

**An investigation of therapist self-disclosure
in the therapeutic and supervisory contexts.**

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Declaration

This work has not been submitted to any other institution or for any other qualification.

Abstract

Introduction: Therapist self-disclosure within the therapeutic context has been the subject of discussion since early on in the history of psychotherapy. However, therapist self-disclosure can also be viewed within the context of supervision. There would now appear to be a movement towards acknowledging the benefits of self-disclosure within both contexts and the investigation of factors involved would seem appropriate for investigation. **Literature review:** The literature review suggested that therapist self-disclosure was facilitated and inhibited by a number of different mechanisms e.g. alliance. Supervisee self-disclosure within supervision appeared largely a function of the development of a good supervisory relationship with supervising therapist self-disclosure and therapist self-disclosure within the therapeutic dyad being much more about personal choice and style. **Research report:** Given that self-disclosure and discussion of clinical mistakes is felt within clinical psychology to be beneficial to the learning and development of trainee clinical psychologists an 'online' questionnaire study based on the Theory of Planned Behaviour (TPB) was devised. The purposes of the study were to assess trainee clinical psychologists' intention to disclose personal clinical mistakes in supervision and whether intention was associated with the strength of supervisory relationship and team climate. The TPB was found to predict intention to disclose personal clinical mistakes in supervision. No other variables were found to add significantly to the model of prediction. However, intention was associated with a number of other variables including supervisory rapport. **Critical Appraisal:** An appraisal of the research process is submitted with discussion of methodological limitations, clinical implications and possible areas for future research.

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The mechanisms involved in the facilitation and inhibition of therapist self-disclosure: A review of the literature.

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Abstract

Objectives

There is some evidence to suggest that therapist self-disclosure may be beneficial within the context of the therapeutic dyad and that the debate about such a form of self-disclosure has moved on from whether or not to self-disclose to how best to utilise it. Within the supervisory dyad it is argued that self-disclosure is essential. This paper reviews and attenuates current understanding of issues that affect the use of self-disclosure by therapists in different contexts.

Method

Research that was concerned with the investigation of factors that facilitated or inhibited therapist self-disclosure within the therapeutic and supervisory dyads was identified. Material was gathered from studies in USA and Britain. Limitations of the research methodology were identified including lack of cross-cultural research.

Results

The findings showed that there are a variety of mechanisms involved in the facilitation and inhibition of therapist self-disclosure e.g. alliance. It appeared that supervisee self-disclosure within supervision was largely a function of the development of a good supervisory relationship with supervising therapist self-disclosure and therapist self-disclosure within the therapeutic dyad being much more about personal choice and style.

Conclusions

This review illustrates that if therapist self-disclosure is believed to be beneficial then more specific thought about what factors influence this behaviour is required in relation to how particular types of material e.g. clinical mistakes, come to be disclosed.

Introduction

Therapist self-disclosure can be considered from three different standpoints: therapist to client, therapist to supervisor therapist and supervisor therapist to therapist. (Farber, 2003a; Stricker, 2003). The purpose of the present review is to examine the factors affecting therapist self-disclosure within two settings, therapy and supervision.

The papers are organised in two sections: (1) Mechanisms facilitating or inhibiting therapist disclosure in the therapeutic dyad and (2) Mechanisms facilitating or inhibiting supervising and supervisee therapist disclosure in supervision. Both sections will include analysis of the limitations of the research. Before doing this I will summarise literature on purpose/effect and ethical considerations of self-disclosure followed by a concise outline of the terminology used and the inclusion criteria for the review.

