 | .17 |
| 64. Your concerns about your supervisor's competence to accurately evaluate you. | .01 | .56 | -.22 | -.17 | -.03 | -.17 |
| 41. Your thoughts or feelings about feeling drawn to or interested in your supervisor in a sexual or physical sense. | .11 | .55 | -.01 | .12 | .05 | -.11 |
| 58. Your negative thoughts or feelings about your supervisor's external image (e.g., dress/fashion habits, visible anxiety/stress). | -.17 | .55 | -.15 | .02 | .11 | -.19 |
| 67. Instances when you daydream about relationships or events triggered by your client(s). | .30 | .53 | -.09 | -.14 | .08 | .12 |
| 18. Your attraction to your supervisor's brilliance. | -.23 | .51 | .25 | -.11 | .20 | -.06 |
| 55. Your concerns about your supervisor's evaluation of your personal characteristics versus your professional characteristics. | -.06 | .49 | .17 | -.17 | .06 | -.25 |

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|---|---|---|---|---|---|---|
| 54. Your positive thoughts or feelings about your supervisor's external image (e.g., dress/fashion habits, visible ability to handle stress, etc.). | -.01 | .44 | .17 | -.05 | .11 | .20 |
| 73. Your personal opinions about the positive characteristics of your supervisor. | -.06 | .42 | .19 | -.20 | .32 | .19 |
| 23. Negative thoughts, feelings, or descriptions of the personal characteristics of your supervisor. | -.26 | .42 | -.18 | .02 | .22 | -.39 |
| 61. Your supervisor's microaggressions toward clients. | .32 | .40 | -.08 | -.05 | -.12 | -.24 |
| 7. Your appreciation for all that your supervisor has done for you. | .11 | .09 | .51 | -.28 | .11 | -.16 |
| 35. Your respect for your supervisor. | -.04 | .14 | .46 | -.32 | .26 | -.14 |
| 53. Instances when you received positive feedback from your client(s). | -.06 | .08 | .01 | -.81 | -.10 | .04 |
| 42. Instances you felt proud of the clinical work you have done with your client(s). | -.01 | -.12 | .05 | -.81 | -.50 | -.07 |
| 62. Instances when you implemented a specific intervention well. | .15 | -.07 | .04 | -.75 | -.23 | -.05 |
| 43. Your feelings of pride for your client(s). | .09 | -.12 | .08 | -.50 | .14 | -.02 |
| 78. Instances when your theoretical orientation differs from your supervisor's. | .25 | .10 | -.23 | -.45 | .11 | .02 |
| 46. Your general positive thoughts, feelings, or characterizations about your client(s) as a person. | .11 | .04 | .06 | -.42 | .12 | .08 |
| 31. Thoughts about your experiences or problems in the context of your life (e.g., issues related to personal or family crisis, when things in your life were overwhelming). | .16 | .04 | .11 | .03 | .70 | .19 |
| 20. Thoughts about yourself in the context of your life (e.g., your sexual orientation, your own beliefs not directly related to therapy). | -.08 | .10 | -.03 | .04 | .65 | -.06 |
| 26. Trouble I'm facing at school with my coursework, research, or other academic/professional area. | .17 | -.05 | .12 | -.02 | .54 | .03 |
| 5. Issues related to your own mental well-being (e.g., feeling anxious or depressed). | .24 | -.06 | .12 | .09 | .47 | -.16 |
| 33. Jealousy of a colleague at the setting (e.g., colleague has a full caseload, a better office, a different supervisor, etc.). | -.09 | .09 | -.07 | -.01 | .46 | -.24 |
| 48. Feeling relieved when workload lessened (e.g., a client not continuing, a group ending, the | .24 | .06 | -.09 | -.21 | .42 | .04 |

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|---|---|---|---|---|---|---|
| semester ending, etc.). | | | | | | |
| 15. Feeling that your supervisor is distracted and/or not listening carefully to you. | -.00 | .17 | -.06 | -.07 | -.02 | -.67 |
| 3. Your concerns that your supervisor does not think you're a good clinician. | .25 | .07 | .14 | .02 | -.13 | -.63 |
| 11.Your concerns about your supervisor's perception of you as a person. | .07 | .12 | .18 | -.05 | .15 | -.58 |
| 24. Your concerns that your supervisor does not like you. | -.04 | .32 | -.08 | -.01 | .19 | -.52 |
| 16. Feeling frustrated with the perceived importance set on quantity of contact hours instead of quality, at your site. | .16 | -.08 | -.14 | -.19 | .16 | -.47 |
| 22. Your own negative opinions about how supervision is structured (e.g., too rigid, too relaxed, lack of structure). | -.70 | .18 | -.35 | -.16 | .17 | -.44 |
| 10. Your feedback about the supervisory alliance. | .22 | .07 | .38 | -.07 | .13 | -.41 |

After reviewing the initial six-factor solution, items with weak loadings (< |.40|) on any factor were identified and excluded (items 1, 8, 12, 17, 19, 27, 32, 34, 37, 38, 47, 51, 52, 57, 65, 70, 72, and 76) from the final exploratory factor analysis (EFA) with principal axis factoring (PAF) with an oblimin oblique rotation for six factors. See Table 4.2 for an overview of the final six-factor structure.

Table 4.2

*Factor Loadings from the Rotated Final Six-Factor Pattern Matrix for the SDS: Principal Axis Factoring with Oblimin Rotation*

| | Factor | | | | | |
|---|---|---|---|---|---|---|
| SDS Items | 1 | 2 | 3 | 4 | 5 | 6 |
| 75.Instances when you felt you made a clinical mistake in implementing specific intervention(s) with a client. | .87 | -.11 | .09 | .00 | -.05 | .02 |
| 49.Instances when you felt you made a clinical mistake in your conceptualization of your client(s). | .84 | -.06 | .09 | -.08 | .00 | -.05 |
| 66.Instances when you felt you made a clinical mistake regarding your diagnosis for your client(s). | .82 | .04 | -.03 | -.03 | .08 | .03 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 44.Instances when you felt you made a clinical mistake in your treatment planning and implementation (e.g., sequencing of issues and interventions). | .80 | -.10 | .13 | -.10 | -.07 | -.03 |
| 68.Instances when you have felt that your clinical decision making may not have been the most appropriate. | .80 | -.03 | .07 | -.10 | .07 | -.01 |
| 39.Instances when you felt you made a clinical mistake in your psychological assessment administration. | .75 | -.04 | .04 | -.07 | -.07 | -.05 |
| 36.Instances when you are having a difficult time feeling empathetic toward your client(s). | .72 | -.07 | -.05 | -.11 | .04 | .10 |
| 59.Instances when your feelings, in response to the dynamics occurring in the counseling relationship, are interfering with your clinical work with your client(s) (e.g., hostility, love, protectiveness, guilt, envy, apathy, etc.). | .70 | -.03 | -.01 | -.03 | .01 | .20 |
| 14.Instances when you feel at a loss regarding treatment for your client(s). | .69 | -.14 | -.17 | -.09 | -.15 | .06 |
| 30.Instances when you expressed resentment toward or about your client(s). | .69 | .14 | -.04 | -.09 | .09 | .09 |
| 69.Instances when you lose neutrality and side with your client(s). | .67 | -.01 | .03 | -.20 | .02 | .08 |
| 4.Instances when your thoughts, in response to the dynamics occurring in the counseling relationship, are interfering with your clinical work with your client(s) (e.g., reflecting on areas not central to a client's concern, your own opinions on topics, et | .66 | -.06 | .01 | .16 | -.16 | .19 |
| 29.Instances when you engaged in too much self-disclosure with your client(s). | .65 | .12 | -.05 | -.11 | -.01 | .00 |
| 28.Instances when you treat your client(s) in a disciplinary manner during session(s). | .64 | .20 | -.04 | -.02 | .08 | -.02 |
| 6.Instances when your behaviors, in response to the dynamics occurring in the counseling relationship, are interfering with your clinical work with your client(s) (e.g., acting in a submissive manner, significant discrepancies between case notes and what | .63 | -.03 | .00 | .03 | -.28 | .07 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 71.Instances when you feel your personal issues are interfering with your clinical work with your client(s). | .63 | .08 | .02 | -.01 | .00 | .22 |
| 9.Issues regarding client-counselor attraction (e.g., bringing up perceived or vocalized client attraction toward you). | .62 | .18 | -.02 | -.01 | -.15 | -.06 |
| 2.Instances when you felt you made a clinical mistake in your interpersonal assessment of a client. | .60 | .00 | .01 | -.06 | -.17 | -.03 |
| 77.Instances when you are frustrated by your client(s) (e.g., perceived lack of progress or motivation). | .57 | .03 | -.21 | -.31 | .14 | .08 |
| 50.Issues regarding counselor-client attraction [e.g., bringing up attraction that you feel toward your client(s)]. | .49 | .35 | -.03 | .03 | -.02 | .08 |
| 13.Instances when you are irritated by behaviors, physical appearance, beliefs, or interpersonal characteristics of your client(s). | .47 | .00 | -.26 | -.16 | -.19 | .22 |
| 74.Instances when your conceptualization of your client(s) differs from your supervisor's conceptualization. | .43 | .12 | -.11 | -.40 | .06 | .05 |
| 56.Negative thoughts, feelings, or descriptions of the professional characteristics of your supervisor. | -.08 | .72 | .10 | -.07 | -.13 | .04 |
| 64.Your concerns about your supervisor's competence to accurately evaluate you. | .03 | .69 | -.02 | -.16 | -.01 | -.01 |
| 58.Your negative thoughts or feelings about your supervisor's external image (e.g., dress/fashion habits, visible anxiety/stress). | -.14 | .64 | .03 | .04 | -.05 | .14 |
| 60.Your thoughts or feelings about perceived or vocalized supervisor attraction toward you. | .21 | .63 | .09 | .08 | -.02 | -.06 |
| 23.Negative thoughts, feelings, or descriptions of the personal characteristics of your supervisor. | -.22 | .61 | -.07 | .01 | -.24 | .23 |
| 63.Instances when you acted flirtatious with your client(s). | .56 | .59 | .05 | .07 | .12 | -.15 |
| 41.Your thoughts or feelings about feeling drawn to or interested in your supervisor in a sexual or physical sense. | .12 | .54 | .14 | .13 | -.05 | .05 |
| 24.Your concerns that your supervisor does not like you. | .00 | .52 | -.03 | -.02 | -.40 | .18 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 22.Your own negative opinions about how supervision is structured (e.g., too rigid, too relaxed, lack of structure). | -.04 | .50 | -.31 | -.18 | -.28 | .18 |
| 67.Instances when you daydream about relationships or events triggered by your client(s). | .32 | .49 | .11 | -.11 | .18 | .08 |
| 61.Your supervisor's microaggressions toward clients. | .31 | .48 | -.01 | -.06 | -.16 | -.09 |
| 25.Boredom with the clinical work you are doing at the setting. | .11 | .44 | -.24 | -.24 | -.11 | .19 |
| 55.Your concerns about your supervisor's evaluation of your personal characteristics versus your professional characteristics. | -.04 | .44 | .31 | -.17 | -.16 | .06 |
| 45.Your concerns about the fairness of your supervisor's evaluation of you. | .06 | .38 | .19 | -.25 | -.29 | .03 |
| 35.Your respect for your supervisor. | .00 | -.03 | .52 | -.30 | -.16 | .19 |
| 7.Your appreciation for all that your supervisor has done for you. | .13 | -.08 | .49 | -.26 | -.20 | .04 |
| 40.Your idolization of your supervisor. | .01 | .40 | .43 | .00 | -.07 | .17 |
| 18.Your attraction to your supervisor's brilliance. | -.21 | .38 | .41 | -.10 | -.06 | .14 |
| 73.Your personal opinions about the positive characteristics of your supervisor. | -.03 | .26 | .37 | -.17 | .21 | .28 |
| 54.Your positive thoughts or feelings about your supervisor's external image (e.g., dress/fashion habits, visible ability to handle stress, etc.). | -.01 | .26 | .36 | -.01 | .20 | .15 |
| 21.Dissatisfaction with the lack of variety of presenting problems on your caseload. | .18 | .23 | -.34 | -.21 | .00 | .28 |
| 42.Instances you felt proud of the clinical work you have done with your client(s). | -.03 | -.10 | .04 | -.81 | -.08 | -.02 |
| 53.Instances when you received positive feedback from your client(s). | -.05 | .08 | .09 | -.76 | .05 | -.08 |
| 62.Instances when you implemented a specific intervention well. | .14 | -.04 | .01 | -.73 | -.04 | -.19 |
| 43.Your feelings of pride for your client(s). | .07 | -.15 | .05 | -.54 | -.06 | .14 |
| 46.Your general positive thoughts, feelings, or characterizations about your client(s) as a person. | .14 | -.02 | .05 | -.45 | .08 | .18 |
| 78.Instances when your theoretical orientation differs from your supervisor's. | .28 | .21 | -.14 | -.41 | .11 | .13 |
| 3.Your concerns that your supervisor does not think you're a good clinician. | .25 | .19 | .10 | -.01 | -.54 | -.14 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 11.Your concerns about your supervisor's perception of you as a person. | .09 | .20 | .15 | -.07 | -.52 | .15 |
| 15.Feeling that your supervisor is distracted and/or not listening carefully to you. | .03 | .40 | -.07 | -.05 | -.51 | .03 |
| 10.Your feedback about the supervisory alliance. | .21 | -.01 | .34 | -.08 | -.44 | .13 |
| 16.Feeling frustrated with the perceived importance set on quantity of contact hours instead of quality at your site. | .18 | .16 | -.17 | -.23 | -.36 | .15 |
| 31.Thoughts about your experiences or problems in the context of your life (e.g., issues related to personal or family crisis, when things in your life were overwhelming). | .18 | -.08 | .16 | .03 | .16 | .72 |
| 20.Thoughts about yourself in the context of your life (e.g., your sexual orientation, your own beliefs and value not directly related to therapy). | -.07 | .11 | -.02 | .02 | -.02 | .71 |
| 26.Trouble I'm facing at school with my coursework, research, or other academic/professional area. | .19 | -.13 | .12 | -.03 | -.01 | .53 |
| 33.Jealousy of a colleague at the setting (e.g., colleague has a full caseload, a better office, a different supervisor, etc.). | -.08 | .18 | -.05 | -.06 | -.18 | .47 |
| 5.Issues related to your own mental well-being (e.g., feeling anxious, depressed, etc.). | .28 | -.05 | .11 | .09 | -.19 | .42 |
| 48.Feeling relieved when workload lessened (e.g., a client not continuing, a group ending, the semester ending, etc.). | .28 | .08 | .03 | -.21 | .05 | .34 |

In the six-factor solution, the content areas of disclosure could be identified as follows: (1) counseling process and implementation concerns, (2) supervisor issues, (3) affective reflections of supervision, (4) clinical confidence, (5) self, and (6) supervisory relationship. Factor 3 is comprised of only two items and the difference between factors two and three is difficult to determine and warranted a decision to examine the eight-factor solution for an increase in factor interpretability. The total variance explained by the six factors is displayed in Table 4.3.

Table 4.3

*Total Variance Explained by the Six Extracted Factors of the SDS*

| | Initial Eigenvalues | | | Extraction Sums of Squared Loadings | | | Rotation Sums of Squared Loadings |
|---|---|---|---|---|---|---|---|
| Factor | Total | % of Variance | Cumulative % | Total | % of Variance | Cumulative % | Total |
| 1 | 20.36 | 33.93 | 33.93 | 19.93 | 33.21 | 33.21 | 16.35 |
| 2 | 6.22 | 10.36 | 44.29 | 5.79 | 9.64 | 42.86 | 9.58 |
| 3 | 2.86 | 4.77 | 49.05 | 2.37 | 3.96 | 46.81 | 2.81 |
| 4 | 2.22 | 3.70 | 52.76 | 1.77 | 2.95 | 49.76 | 9.62 |
| 5 | 1.91 | 3.19 | 55.94 | 1.43 | 2.39 | 52.15 | 5.28 |
| 6 | 1.86 | 3.10 | 59.04 | 1.38 | 2.30 | 54.44 | 7.98 |

Note: Items 1, 8, 12, 17, 19, 27, 32, 34, 37, 38, 47, 51, 52, 57, 65, 70, 72, and 76 are not included in this solution due to weak loadings in the initial EFA with PAF and oblique (direct oblimin) rotation.

Table 4.4

*Factor Loadings from the Rotated Initial Seven-Factor Pattern Matrix for the SDS: Principal Axis Factoring with Oblimin Rotation*

| | Factor | | | | | | |
|---|---|---|---|---|---|---|---|
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | 7.00 |
| 75.Instances when you felt you made a clinical mistake in implementing specific intervention(s) with a client. | .84 | -.07 | .06 | -.02 | .09 | -.04 | -.07 |
| 49.Instances when you felt you made a clinical mistake in your conceptualization of your client(s). | .82 | -.02 | .04 | -.10 | .01 | -.02 | -.07 |
| 66.Instances when you felt you made a clinical mistake regarding your diagnosis for your client(s). | .81 | -.01 | -.06 | -.03 | .08 | .08 | .04 |
| 68.Instances when you have felt that your clinical decision making may not have been the most appropriate. | .80 | .09 | -.04 | -.11 | .04 | .03 | -.19 |

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|---|---|---|---|---|---|---|---|
| 44.Instances when you felt you made a clinical mistake in your treatment planning and implementation (e.g., sequencing of issues and interventions). | .78 | -.08 | .13 | -.13 | .01 | -.05 | -.04 |
| 39.Instances when you felt you made a clinical mistake in your psychological assessment administration. | .74 | .06 | -.01 | -.07 | .00 | -.08 | -.08 |
| 36.Instances when you are having a difficult time feeling empathetic toward your client(s). | .70 | -.08 | -.06 | -.10 | .13 | .00 | .04 |
| 14.Instances when you feel at a loss regarding treatment for your client(s). | .68 | -.19 | -.01 | -.07 | .02 | -.19 | .16 |
| 30.Instances when you expressed resentment toward or about your client(s). | .67 | .06 | -.05 | -.06 | .07 | .08 | .12 |
| 59.Instances when your feelings, in response to the dynamics occurring in the counseling relationship, are interfering with your clinical work with your client(s) (e.g., hostility, love, protectiveness, guilt, envy, apathy, etc.). | .66 | .03 | -.06 | -.05 | .23 | -.03 | -.02 |
| 4.Instances when your thoughts, in response to the dynamics occurring in the counseling relationship, are interfering with your clinical work with your client(s) (e.g., reflecting on areas not central to a client's concern, your own opinions on topics, et | .65 | .01 | .03 | .16 | .18 | -.14 | -.02 |
| 69.Instances when you lose neutrality and side with your client(s). | .64 | .02 | -.03 | -.21 | .14 | .02 | -.02 |
| 28.Instances when you treat your client(s) in a disciplinary manner during session(s). | .63 | .09 | -.03 | -.02 | -.04 | .10 | .14 |
| 29.Instances when you engaged in too much self-disclosure with your client(s). | .63 | .05 | -.02 | -.10 | -.01 | .00 | .14 |
| 6.Instances when your behaviors, in response to the dynamics occurring in the counseling relationship, are interfering with your clinical work with your client(s) (e.g., acting in a submissive manner, significant discrepancies between case notes and what | .62 | -.03 | .13 | .06 | .04 | -.22 | .12 |
| 9.Issues regarding client-counselor attraction (e.g., bringing up perceived or vocalized client attraction toward you). | .60 | -.01 | .14 | .00 | -.11 | -.05 | .30 |

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|---|---|---|---|---|---|---|---|
| 2.Instances when you felt you made a clinical mistake in your interpersonal assessment of a client. | .60 | -.04 | .13 | -.06 | -.06 | -.11 | .09 |
| 71.Instances when you feel your personal issues are interfering with your clinical work with your client(s). | .59 | .16 | -.09 | -.01 | .27 | .00 | -.05 |
| 63.Instances when you acted flirtatious with your client(s). | .57 | .33 | .09 | .07 | -.20 | .28 | .27 |
| 77.Instances when you are frustrated by your client(s) (e.g., perceived lack of progress or motivation). | .54 | -.01 | -.23 | -.29 | .08 | .04 | .08 |
| 50.Issues regarding counselor-client attraction [e.g., bringing up attraction that you feel toward your client(s)]. | .45 | .15 | .05 | .03 | .04 | .08 | .31 |
| 13.Instances when you are irritated by behaviors, physical appearance, beliefs, or interpersonal characteristics of your client(s). | .43 | -.07 | -.10 | -.13 | .15 | -.21 | .27 |
| 74.Instances when your conceptualization of your client(s) differs from your supervisor's conceptualization. | .41 | .27 | -.23 | -.37 | .09 | -.03 | -.08 |
| 65.General doubt you may have about wanting to be a therapist. | .36 | .10 | .17 | -.09 | .06 | .08 | .24 |
| 37.Feeling pressure to do extra shifts, hours, reports, or outreach events at your practicum site | .25 | .15 | .00 | -.06 | .18 | -.08 | .13 |
| 56.Negative thoughts, feelings, or descriptions of the professional characteristics of your supervisor. | -.11 | .76 | .03 | -.02 | .03 | .04 | .14 |
| 64.Your concerns about your supervisor's competence to accurately evaluate you. | .02 | .65 | -.08 | -.10 | -.02 | .12 | .18 |
| 45.Your concerns about the fairness of your supervisor's evaluation of you. | .05 | .62 | .13 | -.20 | .05 | -.17 | -.08 |
| 58.Your negative thoughts or feelings about your supervisor's external image (e.g., dress/fashion habits, visible anxiety/stress). | -.15 | .60 | .01 | .08 | .10 | .10 | .17 |
| 55.Your concerns about your supervisor's evaluation of your personal characteristics versus your professional characteristics. | -.04 | .60 | .22 | -.12 | .11 | .00 | -.08 |
| 47.Times when you felt misunderstood by your supervisor. | .14 | .55 | -.02 | -.26 | .00 | -.22 | -.11 |

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|---|---|---|---|---|---|---|---|
| 15.Feeling that your supervisor is distracted and/or not listening carefully to you. | -.01 | .54 | .06 | -.02 | -.03 | -.39 | .16 |
| 23.Negative thoughts, feelings, or descriptions of the personal characteristics of your supervisor. | -.25 | .53 | .04 | .07 | .15 | -.08 | .33 |
| 32.Your supervisor's microaggressions toward you. | .19 | .50 | .11 | -.03 | .06 | -.10 | .08 |
| 60.Your thoughts or feelings about perceived or vocalized supervisor attraction toward you. | .24 | .49 | .14 | .13 | -.13 | .17 | .20 |
| 38.Previous knowledge about the supervisor gained from previous supervisors/academic advisors/colleagues. | .04 | .47 | .13 | -.05 | .10 | -.01 | -.02 |
| 57.Your concerns about how your supervisor will evaluate you. | .11 | .44 | .05 | -.01 | .17 | -.11 | .10 |
| 76.Disagreement with your supervisor's clinical advice or intervention suggestions for your client(s). | .15 | .43 | -.27 | -.34 | .19 | -.16 | .01 |
| 61.Your supervisor's microaggressions toward clients. | .33 | .42 | .07 | -.01 | -.14 | .00 | .18 |
| 27.Disagreement with your supervisor's diagnosis of your client(s). | .35 | .42 | -.24 | -.05 | .22 | -.18 | .01 |
| 24.Your concerns that your supervisor does not like you. | -.04 | .41 | .19 | .03 | .08 | -.20 | .40 |
| 41.Your thoughts or feelings about feeling drawn to or interested in your supervisor in a sexual or physical sense. | .13 | .35 | .24 | .14 | -.02 | .16 | .26 |
| 67.Instances when you daydream about relationships or events triggered by your client(s). | .31 | .35 | .05 | -.10 | .07 | .30 | .14 |
| 34.Your hesitation and/or concerns about what to share in supervision for fear of it reflecting poorly in your evaluation. | .13 | .35 | -.02 | .11 | .29 | -.08 | .18 |
| 7.Your appreciation for all that your supervisor has done for you. | .11 | -.01 | .55 | -.30 | .10 | -.09 | -.11 |
| 18.Your attraction to your supervisor's brilliance. | -.22 | .21 | .50 | -.11 | .11 | .19 | .20 |
| 35.Your respect for your supervisor. | -.04 | .08 | .49 | -.32 | .25 | -.05 | -.10 |
| 40.Your idolization of your supervisor. | .02 | .39 | .43 | .02 | .15 | .14 | .02 |
| 51.Your appreciation for feeling supported by your supervisor. | .15 | -.18 | .42 | -.38 | .21 | .02 | -.04 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 10.Your feedback about the supervisory alliance. | .21 | .17 | .42 | -.07 | .13 | -.27 | -.05 |
| 53.Instances when you received positive feedback from your client(s). | -.06 | .06 | .06 | -.79 | -.12 | .08 | .09 |
| 42.Instances you felt proud of the clinical work you have done with your client(s). | -.02 | -.03 | .06 | -.79 | -.06 | -.08 | .05 |
| 62.Instances when you implemented a specific intervention well. | .15 | .02 | .02 | -.73 | -.22 | -.05 | .00 |
| 43.Your feelings of pride for your client(s). | .08 | -.12 | .10 | -.50 | .11 | -.05 | .07 |
| 46.Your general positive thoughts, feelings, or characterizations about your client(s) as a person. | .16 | -.03 | .08 | -.41 | .12 | .08 | .03 |
| 78.Instances when your theoretical orientation differs from your supervisor's. | .24 | .29 | -.29 | -.40 | .18 | .05 | .01 |
| 1.Your feelings of flattery that your client(s) enjoy(s) working with you. | -.09 | .10 | .10 | -.34 | .11 | .03 | .16 |
| 31.Thoughts about your experiences or problems in the context of your life (e.g., issues related to personal or family crisis, when things in your life were overwhelming). | .14 | -.06 | .08 | .05 | .72 | .13 | -.03 |
| 20.Thoughts about yourself in the context of your life (e.g., your sexual orientation, your own beliefs and value not directly related to therapy). | -.10 | .08 | .06 | .06 | .61 | .01 | .17 |
| 26.Trouble I'm facing at school with my coursework, research, or other academic/professional area. | .15 | -.04 | .08 | -.01 | .56 | -.02 | -.04 |
| 5.Issues related to your own mental well-being (e.g., feeling anxious, depressed, etc.). | .22 | -.01 | .14 | .09 | .45 | -.14 | .05 |
| 48.Feeling relieved when workload lessened (e.g., a client not continuing, a group ending, the semester ending, etc.). | .22 | .07 | -.06 | -.19 | .42 | .05 | .11 |
| 33.Jealousy of a colleague at the setting (e.g., colleague has a full caseload, a better office, a different supervisor, etc.). | -.10 | .18 | .05 | .01 | .41 | -.11 | .23 |
| 70.Your feelings of closeness with your client(s). | .19 | .03 | .07 | -.29 | .34 | .14 | .08 |
| 72.Feeling overwhelmed by the setting's procedures (e.g., paperwork). | .28 | .04 | -.13 | -.23 | .31 | .02 | .09 |
| 73.Your personal opinions about the positive characteristics of your supervisor. | -.05 | .17 | .28 | -.19 | .31 | .30 | .01 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3.Your concerns that your supervisor does not think you're a good clinician. | .24 | .34 | .22 | .04 | -.14 | -.41 | .08 |
| 11.Your concerns about your supervisor's perception of you as a person. | .06 | .35 | .29 | -.03 | .12 | -.36 | .09 |
| 12.When information received from your supervisor differs from another source (e.g., literature, another supervisor, a textbook, a colleague). | .27 | .29 | -.12 | -.20 | .10 | -.30 | .00 |
| 54.Your positive thoughts or feelings about your supervisor's external image (e.g., dress/fashion habits, visible ability to handle stress, etc.). | .01 | .26 | .19 | -.03 | .15 | .30 | -.12 |
| 25.Boredom with the clinical work you are doing at the setting. | .04 | .10 | -.04 | -.20 | .08 | -.02 | .66 |
| 21.Dissatisfaction with the lack of variety of presenting problems on your caseload. | .14 | -.11 | -.11 | -.16 | .16 | .04 | .58 |
| 17.Instances when you are uninterested in your clinical work. | .05 | .10 | -.10 | -.15 | .16 | -.22 | .52 |
| 22.Your own negative opinions about how supervision is structured (e.g., too rigid, too relaxed, lack of structure). | -.08 | .35 | -.10 | -.12 | .07 | -.18 | .49 |
| 19.Feeling confused about what supervision is. | .29 | .12 | .17 | -.01 | -.10 | -.06 | .44 |
| 8.General issues or discomfort with colleagues and other professionals at the setting. | .04 | .02 | .14 | -.09 | .26 | -.21 | .42 |
| 52.Instances when you are bored with your client(s). | .21 | .02 | -.16 | -.23 | .21 | .09 | .37 |
| 16.Feeling frustrated with the perceived importance set on quantity of contact hours instead of quality at your site. | .14 | .13 | .01 | -.16 | .08 | -.33 | .33 |

The seven-factor structure was evaluated because of previous qualitative findings (Walker et al., 2007; Mehr et al., 2010). In the seven-factor structure, 15 items had weak loadings < |.40|. Additionally, the sixth factor only had one item with a loading > |.40|. Furthermore, the item did not have a strong loading, -.41. Given this uninterpretable factor with one item, the seven-factor structure was not retained as the best fit for the SDS. Items were created for the SDS to adequately represent all seven content areas and

serve as descriptive empirical indicators of the latent constructs of disclosure (Pett, Lackey, & Sulilvan, 2003). As such, the poor fit of the seven-factor structure is not simply due to a weakness of accurate identification of domains of the latent variables (Pett, Lackey, & Sullivan, 2003).

Table 4.5

*Factor Loadings from the Rotated Initial Eight-Factor Pattern Matrix for the SDS: Principal Axis Factoring with Oblimin Rotation*