The literature within the therapist to client relationship encompasses themes that relate to the relationship of self-disclosure with transference. Geller (2003) argues that those utilising the analytic perspective in practice have been involved in an ongoing struggle with Freud's (1912/1958) injunction that: "The analyst should remain opaque to his patients, like a mirror and show them nothing but what is shown to him" (p118). He goes on to suggest that there has been some movement away from the blank screen approach by modern authors (Davies, 1994; Renik, 1995, 1999; Raines, 1996; Goldstein, 1997), towards an approach that considers the role of therapist self-disclosure (Mathews 1988). Much of the focus of discussion within analytic approaches appears now to be directed towards the relationship between self-disclosure and transference/countertransference (Ginot, 1997; Ulman, 2001, Davis, 2002).

Secondly, there have been a number of studies and reviews on the potential impact of therapist self disclosure (Mathews, 1989; Watkins 1990; Hill & Knox, 2001; Barrett &

Berman 2001) in the therapeutic arena. Thirdly there have been a number of papers looking at the implications of the disclosure by therapists of serious ill health and experiences of the therapist. Bram (1995) reviewed the ethical and clinical considerations relating to physically ill or dying therapists and more recently other researchers (Lerner & Cunningham, 2001; Silver, 2001; Farjardo, 2001) have addressed this issue.

The ethical considerations relating to therapist disclosure in therapy have also been reported on by a number of authors (Widmer, 1995; Mahalik, Van-Ormer & Simi, 2000; Peterson, 2002). Peterson (2002) argues that the research overall suggests that therapist self-disclosure leads to both positive and negative experiences for clients. She also argues how ethical a self-disclosure is relates to factors such as personality characteristics of the client, the composition of the disclosure and the rationale of the therapist for the disclosure.

The other area relevant to this review is disclosure within the supervisory relationship. Work in this area appears to be somewhat limited in its scope and depth. There are a number of papers that discuss the disclosure of countertransference in the supervisory relationship and how this can be used to deal with such issues as therapeutic impasses, gridlocked supervision and painful affects (Coburn, 1997; Streat, 2000; Brown & Miller, 2002; Maroda, 2003). Wallace and Alonso (1994) have described the factors relating to how supervisees decide what to disclose or maintain as private in supervision and Ladany & Walker (2003) have provided a framework to enable supervisors to judge the effectiveness of their own disclosure in supervision.

Wallace and Alonso (1994) argue that disclosure is essential to supervision. They assert that it is necessary because of the reliance of the supervisor on information offered by the

supervisee in building a broad and deep understanding about the client and to facilitate development of the trainee's psychotherapeutic skills. It appears from the literature discussed above that there has been some relatively wide attempt to investigate the issues relating to self-disclosure by therapists within the psychotherapeutic context. It seems there has been some recent discussion about the benefits and costs of such a practice (Psychopathology Committee of the Group for the Advancement of Psychiatry, 2001).

It seems that therapist self-disclosure is a potentially useful tool in the context of psychotherapeutic practice. Self-disclosure by supervisees in the context of their supervision is also important in the context of their learning, as well as for other reasons such as safety of the client. In addition, if as suggested by Ladany and Walker (2003), supervisor self-disclosure in supervision may be helpful in terms of supervision outcome then it would be useful to know the mechanisms by which self-disclosure may occur.

Method of Literature Search

A variety of search procedures were employed in combination to enable the identification of pertinent research articles in this area. Initially computerised literature searches were carried out utilising appropriate health and social science databases. Databases included were as follows: PSYCHINFO, Medline, EMBASE, WOS (Web of Science, Citations Index) and ASSIA (Applied Social Sciences Index and Abstracts).

The search period ranged from 1st January 1967 – May 2004 using the following key terms: nondisclosure, self-disclosure, disclosure, psychotherapy, trainee(s), supervisor(s), supervisee(s), supervision, therapist(s), counselor, counsellor, alliance, relationship, style, privacy, development. Some of the studies included in the review were detected through

privacy, development. Some of the studies included in the review were detected through citation in other research papers and through dialogue via e-mail with an author in this area.

Terminology and inclusion criteria

The use of the word therapist in the context of this review covers a broad range of individuals practising psychotherapy including clinical psychologists, trainee clinical psychologists, counselling psychologist, psychotherapists, counsellors, trainee counsellors and social workers¹.