| | Factor | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 75.Instances when you felt you made a clinical mistake in implementing specific intervention(s) with a client. | .79 | -.08 | .18 | .04 | .04 | .01 | .00 | -.11 |
| 49.Instances when you felt you made a clinical mistake in your conceptualization of your client(s). | .77 | -.03 | .15 | -.05 | -.03 | .01 | -.02 | -.13 |
| 66.Instances when you felt you made a clinical mistake regarding your diagnosis for your client(s). | .75 | .07 | .00 | -.04 | .07 | .09 | .06 | -.10 |
| 68.Instances when you have felt that your clinical decision making may not have been the most appropriate. | .75 | .05 | .04 | -.11 | .03 | .01 | -.16 | -.19 |
| 44.Instances when you felt you made a clinical mistake in your treatment planning and implementation (e.g., sequencing of issues and interventions). | .73 | -.03 | .17 | -.12 | .00 | -.04 | -.01 | -.01 |
| 39.Instances when you felt you made a clinical mistake in your psychological assessment administration. | .68 | -.05 | .12 | -.01 | -.05 | -.06 | -.02 | -.19 |
| 36.Instances when you are having a difficult time feeling empathetic toward your client(s). | .65 | -.08 | .08 | -.05 | .07 | .09 | .11 | -.15 |
| 14.Instances when you feel at a loss regarding treatment for your client(s). | .64 | -.20 | .02 | -.08 | .02 | -.09 | .20 | .02 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 4.Instances when your thoughts, in response to the dynamics occurring in the counseling relationship, are interfering with your clinical work with your client(s) (e.g., reflecting on areas not central to a client's concern, your own opinions on topics, et | .63 | .04 | -.17 | -.02 | .33 | -.25 | -.11 | .12 |
| 30.Instances when you expressed resentment toward or about your client(s). | .62 | .15 | -.06 | -.11 | .10 | .03 | .10 | -.06 |
| 59.Instances when your feelings, in response to the dynamics occurring in the counseling relationship, are interfering with your clinical work with your client(s) (e.g., hostility, love, protectiveness, guilt, envy, apathy, etc.). | .61 | .01 | -.06 | -.11 | .26 | -.04 | -.02 | -.10 |
| 6.Instances when your behaviors, in response to the dynamics occurring in the counseling relationship, are interfering with your clinical work with your client(s) (e.g., acting in a submissive manner, significant discrepancies between case notes and what | .60 | -.03 | .00 | -.04 | .13 | -.28 | .09 | .13 |
| 69.Instances when you lose neutrality and side with your client(s). | .59 | .00 | .06 | -.19 | .11 | .03 | .01 | -.15 |
| 28.Instances when you treat your client(s) in a disciplinary manner during session(s). | .58 | .19 | -.03 | -.03 | -.02 | .05 | .13 | -.07 |
| 29.Instances when you engaged in too much self-disclosure with your client(s). | .58 | .07 | .04 | -.09 | -.03 | .00 | .16 | -.10 |
| 2.Instances when you felt you made a clinical mistake in your interpersonal assessment of a client. | .57 | .02 | .05 | -.13 | .00 | -.16 | .07 | .11 |
| 9.Issues regarding client-counselor attraction (e.g., bringing up perceived or vocalized client attraction toward you). | .56 | .13 | .05 | -.05 | -.06 | -.11 | .27 | .13 |
| 71.Instances when you feel your personal issues are interfering with your clinical work with your client(s). | .54 | .09 | -.07 | -.06 | .29 | -.05 | -.05 | -.18 |
| 77.Instances when you are frustrated by your client(s) (e.g., perceived lack of progress or motivation). | .49 | -.07 | -.06 | -.23 | .02 | .13 | .14 | -.25 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 50.Issues regarding counselor-client attraction [e.g., bringing up attraction that you feel toward your client(s)]. | .40 | .30 | -.05 | -.05 | .10 | -.04 | .26 | .04 |
| 13.Instances when you are irritated by behaviors, physical appearance, beliefs, or interpersonal characteristics of your client(s). | .39 | -.15 | -.13 | -.20 | .18 | -.16 | .28 | -.01 |
| 65.General doubt you may have about wanting to be a therapist. | .31 | .19 | .23 | -.02 | .01 | .03 | .27 | -.04 |
| 63.Instances when you acted flirtatious with your client(s). | .51 | .59 | -.04 | .00 | -.13 | .04 | .18 | .02 |
| 60.Your thoughts or feelings about perceived or vocalized supervisor attraction toward you. | .19 | .57 | .01 | .06 | -.07 | -.12 | .12 | -.03 |
| 41.Your thoughts or feelings about feeling drawn to or interested in your supervisor in a sexual or physical sense. | .09 | .53 | .06 | .05 | .05 | -.11 | .16 | .11 |
| 56.Negative thoughts, feelings, or descriptions of the professional characteristics of your supervisor. | -.16 | .53 | .00 | -.03 | .03 | -.26 | .10 | -.29 |
| 67.Instances when you daydream about relationships or events triggered by your client(s). | .26 | .50 | .01 | -.14 | .09 | .10 | .08 | -.10 |
| 58.Your negative thoughts or feelings about your supervisor's external image (e.g., dress/fashion habits, visible anxiety/stress). | -.20 | .50 | -.07 | .03 | .13 | -.17 | .11 | -.18 |
| 40.Your idolization of your supervisor. | -.02 | .48 | .34 | .01 | .16 | -.13 | -.05 | .04 |
| 64.Your concerns about your supervisor's competence to accurately evaluate you. | -.04 | .47 | -.03 | -.06 | -.06 | -.10 | .17 | -.34 |
| 54.Your positive thoughts or feelings about your supervisor's external image (e.g., dress/fashion habits, visible ability to handle stress, etc.). | -.01 | .44 | .08 | -.10 | .21 | .09 | -.23 | .03 |
| 18.Your attraction to your supervisor's brilliance. | -.24 | .42 | .40 | -.09 | .10 | -.02 | .13 | .17 |
| 55.Your concerns about your supervisor's evaluation of your personal characteristics versus your professional characteristics. | -.09 | .38 | .23 | -.09 | .08 | -.25 | -.10 | -.23 |
| 61.Your supervisor's microaggressions toward clients. | .28 | .38 | -.03 | -.08 | -.08 | -.23 | .12 | -.07 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 23.Negative thoughts, feelings, or descriptions of the personal characteristics of your supervisor. | -.29 | .35 | -.04 | .03 | .16 | -.29 | .29 | -.13 |
| 7.Your appreciation for all that your supervisor has done for you. | .08 | -.08 | .76 | -.10 | -.06 | -.10 | -.03 | .00 |
| 35.Your respect for your supervisor. | -.07 | .00 | .63 | -.17 | .13 | -.09 | -.05 | -.03 |
| 51.Your appreciation for feeling supported by your supervisor. | .13 | -.10 | .59 | -.23 | .09 | .09 | .03 | .04 |
| 73.Your personal opinions about the positive characteristics of your supervisor. | -.09 | .31 | .39 | -.08 | .21 | .21 | .02 | -.09 |
| 42.Instances you felt proud of the clinical work you have done with your client(s). | -.05 | -.08 | .02 | -.86 | -.02 | -.08 | .00 | .02 |
| 53.Instances when you received positive feedback from your client(s). | -.09 | .07 | .09 | -.76 | -.13 | .06 | .06 | -.06 |
| 62.Instances when you implemented a specific intervention well. | .13 | -.04 | .02 | -.75 | -.19 | -.06 | -.04 | -.04 |
| 43.Your feelings of pride for your client(s). | .07 | -.09 | .06 | -.55 | .14 | -.02 | .04 | .07 |
| 46.Your general positive thoughts, feelings, or characterizations about your client(s) as a person. | .13 | .05 | .07 | -.44 | .13 | .06 | .00 | .00 |
| 1.Your feelings of flattery that your client(s) enjoy(s) working with you. | -.10 | .12 | .06 | -.36 | .11 | -.03 | .12 | .00 |
| 31.Thoughts about your experiences or problems in the context of your life (e.g., issues related to personal or family crisis, when things in your life were overwhelming). | .12 | .05 | .07 | -.02 | .74 | .13 | -.06 | -.01 |
| 20.Thoughts about yourself in the context of your life (e.g., your sexual orientation, your own beliefs and value not directly related to therapy). | -.12 | .10 | -.01 | -.02 | .65 | -.04 | .14 | .01 |
| 26.Trouble I'm facing at school with my coursework, research, or other academic/professional area. | .12 | -.10 | .19 | .04 | .48 | .04 | .02 | -.11 |
| 5.Issues related to your own mental well-being (e.g., feeling anxious, depressed, etc.). | .20 | -.05 | .08 | .02 | .48 | -.17 | .04 | .04 |
| 33.Jealousy of a colleague at the setting (e.g., colleague has a full caseload, a better office, a different supervisor, etc.). | -.13 | .06 | .02 | -.02 | .40 | -.17 | .23 | -.07 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 70.Your feelings of closeness with your client(s). | .15 | .08 | .18 | -.23 | .27 | .15 | .10 | -.13 |
| 15.Feeling that your supervisor is distracted and/or not listening carefully to you. | -.04 | .15 | -.09 | -.11 | .04 | -.63 | .12 | -.11 |
| 3.Your concerns that your supervisor does not think you're a good clinician. | .20 | .01 | .19 | .05 | -.14 | -.56 | .10 | -.06 |
| 11.Your concerns about your supervisor's perception of you as a person. | .03 | .07 | .17 | -.08 | .16 | -.54 | .07 | .00 |
| 10.Your feedback about the supervisory alliance. | .19 | .03 | .32 | -.11 | .16 | -.42 | -.08 | .10 |
| 24.Your concerns that your supervisor does not like you. | -.08 | .26 | .07 | -.01 | .11 | -.40 | .36 | -.01 |
| 45.Your concerns about the fairness of your supervisor's evaluation of you. | .00 | .24 | .17 | -.16 | .02 | -.39 | -.06 | -.30 |
| 12.When information received from your supervisor differs from another source (e.g., literature, another supervisor, a textbook, a colleague). | .22 | -.10 | -.04 | -.18 | .07 | -.33 | .05 | -.29 |
| 32.Your supervisor's microaggressions toward you. | .14 | .29 | .09 | -.04 | .06 | -.31 | .07 | -.18 |
| 25.Boredom with the clinical work you are doing at the setting. | .00 | .12 | .03 | -.13 | .01 | .00 | .70 | -.07 |
| 21.Dissatisfaction with the lack of variety of presenting problems on your caseload. | .11 | -.01 | -.03 | -.12 | .09 | .15 | .62 | -.03 |
| 17.Instances when you are uninterested in your clinical work. | .01 | -.05 | -.07 | -.14 | .14 | -.19 | .56 | -.09 |
| 22.Your own negative opinions about how supervision is structured (e.g., too rigid, too relaxed, lack of structure). | -.12 | .12 | -.09 | -.10 | .04 | -.26 | .51 | -.18 |
| 8.General issues or discomfort with colleagues and other professionals at the setting. | .01 | -.08 | .20 | -.03 | .19 | -.17 | .48 | -.02 |
| 19.Feeling confused about what supervision is. | .25 | .19 | .13 | .00 | -.11 | -.14 | .44 | .07 |
| 52.Instances when you are bored with your client(s). | .16 | .03 | -.01 | -.16 | .13 | .17 | .43 | -.18 |
| 16.Feeling frustrated with the perceived importance set on quantity of contact hours instead of quality at your site. | .11 | -.11 | .02 | -.16 | .07 | -.33 | .36 | -.08 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 78.Instances when your theoretical orientation differs from your supervisor's. | .17 | .02 | -.01 | -.27 | .05 | .10 | .11 | -.51 |
| 76.Disagreement with your supervisor's clinical advice or intervention suggestions for your client(s). | .09 | -.02 | -.06 | -.25 | .10 | -.17 | .10 | -.51 |
| 74.Instances when your conceptualization of your client(s) differs from your supervisor's conceptualization. | .35 | -.01 | -.02 | -.28 | .00 | -.01 | .00 | -.43 |
| 27.Disagreement with your supervisor's diagnosis of your client(s). | .29 | .04 | -.14 | -.05 | .18 | -.24 | .06 | -.40 |
| 47.Times when you felt misunderstood by your supervisor. | .08 | .10 | .08 | -.20 | -.05 | -.37 | -.06 | -.38 |
| 57.Your concerns about how your supervisor will evaluate you. | .05 | .13 | .25 | .15 | .04 | -.19 | .20 | -.37 |
| 48.Feeling relieved when workload lessened (e.g., a client not continuing, a group ending, the semester ending, etc.). | .17 | -.03 | .17 | -.06 | .28 | .14 | .21 | -.29 |
| 34.Your hesitation and/or concerns about what to share in supervision for fear of it reflecting poorly in your evaluation. | .08 | .11 | .13 | .20 | .20 | -.13 | .26 | -.29 |
| 37.Feeling pressure to do extra shifts, hours, reports, or outreach events at your practicum site | .20 | -.05 | .25 | .11 | .03 | -.02 | .26 | -.29 |
| 72.Feeling overwhelmed by the setting's procedures (e.g., paperwork). | .24 | -.08 | .08 | -.14 | .21 | .12 | .18 | -.28 |
| 38.Previous knowledge about the supervisor gained from previous supervisors/academic advisors/colleagues. | -.01 | .26 | .23 | .04 | .02 | -.17 | .01 | -.26 |

*Note*: Factor loadings < |.40| were suppressed from view for easy of interpretability. SDS items 1, 12, 13, 16, 23, 32, 33, 34, 37, 38, 45, 47, 48, 55, 57, 61, 65, 70, 72, and 73 were dropped from this factor structure due to weak loadings (<|.40|) on any factor.

After reviewing the initial eight-factor solution, items with weak loadings (< |.40|) on any factor were identified and excluded (items 1, 12, 13, 16, 23, 32, 33, 34, 37, 38, 45, 47, 48, 55, 57, 61, 65, 70, 72, and 73) from the final exploratory factor analysis (EFA) with principal axis factoring (PAF) with an oblimin oblique rotation for eight factors. See Table 4.6 for an overview of the final eight-factor structure.

Table 4.6

*Factor Loadings from the Rotated Final Eight-Factor Pattern Matrix for the SDS: Principal Axis Factoring with Oblimin Rotation*

| | Factor | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | 7.00 | 8.00 |
| 75.Instances when you felt you made a clinical mistake in implementing specific intervention(s) with a client. | .83 | -.06 | .21 | .08 | .04 | -.02 | .00 | -.09 |
| 49.Instances when you felt you made a clinical mistake in your conceptualization of your client(s). | .80 | -.01 | .15 | -.05 | -.02 | .03 | .02 | -.04 |
| 68.Instances when you have felt that your clinical decision making may not have been the most appropriate. | .77 | .06 | .04 | -.09 | .03 | -.03 | -.18 | -.19 |
| 66.Instances when you felt you made a clinical mistake regarding your diagnosis for your client(s). | .75 | .06 | -.01 | -.04 | .07 | .02 | .03 | -.10 |
| 44.Instances when you felt you made a clinical mistake in your treatment planning and implementation (e.g., sequencing of issues and interventions). | .75 | -.02 | .16 | -.12 | .00 | -.03 | .00 | .05 |
| 39.Instances when you felt you made a clinical mistake in your psychological assessment administration. | .71 | -.03 | .12 | .01 | -.02 | -.05 | .00 | -.13 |
| 36.Instances when you are having a difficult time feeling empathetic toward your client(s). | .66 | -.08 | .10 | -.03 | .07 | .09 | .16 | -.12 |
| 14.Instances when you feel at a loss regarding treatment for your client(s). | .62 | -.22 | .04 | -.06 | .05 | -.06 | .23 | .02 |
| 30.Instances when you expressed resentment toward or about your client(s). | .62 | .16 | -.08 | -.15 | .07 | .02 | .13 | -.01 |
| 69.Instances when you lose neutrality and side with your client(s). | .61 | .00 | .04 | -.19 | .07 | -.05 | .00 | -.13 |
| 29.Instances when you engaged in too much self-disclosure with your client(s). | .60 | .09 | .01 | -.11 | -.06 | -.03 | .16 | -.02 |

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|---|---|---|---|---|---|---|---|---|
| 28.Instances when you treat your client(s) in a disciplinary manner during session(s). | .60 | .18 | -.03 | -.03 | -.04 | .06 | .16 | -.02 |
| 59.Instances when your feelings, in response to the dynamics occurring in the counseling relationship, are interfering with your clinical work with your client(s) (e.g., hostility, love, protectiveness, guilt, envy, apathy, etc.). | .60 | -.01 | -.04 | -.09 | .27 | -.05 | .03 | -.11 |
| 4.Instances when your thoughts, in response to the dynamics occurring in the counseling relationship, are interfering with your clinical work with your client(s) (e.g., reflecting on areas not central to a client's concern, your own opinions on topics, et | .59 | .02 | -.19 | -.07 | .32 | -.23 | -.09 | .10 |
| 2.Instances when you felt you made a clinical mistake in your interpersonal assessment of a client. | .55 | .00 | .05 | -.10 | -.02 | -.17 | .04 | .05 |
| 6.Instances when your behaviors, in response to the dynamics occurring in the counseling relationship, are interfering with your clinical work with your client(s) (e.g., acting in a submissive manner, significant discrepancies between case notes and what | .55 | -.05 | -.07 | -.12 | .14 | -.30 | .08 | .16 |
| 71.Instances when you feel your personal issues are interfering with your clinical work with your client(s). | .54 | .10 | -.05 | -.05 | .26 | -.12 | -.05 | -.18 |
| 9.Issues regarding client-counselor attraction (e.g., bringing up perceived or vocalized client attraction toward you). | .54 | .11 | -.02 | -.09 | -.06 | -.15 | .25 | .18 |
| 77.Instances when you are frustrated by your client(s) (e.g., perceived lack of progress or motivation). | .51 | -.08 | .04 | -.14 | .03 | .14 | .18 | -.31 |
| 50.Issues regarding counselor-client attraction [e.g., bringing up attraction that you feel toward your client(s)]. | .40 | .30 | -.06 | -.03 | .05 | -.08 | .25 | .06 |
| 63.Instances when you acted flirtatious with your client(s). | .51 | .60 | -.04 | .01 | -.16 | .03 | .13 | .03 |

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|---|---|---|---|---|---|---|---|---|
| 60.Your thoughts or feelings about perceived or vocalized supervisor attraction toward you. | .16 | .57 | -.01 | .06 | -.06 | -.10 | .12 | -.01 |
| 41.Your thoughts or feelings about feeling drawn to or interested in your supervisor in a sexual or physical sense. | .05 | .55 | .03 | .02 | .05 | -.09 | .14 | .11 |
| 56.Negative thoughts, feelings, or descriptions of the professional characteristics of your supervisor. | -.15 | .54 | .02 | .00 | -.01 | -.31 | .10 | -.27 |
| 40.Your idolization of your supervisor. | -.04 | .52 | .28 | -.02 | .14 | -.15 | -.05 | .05 |
| 67.Instances when you daydream about relationships or events triggered by your client(s). | .25 | .51 | .00 | -.14 | .06 | .04 | .06 | -.09 |
| 58.Your negative thoughts or feelings about your supervisor's external image (e.g., dress/fashion habits, visible anxiety/stress). | -.20 | .50 | -.02 | .07 | .10 | -.16 | .11 | -.21 |
| 64.Your concerns about your supervisor's competence to accurately evaluate you. | -.03 | .46 | -.04 | -.05 | -.06 | -.19 | .15 | -.31 |
| 54.Your positive thoughts or feelings about your supervisor's external image (e.g., dress/fashion habits, visible ability to handle stress, etc.). | -.03 | .45 | .07 | -.08 | .18 | .10 | -.17 | .00 |
| 18.Your attraction to your supervisor's brilliance. | -.27 | .41 | .39 | -.06 | .08 | -.09 | .10 | .07 |
| 7.Your appreciation for all that your supervisor has done for you. | .12 | .00 | .79 | -.02 | -.07 | -.08 | -.03 | .01 |
| 35.Your respect for your supervisor. | -.04 | .06 | .66 | -.09 | .11 | -.11 | -.03 | -.06 |
| 51.Your appreciation for feeling supported by your supervisor. | .12 | -.08 | .63 | -.16 | .12 | .11 | .09 | .00 |
| 42.Instances you felt proud of the clinical work you have done with your client(s). | -.11 | -.04 | -.03 | -.96 | -.02 | -.05 | -.02 | .02 |
| 53.Instances when you received positive feedback from your client(s). | -.08 | .09 | .12 | -.68 | -.15 | .06 | .06 | -.12 |
| 62.Instances when you implemented a specific intervention well. | .12 | -.03 | .08 | -.68 | -.20 | -.02 | -.04 | -.12 |
| 43.Your feelings of pride for your client(s). | .02 | -.05 | -.02 | -.67 | .14 | -.03 | .02 | .12 |

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|---|---|---|---|---|---|---|---|---|
| 46.Your general positive thoughts, feelings, or characterizations about your client(s) as a person. | .10 | .04 | .06 | -.44 | .13 | .08 | .05 | -.02 |
| 31.Thoughts about your experiences or problems in the context of your life (e.g., issues related to personal or family crisis, when things in your life were overwhelming). | .08 | .11 | .09 | -.04 | .77 | .17 | .03 | -.03 |
| 20.Thoughts about yourself in the context of your life (e.g., your sexual orientation, your own beliefs and value not directly related to therapy). | -.15 | .11 | .02 | -.03 | .59 | -.05 | .22 | -.01 |
| 26.Trouble I'm facing at school with my coursework, research, or other academic/professional area. | .14 | -.04 | .23 | .06 | .46 | .02 | .03 | -.13 |
| 5.Issues related to your own mental well-being (e.g., feeling anxious, depressed, etc.). | .19 | .00 | .07 | -.01 | .43 | -.23 | .02 | .04 |
| 15.Feeling that your supervisor is distracted and/or not listening carefully to you. | -.03 | .13 | -.02 | -.04 | -.02 | -.64 | .09 | -.17 |
| 11.Your concerns about your supervisor's perception of you as a person. | .02 | .07 | .14 | -.09 | .09 | -.63 | .01 | .00 |
| 3.Your concerns that your supervisor does not think you're a good clinician. | .20 | .00 | .11 | .01 | -.12 | -.59 | .06 | .00 |
| 10.Your feedback about the supervisory alliance. | .15 | .04 | .29 | -.12 | .13 | -.46 | -.09 | .08 |
| 24.Your concerns that your supervisor does not like you. | -.08 | .25 | .10 | .03 | .04 | -.45 | .34 | -.04 |
| 25.Boredom with the clinical work you are doing at the setting. | -.02 | .10 | .05 | -.08 | .02 | -.06 | .71 | -.09 |
| 21.Dissatisfaction with the lack of variety of presenting problems on your caseload. | .10 | -.02 | .01 | -.07 | .08 | .12 | .66 | -.02 |
| 17.Instances when you are uninterested in your clinical work. | .00 | -.06 | -.05 | -.12 | .12 | -.26 | .53 | -.11 |
| 22.Your own negative opinions about how supervision is structured (e.g., too rigid, too relaxed, lack of structure). | -.11 | .09 | -.05 | -.04 | -.01 | -.33 | .52 | -.18 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 52.Instances when you are bored with your client(s). | .16 | .04 | .03 | -.12 | .14 | .16 | .51 | -.15 |
| 8.General issues or discomfort with colleagues and other professionals at the setting. | .01 | -.05 | .14 | -.06 | .19 | -.26 | .43 | .03 |
| 19.Feeling confused about what supervision is. | .25 | .19 | .11 | .01 | -.11 | -.17 | .41 | .12 |
| 76.Disagreement with your supervisor's clinical advice or intervention suggestions for your client(s). | .13 | -.02 | -.01 | -.17 | .07 | -.26 | .12 | -.51 |
| 78.Instances when your theoretical orientation differs from your supervisor's. | .23 | .02 | .04 | -.18 | .04 | .01 | .15 | -.49 |
| 74.Instances when your conceptualization of your client(s) differs from your supervisor's conceptualization. | .37 | -.02 | .05 | -.20 | .02 | -.02 | .05 | -.46 |
| 27.Disagreement with your supervisor's diagnosis of your client(s). | .31 | .05 | -.11 | -.03 | .16 | -.27 | .11 | -.34 |

In the eight-factor solution, the content areas of disclosure could be identified as follows: (1) perceived clinical inadequacy, (2) transference issues, (3) strengths of the supervisory relationship, (4) clinical success, (5) self, (6) weaknesses of the supervisory bond, (7) dissatisfaction related to clinical setting, and (8) own clinical voice. The eight-factor solution teased apart some interesting aspects of the counseling process and implementation concerns factor in the six-factor solution. Specifically, two separate latent variables of dissatisfaction related to clinical setting and clinical aspects that may promote the supervisee's own clinical voice are salient in the eight-factor solution. These two areas are important and interesting dimensions of counseling and therefore the eight-factor solution was chosen and the total variance explained by the eight factors is displayed in Table 4.7.

Table 4.7

*Total Variance Explained by the Eight Extracted Factors of the SDS*

| | Initial Eigenvalues | | | Extraction Sums of Squared Loadings | | | Rotation Sums of Squared Loadings |
|---|---|---|---|---|---|---|---|
| Factor | Total | % of Variance | Cumulative % | Total | % of Variance | Cumulative % | Total |
| 1 | 26.51 | 33.98 | 33.98 | 26.08 | 33.44 | 33.44 | 17.10 |
| 2 | 6.75 | 8.66 | 42.64 | 6.34 | 8.13 | 41.57 | 8.56 |
| 3 | 3.34 | 4.36 | 47.00 | 2.94 | 3.78 | 45.34 | 7.47 |
| 4 | 2.47 | 3.17 | 50.17 | 2.05 | 2.63 | 47.97 | 11.22 |
| 5 | 2.21 | 2.83 | 53.00 | 1.75 | 2.24 | 50.21 | 9.16 |
| 6 | 2.07 | 2.65 | 55.65 | 1.61 | 2.07 | 52.28 | 8.53 |
| 7 | 1.69 | 2.16 | 57.81 | 1.25 | 1.60 | 53.88 | 12.45 |
| 8 | 1.55 | 2.00 | 59.80 | 1.08 | 1.39 | 55.27 | 10.69 |

SDS Item Reduction. Initially, 78 items were analyzed through exploratory factor analysis with principal axis factoring and an oblique (oblimin) rotation. As indicated in Table 4.6, Factor 1 included 20 items with factor loadings > |.40| and the internal consistency estimate for Factor 1 with all 20 items was .96. As a goal of parsimony and item reduction of survey measures to aid in greater participant response, the internal consistency estimates were evaluated. Items with lower factor loadings were progressively deleted from the factor and the internal consistency of the factor was assessed after each deletion, see Table 4.8. Minimal gains in internal consistency were achieved by retaining more than eight items and therefore only the eight items with the highest factor loadings were retained to constitute Factor 1 in the final version of the SDS, for this study. As indicated in Table 4.6 Factor 2 included 10 items with factor loadings > |.40| and the internal consistency estimate for the factor with all 10 items was

.86. The same aforementioned item reduction procedure was conducted for Factor 2, see Table 4.8. Minimal gains in internal consistency were achieved by retaining more than eight items and as a result, only the eight items with the highest factor loadings constitute Factor 2 in the final version of the SDS for this study.

Table 4.8

*Reliability Results from Supervisee Disclosure Scale Item Reduction*

| | | Coefficient Alpha | |
|---|---|---|---|
| Factor | N | α | Gain in α |
| | 8 | .940 | |
| 1 | 10 | .941 | +.001 |
| | 12 | .947 | +.006 |
| | 14 | .952 | +.005 |
| | 16 | .956 | +.004 |
| | 18 | .958 | +.002 |
| | 20 | .958 | +.002 |
| 2 | 4 | .778 | |
| | 6 | .831 | +.053 |
| | 8 | .865 | +.034 |
| | 10 | .860 | -.005 |

After the item reduction for Factors 1 and 2, the EFA with PAF and oblique (oblimin) rotation was re-run with the 43 items, see Table 4.9 for item breakdown.

Table 4.9

*43-item and 8-factor Supervisee Disclosure Scale*

| Factor | Items | | | | | | | | Total Items |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 75 | 49 | 66 | 68 | 44 | 39 | 36 | 14 | 8 |
| 2 | 63 | 60 | 41 | 56 | 67 | 58 | 40 | 64 | 8 |
| 3 | 7 | 35 | 51 | | | | | | 3 |
| 4 | 42 | 53 | 62 | 43 | 46 | | | | 5 |
| 5 | 31 | 20 | 26 | 5 | | | | | 4 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 6 | 15 | 3 | 11 | 10 | 24 | | | 5 |
| 7 | 25 | 21 | 17 | 22 | 8 | 19 | | 6 |
| 8 | 76 | 78 | 74 | 27 | | | | 4 |

Three items had a factor loading of less than |.40| when the 43-item, 8-factor solution was evaluated. These three items were item 5 of Factor 5, item 8 of Factor 7, and item 27 of Factor 8. These items were dropped and the final 40-item, 8-factor Supervisee Disclosure Scale (SDS) was created. See Table 4.10 for the means and standard deviations of items on the final 40-item SDS scale. See Table 4.11 for the pattern matrix for the 40-item, 8-factor SDS using EFA with PAF and oblique (oblimin) rotation. See Table 4.12 for factor correlations and factor alpha coefficients for the 40-item SDS. See Appendix D for the final 40-item, 8-factor Supervisee Disclosure Scale (SDS).

Table 4.10

*Means and Standard Deviations for Items on the 40-Item SDS*

| SDS Item | *M* | *SD* |
|---|---|---|
| Factor 1: Perceived Clinical Inadequacy | 33.60 | 6.0 |
| 75.Instances when you felt you made a clinical mistake in implementing specific intervention(s) with a client. | 4.21 | 0.84 |
| 49.Instances when you felt you made a clinical mistake in your conceptualization of your client(s). | 4.21 | 0.85 |
| 66.Instances when you felt you made a clinical mistake regarding your diagnosis for your client(s). | 4.14 | 0.98 |
| 68.Instances when you have felt that your clinical decision making may not have been the most appropriate. | 4.00 | 0.98 |
| 44.Instances when you felt you made a clinical mistake in your treatment planning and implementation (e.g., sequencing of issues and interventions). | 4.23 | 0.90 |
| 39.Instances when you felt you made a clinical mistake in your psychological assessment administration. | 4.16 | 1.00 |

| | | |
|---|---|---|
| 36.Instances when you are having a difficult time feeling empathetic toward your client(s). | 4.09 | 0.90 |
| 14.Instances when you feel at a loss regarding treatment for your client(s). | 4.50 | 0.79 |
| Factor 2: Transference Issues | 15.34 | 5.71 |
| 63.Instances when you acted flirtatious with your client(s). | 2.66 | 1.30 |
| 60.Your thoughts or feelings about perceived or vocalized supervisor attraction toward you. | 2.19 | 1.24 |
| 41.Your thoughts or feelings about feeling drawn to or interested in your supervisor in a sexual or physical sense. | 1.66 | 0.99 |
| 56.Negative thoughts, feelings, or descriptions of the professional characteristics of your supervisor. | 2.06 | 1.05 |
| 67.Instances when you daydream about relationships or events triggered by your client(s). | 2.91 | 1.24 |
| 58.Your negative thoughts or feelings about your supervisor's external image (e.g., dress/fashion habits, visible anxiety/stress). | 1.61 | 0.88 |
| 40.Your idolization of your supervisor. | 2.26 | 1.20 |
| Factor 3: Strengths of Supervisory Relationship | 15.02 | 2.80 |
| 64.Your concerns about your supervisor's competence to accurately evaluate you. | 2.27 | 1.15 |
| 7.Your appreciation for all that your supervisor has done for you. | 4.30 | 0.90 |
| 35.Your respect for your supervisor. | 4.08 | 0.99 |
| 51.Your appreciation for feeling supported by your supervisor. | 4.40 | 0.84 |
| Factor 4: Clinical Successes | 21.63 | 2.86 |
| 42.Instances you felt proud of the clinical work you have done with your client(s). | 4.35 | 0.77 |
| 53.Instances when you received positive feedback from your client(s). | 4.32 | 0.71 |
| 62.Instances when you implemented a specific intervention well. | 4.32 | 0.71 |
| 43.Your feelings of pride for your client(s). | 4.37 | 0.76 |
| 46.Your general positive thoughts, feelings, or characterizations about your client(s) as a person. | 4.30 | 0.77 |
| Factor 5: Self | 9.73 | 3.21 |
| 31.Thoughts about your experiences or problems in the context of your life (e.g., issues related to personal or family | 3.37 | 1.26 |

| | | |
|---|---|---|
| crisis, when things in your life were overwhelming). | | |
| 20.Thoughts about yourself in the context of your life (e.g., your sexual orientation, your own beliefs and value not directly related to therapy). | 2.85 | 1.40 |
| 26.Trouble I'm facing at school with my coursework, research, or other academic/professional area. | 3.51 | 1.28 |
| Factor 6: Weaknesses of the Supervisory Bond | 13.94 | 4.39 |
| 15.Feeling that your supervisor is distracted and/or not listening carefully to you. | 2.51 | 1.04 |
| 3.Your concerns that your supervisor does not think you're a good clinician. | 2.75 | 1.17 |
| 11.Your concerns about your supervisor's perception of you as a person. | 2.77 | 1.20 |
| 10.Your feedback about the supervisory alliance. | 3.69 | 1.11 |
| 24.Your concerns that your supervisor does not like you. | 2.22 | 1.15 |
| Factor 7: Dissatisfaction Related to Clinical Setting | 15.07 | 4.39 |
| 25.Boredom with the clinical work you are doing at the setting. | 2.77 | 1.27 |
| 21.Dissatisfaction with the lack of variety of presenting problems on your caseload. | 3.33 | 1.26 |
| 17.Instances when you are uninterested in your clinical work. | 3.01 | 1.20 |
| 22.Your own negative opinions about how supervision is structured (e.g., too rigid, too relaxed, lack of structure). | 2.81 | 1.25 |
| 19.Feeling confused about what supervision is. | 3.13 | 1.36 |
| Factor 8: Own Clinical Voice | 11.09 | 2.71 |
| 76.Disagreement with your supervisor's clinical advice or intervention suggestions for your client(s). | 3.33 | 1.13 |
| 78.Instances when your theoretical orientation differs from your supervisor's. | 3.87 | 1.02 |
| 74.Instances when your conceptualization of your client(s) differs from your supervisor's conceptualization. | 3.89 | 0.98 |

Table 4.11

*Factor Loadings from the Rotated Final Eight- Factor Pattern Matrix for the 40-Item SDS: Principal Axis Factoring with Oblimin Rotation*