The articles that have been used in the examination of the mechanisms that may be involved in therapist self-disclosure are from peer reviewed journals. Articles that related to mechanisms involved in therapist self-disclosure in the therapeutic environment, supervisee/trainee self-disclosure in supervision and supervisor self-disclosure in supervision were included, but those articles relating to patient self-disclosure were excluded. In the course of current article reference will be made to literature that can be contested on the grounds of both methodology and in relation to the generalisability of the material.

Mechanisms facilitating or inhibiting therapist disclosure in the therapeutic dyad

Theoretical Orientation

Amongst factors that may be important in enabling therapist disclosure to clients within the context of a therapeutic encounter is the theoretical position of the therapist. In a review of analogue and naturalistic psychotherapy literature, Hill and Knox (2001), in discussing the use of therapist self-disclosure in psychotherapy, indicated that humanistic-

¹ Articles related to social work practice were those that investigated the social worker as therapist as opposed to other roles that social workers are involved in e.g. case management.

experiential therapists self-disclosed more often than psychoanalytically oriented therapists. Brunink and Schroeder (1979) carried out a content analysis of audiotaped therapy interviews employing an instrument constructed by the authors called the System for Assessing Therapeutic Communications. The participants were 18 psychoanalytically oriented, gestalt or behaviour therapists. The three different orientations were compared over six behavioural dimensions including therapist self-disclosure. Findings suggested that gestalt therapists operated in a way that was distinct from the other two types over the six dimensions. The authors record that differences were demonstrable in the amount of self-disclosure that therapists from different orientations engaged in and reported that gestalt therapists employed more self-disclosure than psychodynamically oriented or behaviour therapists.

Findings from other studies have also suggested that orientation may be involved in the use of self-disclosure by therapists. A study of clinical social workers in Oregon, Anderson and Mandell (1989) developed a 148-item questionnaire that examined the extent that professional social workers utilised self-disclosure and adherence to guidelines dictating the use of the technique. The measure included the use of categories from the Jourard Self-Disclosure Questionnaire (Jourard 1971). The authors reported that those respondents who identified themselves as practising from the psychodynamic perspective observed the proscription of self-disclosure in psychodynamic literature.

As with the Brunink and Schroeder (1979), Simon (1988) utilised experienced clinicians as participants. She interviewed eight therapists, exploring the basis on which they utilised intentional therapist self-disclosure. The selection of these therapists for interview was

¹ Articles related to social work practice were those that investigated the social worker as therapist as opposed

achieved through ranking 27 returned questionnaires that scaled high and low disclosers and choosing the four who fell at the extremes of each. The author recounts that the theoretical orientation of the therapist was the principal element in therapist self-disclosure. Those who were labelled high disclosers came from eclectic, humanistic and existential orientations whereas the low disclosers came from orientations where transference was used as a central feature of their practice and were on the whole disinclined to use therapist self-disclosure.

Experience

A second factor that has relevance to the facilitation or prevention of therapist self-disclosure is the experience of the therapist. Andersen and Anderson (1989) developed a questionnaire, to which 96 counsellors responded assessing the frequency with which therapists divulged manifold types of information to their clients and the level of effectiveness that they believed divergent classes of therapist response achieved. One of the suggestions made by the authors about the data is that therapist use of self-disclosure may increase with experience.

In an investigation of the prevalence of self-referent statements of 91 counsellors, Robitschek and McCarthy (1991) found that for male participants that there was a negative correlation between experience and self-reference. The authors describe self-referent statements as positive and negative self-disclosure and positive and negative self-involving responses. The measure used was the Self-Reference Questionnaire (SRQ) that was based on the Self-Disclosure Questionnaire (Berg-Cross, 1984). Data from the survey revealed that for male counsellors, the greater the experience they had the less self-reference they engaged in.