| | Factor | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| SDS Item | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 75.Instances when you felt you made a clinical mistake in implementing specific intervention(s) with a client. | .86 | -.01 | .12 | .07 | .03 | -.05 | .02 | -.03 |
| 49.Instances when you felt you made a clinical mistake in your conceptualization of your client(s). | .82 | .06 | .03 | -.10 | .01 | -.02 | -.01 | .03 |
| 68.Instances when you have felt that your clinical decision making may not have been the most appropriate. | .77 | .07 | .01 | -.07 | .06 | -.01 | -.10 | -.17 |
| 39.Instances when you felt you made a clinical mistake in your psychological assessment administration. | .76 | .04 | -.01 | -.03 | .03 | -.10 | -.05 | -.07 |
| 44.Instances when you felt you made a clinical mistake in your treatment planning and implementation (e.g., sequencing of issues and interventions). | .76 | .02 | .06 | -.15 | .02 | -.09 | -.01 | .09 |
| 66.Instances when you felt you made a clinical mistake regarding your diagnosis for your client(s). | .76 | .11 | -.07 | -.03 | .09 | .03 | .06 | -.09 |
| 14.Instances when you feel at a loss regarding treatment for your client(s). | .63 | -.15 | -.01 | -.07 | .04 | -.09 | .26 | .07 |
| 36.Instances when you are having a difficult time feeling empathetic toward your client(s). | .63 | -.04 | .11 | -.01 | .06 | .05 | .17 | -.09 |
| 41.Your thoughts or feelings about feeling drawn to or interested in your supervisor in a sexual or physical sense. | -.01 | .65 | .03 | -.03 | .07 | -.05 | .05 | .15 |
| 60.Your thoughts or feelings about perceived or vocalized supervisor attraction toward you. | .10 | .64 | .01 | .04 | -.02 | -.04 | .07 | -.01 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 63.Instances when you acted flirtatious with your client(s). | .39 | .63 | -.00 | -.00 | -.14 | .08 | .15 | .01 |
| 56.Negative thoughts, feelings, or descriptions of the professional characteristics of your supervisor. | -.12 | .55 | -.03 | -.04 | .07 | -.32 | -.04 | -.22 |
| 67.Instances when you daydream about relationships or events triggered by your client(s). | .17 | .54 | .04 | -.13 | .07 | .11 | .09 | -.08 |
| 58.Your negative thoughts or feelings about your supervisor's external image (e.g., dress/fashion habits, visible anxiety/stress). | -.17 | .53 | -.07 | .02 | .15 | -.17 | .02 | -.13 |
| 64.Your concerns about your supervisor's competence to accurately evaluate you. | -.07 | .53 | .03 | -.02 | -.05 | -.07 | .13 | -.37 |
| 40.Your idolization of your supervisor. | -.08 | .49 | .24 | -.05 | .21 | -.15 | -.09 | .09 |
| 7.Your appreciation for all that your supervisor has done for you. | -.02 | -.01 | .93 | .05 | -.10 | -.04 | -.01 | -.03 |
| 51.Your appreciation for feeling supported by your supervisor. | .05 | -.07 | .65 | -.13 | .12 | .13 | .12 | .01 |
| 35.Your respect for your supervisor. | -.07 | .05 | .63 | -.08 | .12 | -.10 | -.05 | -.04 |
| 42.Instances you felt proud of the clinical work you have done with your client(s). | -.06 | -.03 | -.02 | -.95 | -.03 | -.05 | -.00 | .04 |
| 62.Instances when you implemented a specific intervention well. | .12 | .02 | .06 | -.69 | -.17 | -.01 | -.07 | -.12 |
| 53.Instances when you received positive feedback from your client(s). | -.08 | .07 | .12 | -.67 | -.08 | .03 | .00 | -.15 |
| 43.Your feelings of pride for your client(s). | .07 | -.04 | -.03 | -.63 | .13 | -.02 | .06 | .14 |
| 46.Your general positive thoughts, feelings, or characterizations about your client(s) as a person. | .10 | .03 | .04 | -.41 | .20 | .08 | .09 | -.03 |
| 31.Thoughts about your experiences or problems in the context of your life (e.g., issues related to personal or family crisis, when things in your life were overwhelming). | .11 | .09 | .08 | -.02 | .75 | .14 | -.02 | -.01 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 20.Thoughts about yourself in the context of your life (e.g., your sexual orientation, your own beliefs and value not directly related to therapy). | -.11 | .05 | -.03 | -.01 | .64 | -.10 | .18 | -.01 |
| 26.Trouble I'm facing at school with my coursework, research, or other academic/professional area. | .22 | -.03 | .12 | .05 | .57 | -.04 | -.07 | -.05 |
| 11.Your concerns about your supervisor's perception of you as a person. | .07 | .06 | .09 | -.09 | .11 | -.65 | .02 | .07 |
| 15.Feeling that your supervisor is distracted and/or not listening carefully to you. | .02 | .13 | -.05 | -.05 | -.00 | -.64 | .06 | -.12 |
| 3.Your concerns that your supervisor does not think you're a good clinician. | .21 | .03 | .12 | .04 | -.14 | -.54 | .08 | -.02 |
| 24.Your concerns that your supervisor does not like you. | -.08 | .27 | .08 | .02 | .07 | -.45 | .29 | -.02 |
| 10.Your feedback about the supervisory alliance. | .14 | .01 | .31 | -.07 | .12 | -.45 | -.04 | .09 |
| 25.Boredom with the clinical work you are doing at the setting. | -.04 | .15 | .07 | -.06 | .03 | -.05 | .67 | -.14 |
| 21.Dissatisfaction with the lack of variety of presenting problems on your caseload. | .08 | .01 | .01 | -.06 | .09 | .10 | .67 | -.03 |
| 22.Your own negative opinions about how supervision is structured (e.g., too rigid, too relaxed, lack of structure). | -.11 | .07 | -.03 | -.01 | .00 | -.35 | .53 | -.18 |
| 19.Feeling confused about what supervision is. | .19 | .26 | .13 | .01 | -.12 | -.12 | .48 | .15 |
| 17.Instances when you are uninterested in your clinical work. | .05 | -.05 | -.07 | -.12 | .11 | -.34 | .45 | -.12 |
| 78.Instances when your theoretical orientation differs from your supervisor's. | .21 | -.03 | .08 | -.12 | .10 | .02 | .17 | -.54 |
| 76.Disagreement with your supervisor's clinical advice or intervention suggestions for your client(s). | .19 | -.00 | .01 | -.15 | .08 | -.23 | .10 | -.48 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 74.Instances when your conceptualization of your client(s) differs from your supervisor's conceptualization. | .37 | -.02 | .10 | -.15 | .06 | .03 | .10 | -.47 |

Table 4.12

*Factor Correlations and Factor Alpha Coefficients for the 40-Item SDS*

| Factor | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|
| 1 Perceived Clinical Inadequacy | (.94) | | | | | | | |
| 2 Transference Issues | .16 | (.87) | | | | | | |
| 3 Strengths of Supervisory Relationship | .35 | .22 | (.81) | | | | | |
| 4 Clinical Successes | -.41 | -.14 | -.42 | (.83) | | | | |
| 5 Self | .20 | .22 | .32 | -.25 | (.74) | | | |
| 6 Weakness of Supervisory Bond | -.13 | -.43 | -.28 | .16 | -.18 | (.83) | | |
| 7 Dissatisfaction Related to Clinical Setting | .36 | .37 | .13 | -.30 | .20 | -.35 | (.84) | |
| 8 Own Clinical Voice | -.21 | -.24 | -.07 | .29 | -.11 | .22 | -.27 | (.83) |

*Note*: Reliability estimates appear in the parentheses on the diagonal.

**Clinical Experience and Factor-Based Scales of the SDS**

Factor-based scales were created in SPSS for each of the eight factors of the SDS. Factor-based scales were a composite measure of scores of all items of each factor (Pett, Lackey, Sullivan, 2003). A participant's score on a specific factor scale was calculated by adding up the participant's responses to all the items of that particular factor (e.g., Factor 1: *Perceived Clinical Inadequacy*). Linear regression analyses were conducted to

evaluate the relationship between clinical experience variables and factor-based scales. Clinical experience variables for each participant include: (1) months of supervised counseling experience, (2) number of previous clients worked with clinically, (3) weeks completed at current site, and (4) number of individual supervision sessions. Months of Supervised Counseling Experience was not a statistically significant predictor to seven of the factor-based scales, Factors 1, 2, 3, 4, 6, 7, and 8. Months of Supervised Counseling Experience was a statistically significant predictor for Factor 5, Self, $R^2 = .03$ $F(1, 200) = 6.85$, $p = .01$. Number of Clients and Number of Individual Supervision Sessions with Current Supervisor were not statistically significant predictors to any of the factor-based scales. Weeks Completed at Site was not a statistically significant predictor to six of the factor-based scales, Factors 1, 2, 3, 6, 7, and 8. Weeks Completed at Site was a statistically significant predictor for Factor 4, *Clinical Successes*, $R^2 = .03$ $F(1, 195) = 5.16$, $p = .02$ and Factor 5, Self, $R^2 = .04$ $F(1, 201) = 9.35$, $p < .01$. The correlations between the clinical experience variables and the factor-based scales are displayed in Table 4.13. There were only three significant correlations; between Months of Supervised Counseling Experience and Factor 5: *Self* and Weeks at Clinical Site and Factor 4: *Clinical Successes* and Factor 5: *Self*, see Table 4.13.

Table 4.13

*Correlations between Factor-Based Scales of Supervisee Disclosure Scale and Clinical Experience Variables*

| | Clinical Experience Variables | | | |
|---|---|---|---|---|
| Factor Based Scales | Months of Previous Supervised Experience | Number of Clients | Weeks at Clinical Site | Number of Previous Individual Supervision Sessions with Current Supervisor |
| 1 | -.09 | .02 | .06 | -.12 |
| 2 | -.04 | .03 | .01 | .09 |
| 3 | -.00 | .08 | .07 | -.01 |
| 4 | .02 | .09 | .16* | .10 |
| 5 | .18* | .12 | .21* | .09 |
| 6 | -.09 | .05 | .02 | .05 |
| 7 | -.01 | .01 | .01 | -.02 |
| 8 | .01 | .03 | .08 | .05 |

*Note*: * indicates correlation was statistically significant at the $p < .05$ level.

**Confirmatory Factor Analysis of the Working Alliance Inventory/Supervision-Short**

Descriptive statistics for the Working Alliance Inventory/Supervision-Short, including correlations, means, and standard deviations for the sample are provided in Table 4.14.

Table 4.14

*Correlations, Means, and Standard Deviations for Working Alliance Inventory-Supervision-Short 12 Items.*

| Item | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | *M* | *SD* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 1 | | | | | | | | | | | | 5.65 | 1.05 |
| 2 | .55 | 1 | | | | | | | | | | | 5.36 | 1.33 |
| 3 | .60 | .47 | 1 | | | | | | | | | | 5.71 | 1.26 |
| 4 | .60 | .50 | .45 | 1 | | | | | | | | | 5.71 | 1.29 |
| 5 | .68 | .69 | .57 | .68 | 1 | | | | | | | | 5.89 | 1.33 |
| 6 | .65 | .64 | .57 | .64 | .83 | 1 | | | | | | | 5.73 | 1.30 |
| 7 | .61 | .50 | .85 | .46 | .65 | .67 | 1 | | | | | | 5.71 | 1.38 |
| 8 | .67 | .66 | .67 | .64 | .80 | .83 | .71 | 1 | | | | | 5.67 | 1.27 |
| 9 | .67 | .62 | .73 | .57 | .80 | .79 | .80 | .81 | 1 | | | | 5.67 | 1.38 |
| 10 | .37 | .33 | .34 | .55 | .47 | .45 | .37 | .47 | .43 | 1 | | | 5.37 | 1.32 |
| 11 | .67 | .65 | .61 | .62 | .78 | .82 | .70 | .83 | .80 | .43 | 1 | | 5.56 | 1.29 |
| 12 | .81 | .83 | .65 | .66 | .82 | .80 | .68 | .88 | .79 | .44 | .78 | 1 | 5.60 | 1.09 |

*Note*. *M* = mean; *SD* = standard deviation. All correlations were statistically significant at the $p < .01$ level. Range for all items = 1-7 with higher scores indicating a strong working alliance.

Initially, two factor structures (i.e., hierarchical bi-level model and three-factor solution) were assessed to evaluate fit. The hierarchical bi-level model specified a *general alliance* factor in addition to the three specific factors of *task*, *bond*, and *goal*. Three of the five goodness of fit criteria were met in the bi-factor model, assessing the *general alliance* factor and the three specific factors of *task*, *bond*, and *goal*, and providing limited support for the model (see Table 4.15); SB $\chi^2(43) = 197.73$, $p < .01$, CFI = .99, TLI = .98, WRMR = .72, RMSEA = .13, 90% CI [.11, .15]. This model has relatively strong factor loadings for the hierarchical factor of *general alliance*; however, there are weak specific factor loadings for four items. The factor loading for item 5 on specific Factor *Bond* was -0.12. The factor loading for item 6 on specific Factor *Goal* was 0.03. The factor loading for item 8 on specific Factor *Task* was 0.10. The factor loading for item 11 on specific Factor *Goal* was less than 0.00. A second model was run to evaluate if removing these four items (items 5, 6, 8, and 11) would improve the fit. In the re-specified bi-level factor (removing items 5, 6, 8, and 11), three of the five goodness of fit indices were met, SB $\chi^2(15) = 124.05$, $p < .01$, CFI = .98 TLI = .97, WRMR = .74, RMSEA = .18, 90% CI [.15, .21]. The re-specified bi-level factor model had similar fit indices of the original bi-level factor model, with a smaller SB $\chi^2$ but larger *df* and therefore is a more restrictive model. Since the re-specified bi-level factor model is not nested within the original bi-level factor model, a SB $\chi^2$ difference test could not be conducted; however, when examining the normed $\chi^2$ ($\chi^2/df$), the re-specified bi-level factor model does not have a more acceptable fit than the original bi-level factor structure (See Table 4.15). The three-factor solution was expected to have worse fit than the bi-

level factor model. Two of the five fit criteria were met in the three-factor model, providing limited support for the model (see Table 4.12); SB $\chi^2(51) = 479.83$, $p < .01$, CFI = .97, TLI = .96, WRMR = 1.4, RMSEA = .20, 90% CI [.18, .21]. Per the Mplus SB $\chi^2$ difference test for nested models, the fit of the three-factor model was significantly worse than that of the bi-level factor model (SB $\chi^2$ of difference = 219.02, *df* difference = 8, p < .01). The factor structure of the bi-level factor structure, re-specified bi-level factor structure (with items 5, 8, 6, and 11 dropped), and three-factor models are presented in Figures 4.1-4.3. The hierarchical bi-level model that specified a *general alliance* factor in addition to the three specific factors of *task*, *bond*, and *goal* was the best fit model and selected factor structure of the WAI-SS.

Table 4.15

*Goodness of Fit Indices of Three Factor-Structure Models of the Working Alliance Inventory-Supervision Short*

| Model | S-B Scaled $\chi^2$ (df) | $\chi^2/df$ | RMSEA [90% CI] | CFI | TLI | WRMR |
|---|---|---|---|---|---|---|
| 1 | 197.73 (43)* | 4.60 | .13 [.11, .15] | .99 | .98 | .72 |
| 2 | 124.05 (15)* | 8.27 | .18 [.15, .21] | .98 | .97 | .74 |
| 3 | 479.83 (51)* | 9.41 | .20[.18, .21] | .97 | .96 | 1.4 |

*Note*. Model 1 = Bi-level factor structure; Model 2 =Bi-level factor structure with items 8,6,11, and 15 dropped; Model 3 = Three factor model *df* = degrees of freedom; RMSEA = Root Mean Square Error of Approximation; CFI = Comparative Fit Index; WRMR = Weighted Root Mean Residual; CI = Confidence Interval; *$p < .05$.

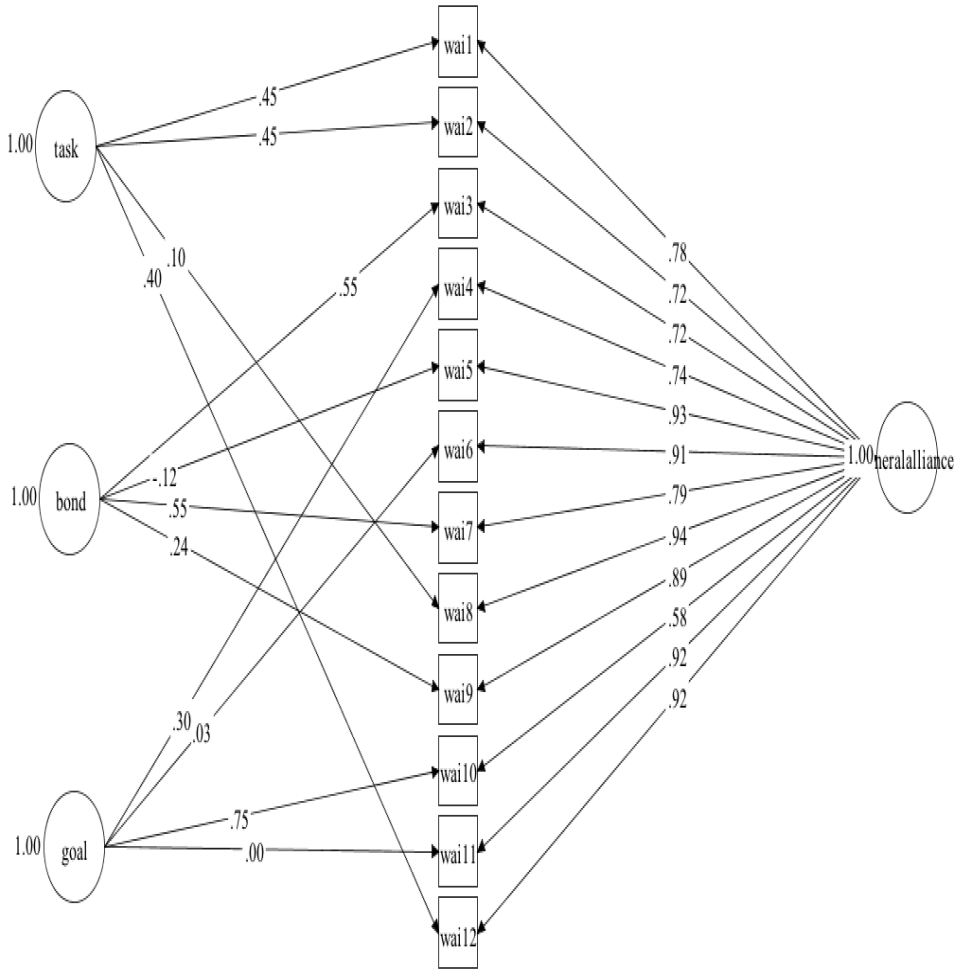


*Figure 4.1*. Bi-level Factor Model, with Standardized Loadings for 12 Items from the Working Alliance Inventory-Supervision-Short.

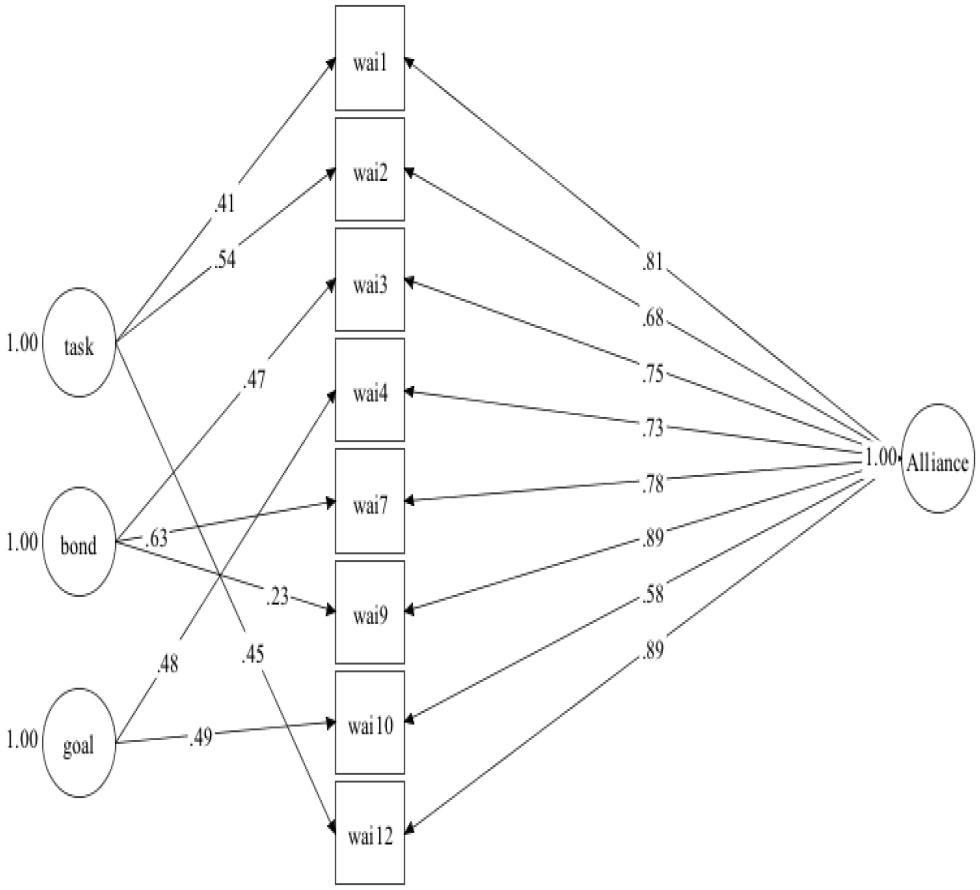


*Figure 4.2*. Re-specified Bi-level Factor Model (items 5, 8, 6, and 11 dropped) with Standardized Loadings for 12 Items from the Working Alliance Inventory-Supervision-Short.

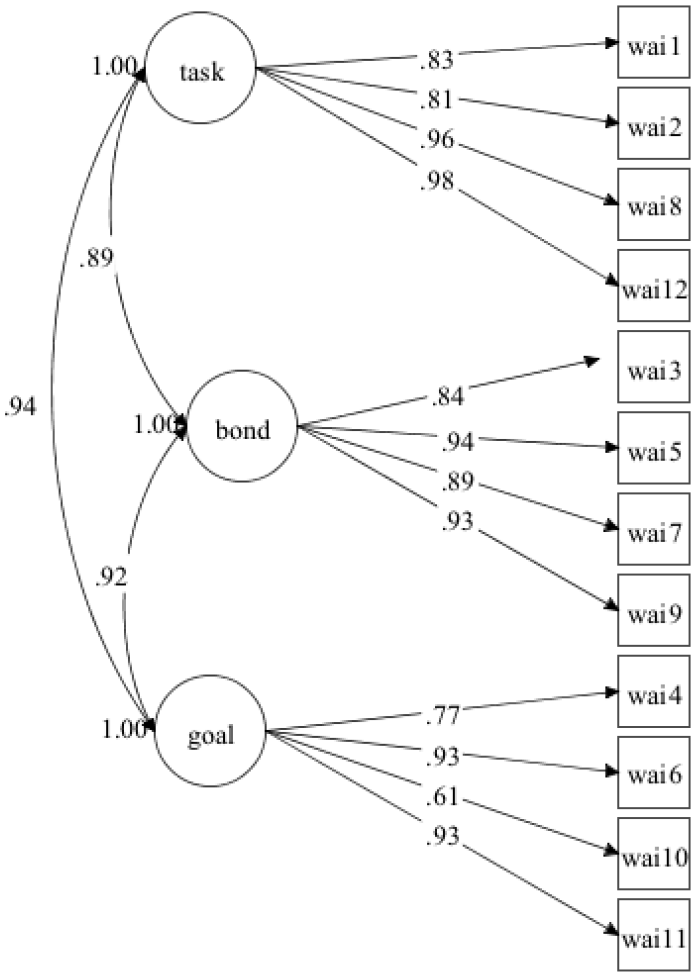


*Figure 4.3*. Three-Factor Model, with Standardized Loadings for 12 Items from the Working Alliance Inventory-Supervision-Short.
*Note*: All parameters were statistically significant at the $\alpha = .05$ level.

**Relationship between Working Alliance Inventory/Supervision-Short and Supervisee Disclosure Scale Content Areas**

Given the bi-level factor structure, ipsatizing scores for the specific factors allows preliminary analyses to examine the relationship between general alliance, task, bond, and goal and the specific content areas of supervisee disclosure. Four scores were calculated: one for the *general alliance* factor and three for the specific factors of *task*, *bond*, and *goal*. The process of ipsatizing scores was necessary to accurately calculate the

four scores, given the bi-level factor structure of the measure. First, the *general alliance* score was created by taking the average of all items of the WAI-SS. Next, the variance of the *general alliance* score was removed to create the specific factor scores by subtracting each participant's total mean from each item response and then these scores were averaged to generate accurate subscale scores (Reise, 2012). Factor-based scales were created in SPSS for each of the eight factors of the SDS. Factor-based scales were a composite measure of scores of all items of each factor (Pett, Lackey, Sullivan, 2003). A participant's score on a specific factor scale was calculated by adding up the participant's responses to all the items of that factor (e.g., Factor 1: *Perceived Clinical Inadequacy*).

To be clear, the specific content areas of supervisee disclosure were only evaluated via an exploratory factor analysis and must be validated with a confirmatory factor analysis with a future sample. First, the correlations between WAI-SS factors and specific content areas of disclosure were evaluated. The factor of General Alliance has a statistically significant positive correlation with all eight factors of the SDS. Additionally, the factor of Bond had a statistically significant positive correlation with the following factors:

Factor 3: *Strengths of the Supervisory Relationship*

Factor 4: *Clinical Successes*

Factor 5: *Self*

Factor 6: *Weaknesses of the Supervisory Bond*

Factor 7: *Dissatisfaction with Clinical Setting*

Factor 8: *Own Clinical Voice*

The factor of Goal had a statistically significant negative correlation with Factor 3:

*Strengths of Supervisory Relationship* and Factor 7: *Dissatisfaction Related to Clinical Setting.* A weaker sense of mutually defined goals of supervision is related to more disclosure of *Strengths of Supervisory Relationship* and *Dissatisfaction Related to the Clinical Setting*. The factor of *Task* was not significantly correlated with any of the specific content areas of supervisee disclosure; however, all the correlations were negative and indicated that stronger focus on tasks of supervision related to less disclosure (See Table 4.16).

Table 4.16

*Correlations between General Alliance, Task, Goal, and Bond Factors for Working Alliance Inventory/Supervision-Short and Factors of Supervisee Disclosure Scale*

| | WAI-SS Factors | | | |
|---|---|---|---|---|
| SDS Factor | General Alliance | Task | Bond | Goal |
| 1 Perceived Clinical Inadequacy | .47** | -.01 | .12 | -.11 |
| 2 Transference Issues | .24** | -.03 | .11 | -.08 |
| 3 Strengths of Supervisory Relationship | .60** | -.12 | .27** | -.17* |
| 4 Clinical Successes | .38** | -.09 | .19** | -.11 |
| 5 Self | .34** | -.04 | .15* | -.12 |
| 6 Weakness of Supervisory Bond | .32** | -.07 | .17* | -.11 |
| 7 Dissatisfaction Related to Clinical Setting | .22** | -.03 | .18* | -.16* |
| 8 Own Clinical Voice | .35** | -.03 | .13* | -.11 |

*Note*: ** indicates correlation is statistically significant at the $p < .01$ level; * indicates correlation is statistically significant at $p < .05$ level.

Given that *general alliance* was positively correlated with all content areas of SDS, a linear regression analysis was conducted to assess the unique versus shared

variance among the specific content areas of SDS and WAI-SS General Alliance. As expected given their correlations, all eight content areas of supervisee disclosure were significant predictors of WAI-*SS General Alliance*, $R^2 = .45$, $F(8,184) = 18.67$, $p < .01$. When examining the standardized coefficients of each specific content area of supervisee disclosure, only two content areas were significant, Factor 1 *Perceived Clinical Inadequacy* and Factor 3 *Strengths of Supervisory Relationship* (See Table 4.17). WAI-SS *Task* was not significantly related to any of the eight content areas of supervisee disclosure (See Table 4.18). Given that bond was positively correlated with six content areas of SDS, a linear regression analysis was conducted to assess the unique versus shared variance among the specific content areas of SDS and WAI-SS *Bond*. As expected given their correlations, all eight content areas of supervisee disclosure were significant predictors of WAI-SS *Bond*, $R^2 = .90$, $F(8,184) = 2.28$, $p = .02$. When examining the standardized coefficients of each specific content areas of supervisee disclosure, only one content area was significant, Factor 3 *Strengths of Supervisory Relationship* ($\beta = .25$, $t = 2.53$, $p = .01$. Finally, WAI-SS *Goals* was significantly related to two specific content areas of supervisee disclosure. Specifically, WAI-SS *Goals* was significantly related to Factor 3: *Strengths of Supervisory Relationship*, $R^2 = .03$ $F(1, 198) = 6.07$, $p = .02$ and Factor 7: *Dissatisfaction Related to Clinical Setting*, $R^2 = .03$, $F(1, 202) = 5.47$, $p = .02$.

Table 4.17

*Standardized Coefficients from the Linear Regression Analyses Predicting Working Alliance Inventory/Supervision-Short General Alliance Factor from Specific Content Areas of Supervisee Disclosure*

| | WAI-SS General Factor | | |
|---|---|---|---|
| SDS Factor | *β* | *t* | *p* |
| 1 Perceived Clinical Inadequacy | .31 | 4.25 | .01 |
| 2 Transference Issues | -.13 | -1.62 | .11 |
| 3 Strengths of Supervisory Relationship | .54 | 7.08 | .01 |
| 4 Clinical Successes | .06 | 0.82 | .42 |
| 5 Self | .09 | 1.36 | .18 |
| 6 Weakness of Supervisory Bond | .04 | 0.53 | .60 |
| 7 Dissatisfaction Related to Clinical Setting | -.14 | -1.80 | .07 |
| 8 Own Clinical Voice | -.07 | -0.78 | .44 |

*Note*: All regressions were significant at the $p < .01$ level.

# CHAPTER 5

# DISCUSSION

## Supervisee Disclosure Scale Factor Structure

The factor structure of the Supervisee Disclosure Scale (SDS), a scale developed and empirically tested for this research project, was evaluated through exploratory factor analysis and an eight-factor solution was determined as the best fit to describe the latent variables of different content areas of supervisee disclosure. The SDS is a 40-item self-report measure that captured about 55% of the total shared variance among measures. Parallel analysis indicated a six-factor solution; however, the theoretical interpretability was not as strong as the eight-factor solution that was indicated by the minimum average partial (MAP) test. All empirical tools used to evaluate the factor structure (i.e., Kaiser criterion, scree plot, parallel analysis, MAP, and maximum likelihood estimation) were carefully judged with the theoretical understanding of supervisee disclosure in clinical supervision. The eight content areas of supervisee disclosure of the SDS include the following: (1) *Perceived Clinical Inadequacy*, (2) *Transference Issues*, (3) *Strengths of Supervisory Relationship*, (4) *Clinical Successes*, (5) *Self*, (6) *Weaknesses of the Supervisory Bond*, (7) *Dissatisfaction Related to Clinical Setting*, and (8) *Own Clinical Voice*. Factor 1: *Perceived Clinical Inadequacy* includes disclosure of items all related to instances in the counseling room or counseling process. Specifically, the eight items of Factor 1 refer to instances when supervisees felt they made a clinical mistake (e.g., implementing specific interventions, in their conceptualization of their client(s), regarding diagnosis, treatment planning and implementation, in psychological assessment

administration) and when supervisees felt conflicted about their counseling (e.g., felt their clinical decision making may not have been the most appropriate, having a difficult time feeling empathetic toward client(s), and feeling at a loss regarding treatment for client(s). Given the nature of all of these items, the label *Perceived Clinical Inadequacy* was chosen to reflect the importance of the supervisees' perception of their clinical mistakes and feelings of inadequacy, confusion, or confliction. Factor 2: *Transference Issues* includes disclosure of items all related to the supervisee in relation to another person (i.e., client(s) or supervisor). Items within this factor address both transference and countertransference but the general label of *Transference Issues* was used to signify the supervisees' reactions, redirection of feelings, and expectations in the counseling and supervision domains. Factor 3: *Strengths of the Supervisory Relationship* includes disclosure of items related to appreciation and respect for the supervisor. Factor 4: *Clinical Successes* includes items involving instances of positive clinical experiences (e.g., felt proud of the clinical work, received positive feedback from client(s), and implemented a specific intervention well) and positivity for the client(s) (e.g., feelings of pride for client(s) and general positive thoughts, feelings, or characterizations about client(s) as a person). While the items related to general positivity for the client(s) does not necessarily imply that a clinical success has occurred, the label *Clinical Successes* was chosen to highlight the positive nature of these disclosures related to the clinical experience. Factor 5: *Self* includes items relating to the supervisees' own life and identities beyond therapist and supervisee that may impact these roles. Items include difficulties in the supervisees' lives (e.g., thoughts about experiences or problems in the context of your life and trouble I'm facing with coursework, research, or other

academic/professional area) and general thoughts about self (e.g., thoughts about yourself in the context of your life). Factor 6: *Weaknesses of the Supervisory Bond* include items that reflect aspects related to Bordin's (1983) bond component of the supervisory working alliance. There is also one item that is not necessarily a concern regarding the bond but instead feedback about the supervisory alliance. Supervisees' disclosure of feedback about the supervisory alliance may or not may be related to weaknesses of the supervisory bond; however, this item hung with the other clearly identified items relating to weaknesses of the supervisory bond. Factor 7: *Dissatisfaction with Clinical Setting* includes items relating to boredom, dissatisfaction, negative opinions, and confusion with counseling and supervision components. Three items refer to dissatisfaction with counseling aspects that seem to stem from the nature of the clinical setting (e.g., boredom with the clinical work you are doing at the setting, dissatisfaction with the lack of variety of presenting problems on your caseload, and instance when you are uninterested in your clinical work). Two of the items refer to dissatisfaction with supervision (e.g., negative opinions about how supervision is structured and feeling confused about what supervision is). Participants were given the prompt, "please respond to the questions based on your experience with your current, primary supervisor" and therefore dissatisfaction with supervision is related to the supervision provided at a specific clinical setting rather than dissatisfaction with the general structure or purpose of the supervision as a process. Factor 8*: Own Clinical Voice* includes items that reflect supervisees choosing to venture into autonomy in their clinical work rather than mirroring their supervisor. Items include differences (e.g., instances when your theoretical orientation differs from your supervisor's and instances when your conceptualization of your

client(s) differs from your supervisor's conceptualization) and disagreement with supervisors (e.g., disagreement with your supervisor's clinical advice or intervention suggestions for your client(s).

The eight content areas of the SDS encompass the previously identified content areas from qualitative and quantitative findings (Wallace & Alonso, 1994; Ladany et al., 1996; Yourman & Farber, 1996; Mehr et al. 2010; and Hess et al., 2008). Table 5.1 provides an overview of the different content areas of supervisee nondisclosure found in the literature and the eight content areas of the SDS. All content areas of previous research seem to be captured by the 40-item SDS measure with an expansion of the content area *Dissatisfaction Related to Clinical Setting*. The previous research on supervisee non-disclosure identified supervision setting concerns; however, the SDS has items that also capture therapeutic dissatisfaction at the clinical setting. This is an important addition, as many supervisees are clinicians in training and as such need to determine what clinical settings, presenting problems, and client populations they are most interested in working with as part of their professional development. A large component of growth in supervision focus on professional development (Stoltenberg & McNeill, 2010) and assessing supervisee disclosure of this content area is important.

Table 5.1

*Eight Content Areas of Disclosure of the SDS and Content Areas of Non-Disclosure from Past Research*

| Content Areas of SDS | Content present in research: |
|---|---|
| Factor 1: Perceived Clinical Inadequacy | |
| Clinical mistakes | W (1994); L (1996); Y (1996); M (2010); H (2008) |
| Negative reactions to client | L (1996); Y (1996); M (2010) |
| Concerns about professional inadequacy | Y (1996); M (2010) |
| Factor 2: Transference Issues | |
| Countertransference | W (1994); L (1996); M (2010) |
| Client-counselor attraction issues | L (1996); M (2010) (combined intro attraction within the triad) |
| Supervisee-supervisor attraction issues | L (1996); M (2010) (combined intro attraction within the triad) |
| Supervisor appearance | L (1996) |
| Factor 3: Strengths of Supervisory Relationship | |
| Positive reactions to supervisor | L (1996); Y (1996); M (2010) |
| Factor 4: Clinical Successes | |
| Clinical successes | M (2010) |
| Positive reactions to client | L (1996) |
| General client observations | L (1996); M (2010) |
| Factor 5: Self | |
| Personal issues | L (1996); M (2010) |
| Professional and academic concerns | M (2010) |
| Factor 6: Weaknesses of the Supervisory Bond | |
| Negative perceptions of supervisor | L (1996); Y (1996); M (2010); H (2008) |
| Evaluation concerns | L (1996); Y (1996); M (2010) |
| Negative supervision experience | M (2010); H (2008) |
| Concerns about supervisor's perception of supervisee | M (2010) |
| Factor 7: Dissatisfaction Related to Clinical Setting | |
| Supervision setting concerns | L (1996) |
| Factor 8: Own Clinical Voice | |
| Therapeutic and theoretical difference with supervisor | W (1994); Y (1996); M (2010) |

*Note*: W = Wallace & Alonso, 1994; L = Ladany et al., 1996; Y = Yourman & Farber, 1996; M = Mehr et al., 2010; H = Hess et al., 2008.