Some researchers have suggested that inexperienced therapists are more likely to self-disclose. In a qualitative study of neophyte and experienced therapists Nutt-Williams, Polster, Grizzard, Rockenbaugh and Judge (2003), found that inexperienced therapists used self-disclosure to enable the management of distracting self-awareness. In this investigation the authors interviewed 12 therapists, (6 novice therapists and 6 experienced therapists). The six novice therapists were first year doctoral counselling psychology students and the experienced therapists were doctoral level licensed psychologists who had at least three years experience in private practice. The authors carried out a pilot interview with one counselling psychologist who was not associated with the research. The interviews were conducted over the phone and were recorded on audiotape. The protocol for the interviews included several open questions relating to the therapist's experiences based on the knowledge of the literature of the researchers but were mainly related to the research study questions.

Simone, McCarthy and Skay (1998) carried out the only direct investigation into the variables affecting the likelihood of self-disclosure by counsellors. These authors developed a questionnaire that included three parts. These were demographic data, including age, gender, ethnicity, theoretical orientation and experience. Secondly, four disclosure scenarios containing four vignettes about which participants had to imagine themselves involved and then rate the likelihood that they would disclose under those circumstances on a 5-point Likert scale (1=never/almost never to 5 = very likely) for 9 diagnostic categories and self-disclosure criteria. The results of this study suggested that there was no difference in self-disclosure based on the level of experience though all of the counsellors interviewed were categorised as experienced counsellors.

Education

Simone et al (1998) report that those counsellors who had experienced at least one helpful self-disclosure in their own counselling experience by their own counsellor they were more likely to disclose. Simon (1988) reports that the high disclosers in her study had considerably fewer hours of personal psychotherapy experience. Anderson and Mandell (1989) who found 82% of respondents in their study had some professional education in self-disclosure record that 36% increased their use of the technique due to education whereas 22% decreased their use of it.

Other factors

Constantine and Kwong-Liem (2003) argue that cross-cultural therapeutic dyads may lead to more disclosure by therapists. They utilise case illustrations to demonstrate this. Flaherty (1979) described in 6 clinical vignettes the variety of reactions by his clients to his self-disclosure that he was that he was about to get married. He proposes a broad range of reasons for self-disclosure by the therapist. These include therapist variables such as personality, style and background and patient related variables, e.g. patient diagnosis and patient/therapist interaction factors such as precedents for disclosure. Simone et al (1998) also recount that the diagnoses of the individual affected the likelihood of disclosure i.e. participants were more likely to disclose to clients with anxiety, adjustment or post-traumatic stress disorders than those with personality, conduct and impulse control disorders. This finding was also reflected in the study carried out by Anderson and Mandell (1989) who found that self-disclosure of the therapist was more likely to occur where the client had an anxiety or adjustment disorder as opposed to psychotic, personality, substance abuse or affective disorder.

Lastly, Anderson and Mandell (1989) suggest that therapist/client similarity may be a factor in facilitating therapist self-disclosure. They found when gender, marital status, age, social class, race and diagnostic category were taken into account that the most likely recipient of self-disclosure was a married middle class white female between the ages of 20-50.

The research that has been carried out in relation to this area appears to have shown that there are a number of factors that may facilitate or hinder the self-disclosure of the therapist in the context of a therapeutic encounter. These include therapist orientation, (Brunink and Schroeder, 1979; Anderson & Mandell, 1989; Simon, 1988) and experience, (Andersen and Anderson, 1989; Simone et al 1998). There are a number of issues that can be raised in relation to the research in this area.

Firstly, it would be difficult to generalise the findings from these studies in that they are all studies carried out in the United States of America and so we do not know whether and how the inferences made from the data would apply to counsellors in Europe for instance. In fact the studies cited are not particularly widespread in terms of the United States and they certainly could not be said to reflect a nationwide sample.