**Supervisee Disclosure Scale: Disclosure and Nondisclosure**

The Supervisee Disclosure Scale is useful in helping to conceptualize a supervisee's willingness to disclose certain content areas. In this sample, content areas about the counseling process, both *perceived clinical inadequacy* and *clinical successes*, were the most likely to be discussed with supervisors. It is important to note the number of items per factor differs among the eight factors and therefore calculating the average item response per factor allowed statistical comparison among factor means to be evaluated. All factor means had a statistically significant difference from each other. It is interesting that supervisees were almost equally as likely to bring up issues of *Perceived Clinical Inadequacy*, Factor $M = 33.60$ ($SD = 6.0$), maximum = 40.0, average item score = 4.2, and *Clinical Successes*, Factor $M = 21.62.59$ ($SD = 2.86$), maximum = 25.0, average item score = 4.3. Using supervision as an outlet to discuss and analyze clinical skill implementation, conceptualization, and process seems to be important to supervisees, as evidenced by their willingness to disclose these topics. These two latent factors encompass the specific domains of clinical practice outlined in the integrative developmental model (IDM) of supervision: intervention skill competence, assessment techniques, interpersonal assessment, client conceptualization, and treatment plan and goals (Stoltenberg & McNeill, 2010). Supervisee disclosure of specific domains of clinical practice is an important aspect of the purpose of supervision; however, there are other important purposes of supervision such as fostering professional development of the supervisee (Bernard & Goodyear, 2014). Additionally, the discrimination model of supervision (Bernard, 1979) highlights the different roles of the supervisor (i.e., teacher,

counselor, and consultant) and foci of supervision (i.e., intervention, conceptualization, and personalization, i.e., processing). It seems that supervisees are very likely to disclose information that allows focus on intervention and conceptualization but may be less likely to disclose information that would focus on personalization or processing, such as items in Factor 2: *Transference Issues* (average item score = 2.2) and Factor 6: *Weaknesses of the Supervisory Bond* (average item score = 2.8). In this sample, items within Factor 2: *Transference Issues* were least likely to be discussed with supervisors and therefore could be conceptualized as an area of non-disclosure. Identifying issues of transference and countertransference is important when analyzing the clinical process and supervisees may greatly benefit from discussing these issues with their supervisor. Additionally, items within Factor 6: *Weaknesses of the Supervisory Bond* were on average rated as 'fairly unlikely' to 'unsure' by this sample and therefore could be conceptualized as another area of non-disclosure. Processing the supervisees' dissatisfaction with supervisory bond could be a fruitful learning experience in understanding the power differential and expectations within the dyadic helping relationship.

The Supervisory Disclosure Scale (SDS) seems to be a beneficial measure for identifying content areas of disclosure and non-disclosure. It is valuable to have a measure of both disclosure and non-disclosure for specific content areas for future research projects to specifically examine relationship with other variables. Additionally, supervisors and supervisees could evaluate their own content areas of disclosure and non-disclosure to raise awareness to potential areas of further exploration within supervision.

**Clinical Experience and Supervisee Disclosure**

Previous research findings have not supported supervisees' number of years in the training program (Yourman & Farber, 1996), months of counseling experience, total number of clients worked with, or number of supervision sessions with supervisor (Mehr et al., 2010) as predictor variables for aggregate supervisee disclosure. This study examined the aspects of clinical experience to include *months of supervised counseling experience, number of clients worked with clinically, weeks at current site, and number of individual supervision sessions with current supervisor* to better understand the relationship among clinical experience and specific content areas of supervisee disclosure. Following the Integrative Developmental Model (IDM) of supervision, it was hypothesized that greater clinical experience, for all four variables, would be related to an increase in disclosure of the content areas of the SDS. The variables of *Number of Clients* and *Number of Previous Individual Supervision Sessions with Current Supervisor* were not statistically significant predictors of any specific content areas of supervisee disclosure. The variable of *Months of Supervised Counseling* was a statistically significant predictor for only one specific content area of supervisee disclosure: Factor 5: *Self*. The variable of *Weeks at Clinical Site* was a statistically significant predictor for two factors: Factor 4: *Clinical Successes* and Factor 5: *Self*. As previously outlined, items within Factor 5: *Self* relate to the supervisee's personal life and identities beyond therapist and supervisee that may impact these roles. Items include difficulties in the supervisees' lives (e.g., thoughts about experiences or problems in the context of your life and trouble I'm facing with coursework, research, or other academic/professional area)

and general thoughts about self (e.g., thoughts about yourself in the context of your life). Understanding oneself and its relation to the counseling process is an important aspect of professional development of a clinician. Disclosure in supervision of one's own experiences, identities, and difficulties may be easier for clinicians with greater clinical experience because they have a greater focus on self/other awareness (Stoltenberg & McNeill, 2010). Given the same logic, that greater clinical experience may allow a clinician to have greater self/other awareness, it was expected to see greater disclosure of the factors of *Transference Issues, Strengths of Supervisory Relationship*, *Weaknesses of the Supervisory Bond*, and *Dissatisfaction Related to Clinical Setting*, since these content areas involve a greater awareness of self in relation to others, rather than a myopic focus on self and implementation of clinical skill. The results of this study did not support a relationship between aspects of greater clinical experience and disclosure of these specific content areas. It is possible that greater clinical experience is not a crucial component for disclosure. Instead, the relationship between the supervisor and supervisee may be more important for predicting disclosure than clinical experience itself.

**Working Alliance Inventory-Supervision, Short Factor Structure**

The factor structure of the Working Alliance Inventory-Supervision, Short (WAI-SS) was evaluated through confirmatory factor analysis using mean-and variance-adjusted weighted least squares (WLSMV) estimation due to the ordered nature of the data (i.e., categorical Likert responses). The WAI-SS was modified from the original Working Alliance Inventory-Short Form (Tracey & Kokotovic, 1989), which assessed the working alliance between client and therapist. The WAI-Short Form has a hierarchical bi-level factor structure of three specific first order factors of specific factors of *task*, *bond*,

and *goal* and then one *general alliance* second order factor. The hierarchical bi-level factor structure, a re-specified bi-level factor structure, and a three-factor structure were evaluated for the WAI-SS and the original bi-level model had the best fit indices. Despite the lack of good fit for all five fit indices, Satorra Bentler scaled chi-square (SB $\chi^2$), root mean square error of approximation (RMSEA) 90% confidence interval, weighted root mean square residual (WRMR), Tucker-Lewis index (TLI), and the comparative fit index (CFI), the hierarchical bi-level factor structure fit the data best. The bi-level factor structure had the best values for all the fit indices (i.e., higher TLI, CFI, lowest RMSEA, WRMR, and SB $\chi^2$. The standardized factor loadings of the first-order specific factors of the alliance, *task*, *bond*, and *goal* are similar to the standardized factor loadings of the original WAI-Short Form for clients, since supervisees would have the same position as clients in the client-therapist relationship (Tracey & Kokotovic, 1989). The confirmatory factor analyses conducted by Tracey and Kokotovic (1989) and of this study were conducted using different statistical analysis software and reported different model fit indices but information can still be gleaned from the standardized factor weights. Furthermore, the correlation residuals in the bi-level factor structure did not have high correlation residuals with indicators of another factor.

Although the hierarchical bi-level factor structure of the WAI-SS was the best fitting model, it is possible, given the weak factor loadings for items of the *bond* and *goals* factors, that this factor structure is not adequate. The factor of *goals* for the WAI-SS appears to be the most different in terms of factor loadings than the goals factor of the WAI-Short Form. It is possible that the *goals* aspect of the working alliance in therapy could be different than the *goals* aspect in supervision. In understanding the therapeutic

alliance, goals involve the need for the therapist and client to mutually value the outcomes of the intervention (Bordin, 1979). In the supervisory working alliance, it is possible that the goal could be less clearly defined given the dual purpose of evaluation/gatekeeping and professional growth and development of supervision (Bordin, 1983; Bernard & Goodyear, 2014). For example, the supervisee and supervisor may not have clearly defined and mutually valued outcomes of supervision because the purposes of supervision include evaluation/gatekeeping, fostering professional development of the counselor, and ensuring client welfare. Given the multifaceted purpose of supervision, it is possible that supervisees' goals for supervision and supervisors' goals for supervision are less clearly aligned than within therapy. In therapy, this dual purpose of evaluation/gatekeeping and personal growth/symptom reduction is not an issue and perhaps may lead to more clearly defined and mutually valued outcomes of the intervention. Therefore, the clarity of goals within therapy may contribute to the stronger factor loadings for the specific alliance factor of goals on the Working Alliance Inventory-Short Form than the specific factor of goals on the Working Alliance Inventory/Supervision-Short Form. Additionally, when Bahrick (1989) adapted the WAI for use in supervision, he found the lowest inter-rater agreement (60%) for statements relevant to the *goal* factor. Despite the weaker factor loadings for items of the factors of *goal* and *bond* for the WAI-SS, these two factors are related to more specific content areas of supervisee disclosure than the factor of task.

**WAI-SS Factors and SDS Specific Content Areas**

It is important to note that the analyses of the relationship between the factors of the supervisory working alliance and the specific content areas of supervisee disclosure

are based on factors identified through an exploratory factor analyses and therefore caution should be taken when interpreting these results. The factor structure of the Supervisee Disclosure Scale (SDS) should be validated via a confirmatory factor analysis in a future sample. Despite these caveats, conducing primary analyses of the relationship between the measures is beneficial in exploring potential relationships. As hypothesized, the hierarchical factor of general alliance had a statistically positive correlation with all specific content areas of disclosure. Additionally, all eight content areas of supervisee disclosure were statistically significant predictors of the hierarchical factor of general alliance; however, when examining the standardized coefficients only two content areas were significant, Factor 1, *Perceived Clinical Inadequacy*, and Factor 3*, Strengths of the Supervisory Relationship*. These findings support previous research suggesting the strength of the supervisory working alliance as a powerful predictor for supervisee disclosure (Webb & Wheeler, 1998; Mehr et al., 2015). Conversely, research has found a weaker supervisory working alliance to be related to supervisee nondisclosure (Ladany et al., 1996; Ladany et al., 1997; Gray et al., 2001). Unique to the literature regarding the relationship between supervisory working alliance and supervisee disclosure is this empirical examination of the hierarchical general alliance factor and the specific factors of bond, task, and goal. The findings of this study highlight the important differences in the relationships among the specific factors of the supervisory working alliance and specific content areas of supervisee nondisclosure.

The factor of *task* was not significantly correlated with any of the specific content areas. Of note, all correlations between task and specific content areas of supervisee disclosure were negative. If greater focus on the tasks of supervision is related to less

supervisee disclosure of all content areas, it is possible that this specific factor is important to keep in mind if supervisee disclosure is lacking.

The factor of *bond* had a statistically positive correlation with six specific content areas of supervisee disclosure; Factor 3: *Strengths of Supervisory Relationship*, Factor 4: *Clinical Successes*, Factor 5: *Self*, Factor 6: *Weaknesses of the Supervisory Bond*, Factor 7: *Dissatisfaction of Clinical Setting* and Factor 8: *Own Clinical Voice*. Furthermore, all eight content areas of supervisee disclosure were statistically significant predictors for *bond*; however, when examining the standardized coefficients, only one content area was significant, Factor 3, *Strengths of the Supervisory Relationship*. Understanding the unique importance that the bond has with supervisee disclosure may be especially important for increasing supervisee disclosure of the content areas that are less freely discussed (i.e., *Self*, *Weaknesses of the Supervisory Bond*, and *Dissatisfaction with Clinical Setting*). Supervisors could purposely focus on strengthening the bond with supervisees to more effectively supervise because more information will be disclosed.

The factor of *goal* had a statistically negative correlation with two specific content areas of supervisee disclosure, Factor 3: *Strengths of the Supervisory Relationship* and Factor 7: *Dissatisfaction with Clinical Setting*. Moreover, the factor of goal was a significant predictor for these specific content areas of supervisee disclosure. Understanding that a lack of clearly identified goals between supervisee and supervisor may relate to an increase in disclosure of dissatisfaction with the clinical setting is important for supervisee professional development. The goals of working in particular clinical settings, with certain populations, and engaging in certain types of therapy modalities may be misaligned with the supervisees' ultimate goals for their own

professional development. Supervisors should be listening for supervisees' disclosures regarding dissatisfaction with clinical setting and then encourage discussions related to the supervisees' short-term and longer-term professional development goals. In a paradoxical way, it may be that supervisees who feel less in sync with their supervisor's goals may try to connect by disclosing strengths of the supervisory relationship rather than focus on clinical components, as these could be misaligned with the supervisees' strengths.

**Limitations**

This study was designed and conducted as an attempt to further the literature on supervisee disclosure in clinical supervision. Creating a quantitative scale of the different content areas of supervisee disclosure and empirically evaluating its psychometric properties is helpful; however, there are several limitations to this study and should be taken into consideration for future research and generalization of the findings of this study.

The first major limitation of this study is one of measurement. In this study, the use of self-report data with the prompt, *ask yourself how likely are you to bring up issues of _____ with your current supervisor* was implemented as a method for evaluating supervisee disclosure. This method captures supervisees' perceptions of their willingness to disclose information to their supervisor; however, it does not capture actual disclosure or non-disclosure. This is an important difference. Additionally, responses of the Supervisee Disclosure Scale (SDS) are not necessarily indicative of the supervisee's intentions for disclosure. A response of not at all likely may be because that type of disclosure is not relevant for the supervisee and/or supervisor and not necessarily because

the supervisee does not want to disclose it. For example, a response of *not at all likely* for item 16: "Your concerns about your supervisor's competence to accurately evaluate you" could be because the supervisee does not have concerns about the supervisor's competence to accurately evaluate. On the other hand, the supervisee could have grave concerns about the supervisor's competence to accurately evaluate but is not at all likely to bring it up with the supervisor. The final measure limitation of the SDS is in item creation and lack of expert review of the items after their creation. Some of the items are wordy and unclear and thus may add layers of confusion in participant interpretation of each item. For example, SDS item 26: "Thoughts about yourself in the context of your life (e.g., your sexual orientation, your own beliefs not directly related to therapy)" could be interpreted numerous ways by different participants.

Another limitation of this study is the small sample size. Given the number of items of the SDS, a sample of at least 400 participants would have been ideal to split the dataset and run a confirmatory factor analysis after identification of the eight-factor structure through exploratory factory analysis. Related to sample size, the sample used in this study was primarily White (71%), female (81%), and heterosexual (80%). It is possible that different latent factors of disclosure may arise from a greater diversity in participant demographics.

**Directions for Future Research**

The results from this study present many opportunities for future research. First, a confirmatory factor analysis of the Supervisee Disclosure Scale (SDS) is necessary to confirm the eight-factor structure with a new sample of supervisees. Once the factor structure has been confirmed, examining the relationship with the supervisory working

alliance through structural equation modeling would be extremely beneficial. Mehr and colleagues (2015) found empirical support for the stronger supervisory working alliance and higher willingness to disclose in supervision; however, that study only assessed a total score of willingness to disclose. Additionally, given a potential bi-level factor structure for the WAI-SS, ipsatizing scores will be necessary for a valid assessment of the factors of the supervisory working alliance and this was not outlined in previous studies. A future study utilizing the SDS to identify specific content areas and their relationship with the supervisory working alliance could help to identify some important clinical implications for supervision.

An additional future research idea involves the dyadic relationship between supervisee and supervisor in terms of disclosure and supervisory working alliance. Understanding both sides of the supervisory relationship would be beneficial for both clinician and supervisors in training. Assessing actual supervisee non-disclosure longitudinally throughout a semester or year would be extremely informative to the clinical supervision field. Supervisees could complete the WAI-SS and the SDS after each supervision session with the following prompt, *In your last supervision session, if the following issue was relevant did you bring it up with your supervisor?* Individual growth models of the supervisory working alliance and supervisee disclosure and nondisclosure could be created and, similar to process and outcome research in psychotherapy, important patterns may arise that could generate potential supervision interventions or areas of awareness.