The data also apply only to counsellors and clinical social workers and not to other practitioners e.g. counselling or clinical psychologists. In one case (Nutt-Williams et al 2003) some of the participants were from private practice. There may be different attitudes towards self-disclosure in private practice because of the financial relationship involved than there would be in somewhere like a National Health Service setting. The numbers of participants in the studies tend to be small with the largest number of participants being 160 (Anderson & Mandell, 1989). The authors mostly devised the questionnaires used and so they are specifically related to the individual study and only one (Robitschek & McCarthy 1991) report the internal reliability of the devised scales.

The favoured methodologies are questionnaires and interview with clinicians and there is only one attempt at some form of experimental design (Simon 1988). A couple of the studies employ idiosyncratic methods (Flaherty, 1979; Simon, 1988). Robitschek and McCarthy (1991) and Anderson and Mandell (1989) are the only two sets of authors to utilise standardised measures in the development of their own instruments. Of the other two studies Simon (1988) does not describe the way in which the content analysis was carried out in order to derive the stated themes and Flaherty (1979) writes that his study lacks experimental design.

Lastly, there is generally a lack of clarity in terms of the definitions of self-disclosure. There is a wide range of potential material that might be disclosed e.g. demographic information such as marital status, positive or negative feelings toward the client or their situation and personal revelations of comparable experience. This is reflected in a couple of the studies (Andersen & Anderson, 1989; Robitschek and McCarthy, 1991). The investigation by Simone et al (1998) emphasises the varied scenarios and clients that a therapist may encounter. These studies highlight the complexity of self-disclosure but none of the studies appear to focus on any one particular area in order to draw out some more specific data about the nature of self-disclosure in this situation.

Mechanisms facilitating or inhibiting supervising and supervisee therapist disclosure in supervision

Supervisor disclosure

Three studies (Ladany & Lehrman-Wateman, 1999; Ladany and Melincoff, 1999; Ladany, Walker & Melincoff, 2001) have looked at factors relating to supervisor disclosure in the context of supervision. Ladany and Lehman-Wateman 1999 used the Supervisor Self-Disclosure Questionnaire that was developed specifically for the study. This again used the

same thought listing technique (Cacioppo & Petty 1981) as in the Ladany et al (1996) study. They also utilised the Supervisory Styles Inventory (Friedlander & Ward, 1984) and the Working Alliance Inventory-Trainee Version (Bahrck, 1990). The authors surveyed 105 trainee counselling and clinical psychologists. Ladany and Lehrman-Waterman (1999) argue that the results demonstrated that supervisors who were more friendly and open and had an attractive style were perceived to have disclosed more frequently. They also argued that the data supported their contention that the strength of the supervisory working alliance would be predicted by supervisor self-disclosure.

In a study that investigated supervisor perceptions of their supervisory style and components of the supervision process, Ladany, Walker and Melincoff (2001) found a significant positive correlation between attractive, interpersonally sensitive and task-oriented supervisory styles and the frequency of supervisor self-disclosure. The authors utilised Supervisory Styles Inventory (Friedlander & Ward, 1984), the Working Alliance Inventory-Supervisor version (WAI-S), the Supervisor Self-Disclosure Inventory (SSDI) (Ladany & Lehrmann-Waterman, 1999) and a demographic questionnaire to gather data from 137 counsellor supervisors.

Ladany and Melincoff (1999) examined the kinds of information that is not disclosed by counsellor supervisors. Using the same method of questionnaire development as Ladany and Lehrman-Waterman (1999) and Ladany et al (1996) they produced the Supervisor Nondisclosure Questionnaire. They surveyed 90 supervisors of counselling and clinical psychology trainees. Of the many factors related to the 12 categories of nondisclosure included were concerns over possible damage to the supervisory relationship and anticipated negative trainee reaction.

Supervisor variables

Duan and Roehlke (2001) surveyed 60 professional psychology predoctoral interns and 58 supervisors who had been recognised as engaged in supervisory dyads that were cross-racial. They developed the Cross-Racial Supervision Survey that included scaled items and open-ended questions. The authors report that supervisees in these dyads were more comfortable self-disclosing in these relationships than their supervisors understood them to be and that the degree of comfort was related to the positive personal attitudes and positive characteristics of the supervisor.

Supervisee disclosure

The alliance (Bordin 1983; Efstation, Patton & Kardash, 1990; Ladany & Friedlander 1995) between supervising therapist and supervisee has been identified as a mechanism involved in supervisee disclosure within the supervisory relationship. In a questionnaire study of 108 supervisees Ladany, Hill, Corbett and Nutt (1996) found a wide range of factors influencing what supervisees did not tell their supervisors. This included poor alliance with the supervisor that reflected negative feelings or thoughts associated with the supervisor-supervisee interaction. The questionnaire used for the study (The Supervisee Nondisclosure Survey) was developed for the investigation by the authors through a number of pilot studies. The questionnaire's format was founded on the cognitive assessment research technique of thought listing (Cacioppo & Petty, 1981). The technique lets participants report thoughts in freeform. The participants in this study were asked to record thoughts, feelings and reactions that had not been disclosed by them in their supervision so far. They were supplied with definitions of a number of areas in which nondisclosures might take place. They also used the Supervisory Styles Inventory (Friedlander & Ward, 1984) a 33-item self report measure, the Supervisory Satisfaction Questionnaire which was a modified

version of the Client Satisfaction Questionnaire (Larsen, Attkisson, Hargreaves & Nguyen, 1979) and a demographic questionnaire.

Several other studies have found that relationship plays a role in disclosure (Ladany, O'Brien, Hill, Melincoff, Knox & Peterson, 1997; Walsh, Gillespie, Greer & Eanes 2002; Webb & Wheeler, 1998). Ladany et al (1997) carried out interviews with 13 predoctoral interns in regard to an occurrence of sexual attraction toward a client, how supervision was used to deal with the issue and training around sexual attraction that had occurred prior to the incident. They used a semi-structured interview using open-ended questions, as propounded by McCracken (1988). The authors found that the key factor in whether a trainee disclosed the sexual attraction was the supervisory relationship. Supervisees were particularly likely to disclose where the relationship was mainly positive and supportive.

Webb and Wheeler (1998) investigated the level to which psychodynamic counsellors felt able to disclose in supervision. In this study 96 counselling trainees were surveyed using a questionnaire developed by the authors to measure participant sensitivity to disclosing notable issues in supervision and to enable the evaluation of particular barriers to disclosure. The authors also employed the Supervisory Working Alliance Inventory (SWAI) designed by Efstation et al (1990) as a section of the newly designed questionnaire. Webb and Wheeler (1998) found a positive correlation between the level of rapport perceived by supervisees and the capacity of those supervisees to disclose issues that related to their clients or counselling.

Walsh et al (2002) surveyed 75 pastoral counselling students employing the Factors Affecting Supervisee Disclosure to Supervisors checklist and the Self-Disclosure of Clinical Mistakes Form that were developed specifically for the study. They also used the Mutual

Psychological Development Questionnaire (Genero, Miller & Surrey 1992) and the Relational Health Indices (Liang et al 2002). The authors record that the most important factor governing trainees' readiness to disclose awkward material to supervisors was the quality of the supervisory relationship and assert that mutuality within the relationship was also an influential factor.

Shame

Two studies (Yourman, 2003; Yourman & Farber, 1996) have found a relationship between shame and disclosure. Yourman and Farber (1996) conducted a study looking at disclosure patterns of psychotherapy trainees. Specifically, the focus was conscious concealment and distortion of event and feelings that occurred in therapy. A 66 item Supervisory Questionnaire was developed for the study based on literature review and a questionnaire that looked at supervisees' experience of supervision and their supervisors (Black, 1987) and 93 participants, mainly doctoral students in clinical psychology, completed the questionnaire. The authors argued from the results that supervisee feelings of shame was most instrumental in giving rise to supervisees not disclosing and distorting within supervision.