## Implications

The creation of the Supervisee Disclosure Scale and initial exploratory factor analysis of the factor structure of supervisee disclosure have clear implications for future research. The majority of previous research on supervisee nondisclosure was qualitative and the quantitative research focused on total scores of nondisclosures rather than identifying the specific content areas. The use of an empirically validated measure of supervisee disclosure (after confirmatory factor analysis supports the proposed eight-factor structure) will expand opportunities for research in clinical supervision. Increased awareness of unique factors of supervisee disclosure can lead to better supervision interventions. Eventually, a more thorough understanding of the supervisory working alliance for supervisees at risk for nondisclosure can help guide the supervisor to employ effective strategies for growth for these supervisees.

## Conclusion

This research study built on the previous research about the nature, extent, and importance of supervisee nondisclosure in clinical supervision (Wallace & Alonso, 1994; Ladany et al., 1996; Yourman & Farber, 1996; Mehr et al., 2010, Hess et al., 2008). Previous research on supervisee nondisclosure had either been qualitative in nature and helpful in explaining the content areas of supervisee nondisclosure or quantitatively examined a total score of occurrence of nondisclosure. This study created a quantitative measure, the Supervisee Disclosure Scale (SDS), to identify the different types of supervisee disclosure in clinical supervision. An exploratory factor analysis of the SDS revealed an eight-factor solution with latent factors of the following content areas of supervisee disclosure in supervision: (1*) perceived clinical inadequacy*, (2) *transference*

*issues*, (3) *strengths of supervisory relationship*, (4) *clinical successes*, (5) *self*, (6) *weaknesses of the supervisory bond*, (7) *dissatisfaction related to clinical setting*, and (8) *own clinical voice*. Often supervisors are unable to directly observe or review audio or video of the supervisee's clinical work and therefore rely on the supervisees to bring up issues for discussion in supervision (Amerikaner & Rose, 2012). The SDS is important because it highlights the unique importance of different content areas of supervisee disclosure. Further evaluation of the specific content areas of supervisee disclosure is necessary to be able to accurately assess potential differential relationships between types of supervisee nondisclosure and importance aspects of effective supervision. Understanding the manner in which specific types of supervisee nondisclosure relate to the specific factors of the supervisory working alliance may define practical considerations for tailoring responsive supervision to specific supervisees concerns.

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# APPENDIX A

[DEMOGRAPHIC INFORMATION]

Please answer the following questions about yourself:

1. Please select the gender with which you identify?
Male
Female
Transgender
Other, specify (free response)

2. What is your age?
(free response)

3. Please select the race with which you identify?
African American
Asian American
Caucasian/White
Latino/a/Hispanic
Native American or Alaska Native
Native Hawaiian or Other Pacific Islander
Biracial/Multiracial
Other, specify (free response)

4. Please select the sexual orientation with which you identify?
Gay
Lesbian
Heterosexual
Bisexual
Asexual
Pansexual
Other, specify

5. What is your current degree program of study?
Clinical Psychology
Counseling Psychology
Clinical Mental Health Counseling

6. What degree are you currently seeking?
Ph.D.
Psy.D.
Master's
Other, specify
(free response)

7. How many semesters have you completed in your program?
(free response)

8. Did you attend a different clinical or counseling graduate program, prior to your current program? If yes, how many semesters did you complete in that program?
Yes (free response box)
No

9. How many months of supervised counseling experience do you have?
(free response)

10. How many previous practica or supervised fieldwork sites have you completed?
(free response)

11. How many supervisors have you worked with prior to your current supervisor?
(free response)

12. At what setting are you currently doing clinical work?
Private Practice
Hospital/Medical Center
University Counseling Center
Community Mental Health Agency
Other, specify (free response)

13. How many weeks have you completed at your current site?
(free response)

14. How many clients have you worked with (please include clients you are presently working with)?
(free response)

15. How many individual supervision sessions have you completed with your current supervisor?
(free response)

16. How many hours of individual supervision do you receive per week?
(free response)

17. Is your supervisor for individual supervision your group supervisor, as well?
Yes
No
N/A (I don't receive group supervision)

18. How many group supervision sessions have you completed at your site?
(free response)

19. How many hours of group supervision do you receive per week?

(free response)

Please answer the following questions about your current supervisor:

1. Is your current supervisor a:
Student peer
Doctoral Student
Pre-doctoral Intern
Post-doc
Licensed Professional
Other, specify (free response)

2. What is your current supervisor's gender?
Male
Female
Transgender
Other, specify if known (free response)

3. What is your current supervisor's race/ethnicity?
African American
Asian American
Caucasian/White
Latino/a/Hispanic
Native American or Alaska Native
Native Hawaiian or Other Pacific Islander
Biracial/Multiracial
Other, specify (free response)
Don't know

4. What is your current supervisor's sexual orientation?
Gay
Lesbian
Heterosexual
Bisexual
Asexual
Pansexual
Don't Know

5. How many supervisees does your current supervisor have for individual supervision?
(free response)

# APPENDIX B

## WORKING ALLIANCE INVENTORY/SUPERVISION-SHORT (WAI-SS)

The following sentences describe some of the different ways a person might think or feel about her or his supervisor. Please reflect on your current supervisory experience. With each statement there is a seven-point scale:

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

1. My supervisor and I agree about the things I will need to do in supervision.
2. What I am doing in supervision gives me a new way of looking at myself as a counselor.
3. I believe my supervisor likes me.
4. My supervisor does not understand what I want to accomplish in supervision.
5. I am confident in my supervisor's ability to supervise me.
6. My supervisor and I are working towards mutually agreed-upon goals.
7. I feel that my supervisor appreciates me.
8. We agree on what is important for me to work on.
9. My supervisor and I trust one another.
10. My supervisor and I have different ideas on what I need to work on.
11. We have established a good understanding of the kinds of things I need to work on.
12. I believe the way we are working with my problems is correct

# APPENDIX C

## SUPERVISEE DISCLOSURE SCALE (SDS)

Please respond to the questions based on your experience with your current, primary supervisor.
Under each item there is a 5-point scale:

1= not at all likely, 2=fairly unlikely, 3=unsure, 4=fairly likely, 5=very likely

For each question, ask yourself how likely are you to bring up issues of _____ with your current supervisor?

1. Your feelings of flattery that your client(s) enjoys working with you.
2. Instances when you felt you made a clinical mistake in your interpersonal assessment of a client within or across sessions.
3. Your concerns that your supervisor does not think you're a good clinician.
4. Instances when your thoughts, in response to the dynamics occurring in the counseling relationship, are interfering with your clinical work with your client(s) (e.g., reflecting on areas not central to a client's concern, your own opinion on topics, etc.).
5. Issues related to your own mental well-being (e.g., feeling anxious or depressed).
6. Instances when your behaviors, in response to the dynamics occurring in the counseling relationship, are interfering with your clinical work with your client(s) (e.g., acting in a submissive manner, significant discrepancies between case note and what actually occurred, avoiding eye contact in session, making more suggestions to a client than usual, etc.).
7. Your appreciation for all that your supervisor has done for you.
8. General issues or discomfort with colleagues and other professionals at the setting.
9. Issues regarding client-counselor attraction (e.g., bringing up perceived or vocalized client attraction toward you).
10. Your feedback about the supervisory alliance.
11. Your concerns about your supervisor's perception of you as a person.
12. When information received from your supervisor differs from another source (e.g., literature, another supervisor, a textbook, a colleague).
13. Instances when you are irritated by behaviors, physical appearance, beliefs, or interpersonal characteristics of your client(s).
14. Instances when you feel at a loss regarding treatment for your client(s).
15. Feeling that your supervisor is distracted and/or not listening carefully to you.
16. Feeling frustrated with the perceived importance set on quantity of contact hours instead of quality, at your site.
17. Instances when you are uninterested in your clinical work.
18. Your attraction to your supervisor's brilliance.
19. Feeling confused about what supervision is.
20. Thoughts about yourself in the context of your life (e.g., your sexual orientation, your own beliefs not directly related to therapy).
21. Dissatisfaction with the lack of variety of presenting problems on your caseload.
22. Your own negative opinions about how supervision is structured (e.g., too rigid, too relaxed, lack of structure).

23. Negative thoughts, feelings, or descriptions of the personal characteristics of your supervisor.
24. Your concerns that your supervisor does not like you.
25. Boredom with the clinical work you are doing at the setting.
26. Trouble I'm facing at school with my coursework, research, or other academic/professional area.
27. Disagreement with your supervisor's diagnosis of your client(s).
28. Instances when you treat your client(s) in a disciplinary manner during session(s).
29. Instances when you engaged in too much self-disclosure with your client(s).
30. Instances when you expressed resentment toward or about your client(s).
31. Thoughts about your experiences or problems in the context of your life (e.g., issues related to personal or family crisis, when things in your life were overwhelming).
32. Your supervisor's microaggressions toward you.
33. Jealousy of a colleague at the setting (e.g., colleague has a full caseload, a better office, a different supervisor, etc.).
34. Your hesitation and/or concerns about what to share in supervision for fear of it reflecting poorly in your evaluation.
35. Your respect for your supervisor.
36. Instances when you are having a difficult time feeling empathetic toward your client(s).
37. Feeling pressure to do extra shifts, hours, reports, or outreach events at your practicum site.
38. Previous knowledge about the supervisor gained from previous supervisors/academic advisors/colleagues.
39. Instances when you felt you made a clinical mistake in your psychological assessment administration.
40. Your idolization of your supervisor.
41. Your thoughts or feelings about feeling drawn to or interested in your supervisor in a sexual or physical sense.
42. Instances you felt proud of the clinical work you have done with your client(s).
43. Your feelings of pride for your client(s).
44. Instances when you felt you made a clinical mistake in your treatment planning and implementation (e.g., sequencing of issues and interventions).
45. Your concerns about the fairness of your supervisor's evaluation of you.
46. Your general positive thoughts, feelings, or characterizations about your client(s) as a person.
47. Times when you felt misunderstood by your supervisor.
48. Feeling relieved when workload lessened (e.g., a client not continuing, a group ending, the semester ending, etc.).
49. Instances when you felt you made a clinical mistake in your conceptualization of your client(s).
50. Issues regarding counselor-client attraction [e.g., bringing up attraction that you feel toward your client(s)].
51. Your appreciation for feeling supported by your supervisor.
52. Instances when you are bored with your client(s).

53. Instances when you received positive feedback from your client(s).
54. Your positive thoughts or feelings about your supervisor's external image (e.g., dress/fashion habits, visible ability to handle stress, etc.).
55. Your concerns about your supervisor's evaluation of your personal characteristics versus your professional characteristics.
56. Negative thoughts, feelings, or descriptions of the professional characteristics of your supervisor.
57. Your concerns about how your supervisor will evaluate you.
58. Your negative thoughts or feelings about your supervisor's external image (e.g., dress/fashion habits, visible anxiety/stress).
59. Instances when your feelings, in response to the dynamics occurring in the counseling relationship, are interfering with your clinical work with your client(s) (e.g., hostility, love, protectiveness, guilt, envy, apathy, etc.).
60. Your thoughts or feelings about perceived or vocalized supervisor attraction toward you.
61. Your supervisor's microaggressions toward clients.
62. Instances when you implemented a specific intervention well.
63. Instances when you acted flirtatious with your client(s).
64. Your concerns about your supervisor's competence to accurately evaluate you.
65. General doubt you may have about wanting to be a therapist.
66. Instances when you felt you made a clinical mistake regarding your diagnosis for your client(s).
67. Instances when you daydream about relationships or events triggered by your client(s).
68. Instances when you have felt that your clinical decision making may not have been the most appropriate.
69. Instances when you lose neutrality and side with your client(s).
70. Your feelings of closeness with your client(s).
71. Instances when you feel your personal issues are interfering with your clinical work with your client(s).
72. Feeling overwhelmed by the setting's procedures (e.g., paperwork).
73. Your personal opinions about the positive characteristics of your supervisor.
74. Instances when your conceptualization of your client(s) differs from your supervisor's conceptualization.
75. Instances when you felt you made a clinical mistake in implementing specific intervention(s) with a client.
76. Disagreement with your supervisor's clinical advice or intervention suggestions for your client(s).
77. Instances when you are frustrated by your client(s) (e.g., perceived lack of progress or motivation).
78. Instances when your theoretical orientation differs from your supervisor's.
79. Other*
*Please describe and rate using Likert scale above (free response box provided)

# APPENDIX D

## 40-ITEM SUPERVISEE DISCLOSURE SCALE (SDS)

Please respond to the questions based on your experience with your current, primary supervisor.

Under each item there is a 5-point scale:
1= not at all likely, 2=fairly unlikely, 3=unsure, 4=fairly likely, 5=very likely

For each question, ask yourself how likely are you to bring up issues of _____ with your current supervisor?

Factor 1: Perceived Clinical Inadequacy
1. Instances when you felt you made a clinical mistake in implementing specific intervention(s) with a client.
2. Instances when you felt you made a clinical mistake in your conceptualization of your client(s).
3. Instances when you felt you made a clinical mistake regarding your diagnosis for your client(s).
4. Instances when you have felt that your clinical decision making may not have been the most appropriate.
5. Instances when you felt you made a clinical mistake in your treatment planning and implementation (e.g., sequencing of issues and interventions).
6. Instances when you felt you made a clinical mistake in your psychological assessment administration.
7. Instances when you are having a difficult time feeling empathetic toward your client(s).
8. Instances when you feel at a loss regarding treatment for your client(s).

Factor 2: Transference Issues
9. Instances when you acted flirtatious with your client(s).
10. Your thoughts or feelings about perceived or vocalized supervisor attraction toward you.
11. Your thoughts or feelings about feeling drawn to or interested in your supervisor in a sexual or physical sense.
12. Negative thoughts, feelings, or descriptions of the professional characteristics of your supervisor.
13. Instances when you daydream about relationships or events triggered by your client(s).
14. Your negative thoughts or feelings about your supervisor's external image (e.g., dress/fashion habits, visible anxiety/stress).
15. Your idolization of your supervisor.
16. Your concerns about your supervisor's competence to accurately evaluate you.

Factor 3: Strengths of Supervisory Relationship
17. Your appreciation for all that your supervisor has done for you.
18. Your respect for your supervisor.

19. Your appreciation for feeling supported by your supervisor.

Factor 4: Clinical Successes
20. Instances you felt proud of the clinical work you have done with your client(s).
21. Instances when you received positive feedback from your client(s).
22. Instances when you implemented a specific intervention well.
23. Your feelings of pride for your client(s).
24. Your general positive thoughts, feelings, or characterizations about your client(s) as a person.

Factor 5: Self
25. Thoughts about your experiences or problems in the context of your life (e.g., issues related to personal or family crisis, when things in your life were overwhelming).
26. Thoughts about yourself in the context of your life (e.g., your sexual orientation, your own beliefs not directly related to therapy).
27. Trouble I'm facing at school with my coursework, research, or other academic/professional area.

Factor 6: Weakness of the Supervisory Bond
28. Feeling that your supervisor is distracted and/or not listening carefully to you.
29. Your concerns that your supervisor does not think you're a good clinician.
30. Your concerns about your supervisor's perception of you as a person.
31. Your feedback about the supervisory alliance.
32. Your concerns that your supervisor does not like you.

Factor 7: Dissatisfaction with the Clinical Setting
33. Boredom with the clinical work you are doing at the setting.
34. Dissatisfaction with the lack of variety of presenting problems on your caseload.
35. Instances when you are uninterested in your clinical work.
36. Your own negative opinions about how supervision is structured (e.g., too rigid, too relaxed, lack of structure).
37. Feeling confused about what supervision is.

Factor 8: Own Clinical Voice
38. Disagreement with your supervisor's clinical advice or intervention suggestions for your client(s).
39. Instances when your theoretical orientation differs from your supervisor's.
40. Instances when your conceptualization of your client(s) differs from your supervisor's conceptualization.

# APPENDIX E

# IRB APPROVAL LETTER

EXEMPTION GRANTED

Bianca Bernstein
CLS - Counseling and Counseling Psychology
480/965-2920
bbernstein@asu.edu

Dear Bianca Bernstein:

On 6/20/2016 the ASU IRB reviewed the following protocol:

| | |
|---|---|
| Type of Review: | Error! Hyperlink reference not valid. |
| Title: | Are all nondisclosures created equally? An exploratory factor analysis of the content of supervisee nondisclosure in clinical supervision. |
| Investigator: | Bianca Bernstein |
| IRB ID: | STUDY00004505 |
| Funding: | None |
| Grant Title: | None |
| Grant ID: | None |
| Documents Reviewed: | • Survey Measures , Category: Measures (Survey questions/Interview questions /interview guides/focus group questions);<br>• Informed Consent, Category: Consent Form;<br>• Recruitment Script, Category: Recruitment Materials;<br>• HRP-503a Protocol Social Behavioral, Category: IRB Protocol; |

The IRB determined that the protocol is considered exempt pursuant to Federal Regulations 45CFR46 (2) Tests, surveys, interviews, or observation on 6/20/2016.

In conducting this protocol you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

Sincerely,

IRB Administrator

cc: Laura Hachiya