A more recent study by Yourman (2003) focussed specifically on the impact of shame in relation to trainee disclosure in psychotherapy supervision. The author presents discussions about four supervisory dyads in relation to trainee shame. He describes potential triggers for the supervisee's shame, the disruption to communication that ensues and how improvements might have been made to the situation.

Other factors

In the study by Ladany et al (1996) they describe a wide variety of material that trainees do not disclose in supervision, including negative reactions to the supervisor, clinical mistakes, negative reactions to the client and supervisee/supervisor attraction issues. A broad range of factors relating to the decision not to disclose are also derived from the data, such as perceived unimportance, impression management, political suicide and deference.

Yourman and Farber (1996) argue factors such as the intrinsic difficulty of communicating accurately the complexity of interaction between therapist and client, lack of awareness by the trainee in regard to some events and interactions in therapy sessions are relevant. This is a factor that is also alluded to by Yerushalmi (1992). These variables and feelings relating to self-esteem and fear of conflict may interfere with disclosure. Webb and Wheeler (1998) argue that other variables as well as the supervisory relationship have some bearing on disclosure. These include trainee status, significance of the supervision setting and choice of supervisor.

Ladany and Melincoff (1999) report a number of factors that lead supervisors to withhold disclosures to trainees. These incorporated perceived unimportance, inappropriateness of topic for supervision, possible damage to the supervisory relationship, or discomfort that discussion of some issues might cause a trainee e.g. sexual attraction of supervisor to trainee. In a paper by Yerushalmi (1992) the concealment of the unique object-relational therapeutic reality is discussed. The author proposes that there are a number of structural variables that underlie the supervisory interview that contribute to supervisees resisting full disclosure of the therapeutic reality and different styles of concealment are drawn.

Yerushalmi (1992) cites Fleming and Benedek (1983) who have argued that shame,

anticipation of humiliation and a fear of being found lacking in some respect is the anxiety most frequently behind unwillingness to disclose therapeutic actuality. The author also argues that elements such as the wish to keep a feeling of separation and individuation, ambivalence, resistance to inner change and jealousy may all be involved in concealment within supervision.

The research in this area has shown that there is a range of variables influencing whether an individual will disclose material in supervision. It would seem that the quality of the supervisory relationship in terms of factors such as alliance (Ladany et al, 1996), rapport (Webb & Wheeler, 1998) and mutuality (Walsh et al, 2002) is influential in decisions about disclosure where trainee therapists are concerned. Affective factors such as shame (Yourman, 2003; Yourman & Farber, 1996) are also believed to have a role in disclosure. There are hints in the research as to how such elements as the supervisory relationship may be acting as a mechanism for disclosure e.g. through being a positive and supportive relationship (Ladany et al, 1997).

There are again limits to the generalisability of the research in this area. The numbers of participants in all studies are small with 137 (Ladany, Walker & Melincoff) and 118 (Duan & Roehlke, 2001) having the greatest number of participants. The papers relating to self-disclosure mechanisms are all from either American or British studies and are on the whole culturally homogenous and therefore reflect a restricted cultural view of self-disclosure.

There appears to be a lack of diversity in the make up of participants in terms of ethnic background and gender though this may reflect the make up of the professions of the participants. Apart from two of the studies (Webb & Wheeler, 1998; Yerushalmi, 1992) all of the studies were carried out in the United States and therefore this leaves questions about their applicability in other areas e.g. Europe.

The favoured methodology is questionnaire survey with one study using a qualitative methodology (Ladany et al, 1997), one a case study format (Yourman, 2003) and one that uses illustration (Yerushalmi, 1992) rather than direct assessment to describe possible factors involved in therapist self-disclosure within supervision. The studies are in the main correlational and therefore nothing can be said about causality in terms of the factors involved in disclosure. The data comes mostly through self-report measures, so leaving them open to the possibility of response bias.

Discussion

A variety of mechanisms relating to the therapist, the relationship, feelings associated with self-disclosure, knowledge and awareness are involved in the facilitation and inhibition of therapist self-disclosure. A summary of the different factors that have been reported as important in enhancing or curbing therapist self-disclosure can be found in Table 1.

Relationship factors include alliance (Ladany, Hill, Nutt & Corbett, 1996), rapport (Webb & Wheeler, 1998) and mutuality (Walsh, Gillespie, Greer & Eanes, 2002). The knowledge factors include theoretical orientation (Brunink & Schroeder, 1979), experience (Andersen & Anderson, 1989; Robitschek & McCarthy, 1991) and education (Simone, McCarthy & Skay, 1998). The key therapist factors appeared to be therapist style (Ladany & Lehrman-Waterman, 1999) and positive characteristics and attitudes (Duan & Roehlke, 2001).

Factors related to affect and awareness include shame, (Yourman, 2003; Yourman & Farber, 1996) and impression management (Ladany et al, 1996).

Table 1

Summary of mechanisms involved in facilitation and inhibition of therapist self-disclosure

Variables Affecting Supervisee Therapist Self- Disclosure in Supervision	Variables Affecting Therapist Self-Disclosure in Therapeutic Environment	Variables Affecting Supervisor Self-Disclosure in Supervision
Alliance	Theoretical orientation	Open Style
Rapport	Experience	Friendliness
Mutuality	Education	Attractiveness
Positive and supportive relationship	Personality	Interpersonal Sensitivity
Positive attitudes and characteristics of supervisor	Open style	Possible damage to supervisory relationship
Shame	Background	Anticipated negative trainee reaction
Negative feelings	Similarity (to client)	
Self-esteem	Client diagnosis	
Perceived unimportance		
Lack of awareness of issues to disclose		
Trainee status		
Choice of supervisor		
Deference		
Impression management		
Political Suicide		
Inherent difficulty of disclosure		

A larger number of mechanisms have been identified relating to supervisee therapist self-disclosure in supervision but this may be because more research on the variables involved has been carried out in this area. The variables in this area appear to fall into five categories: (1) Factors relating to the strength of the supervisory relationship e.g. rapport. (2) Factors relating to the therapists personal qualities e.g. positive attitudes. (3) Factors relating to the supervisee's feelings e.g. Shame. (4) Factors relating to awareness of issues e.g. perceived unimportance and (5) Factors relating to power within the supervisory relationship e.g. deference.

For therapist self-disclosure within the therapeutic environment variables appear to fall into three categories: (1) Factors relating to the type of learning a therapist has engaged in e.g. Experience. (2) Factors relating to the therapist personal qualities e.g. Personality (3) Factors relating to the client e.g. Client diagnosis.

The variables influencing supervisor therapists to self-disclose in supervision would seem to fall into two categories: (1) Factors that relate to the therapist's personal qualities e.g. Friendliness (2) Factors that relate to the relationship with the supervisee e.g. possible damage to the relationship.

Wallace and Alonso (1994) argue that the force that draws the trainee therapist towards disclosure is in part driven by the necessity of revealing psychotherapeutic work to enable learning to take place. The variables that appear to influence this would indicate that self-disclosure by a trainee within supervision is a function of the supervisors' ability to create a positive relationship with the supervisee especially where an issue to be disclosed involves negative feelings for the supervisee. The relationship that is developed would also seem to need to be equitable and a supervisor to be non-judgemental if the influence of the power

differential within the relationship is not to prevent self-disclosure. It seems that the mechanisms that are involved in therapist self-disclosure within the therapeutic dyad and where the supervising therapist self-discloses in supervision are more related to personal choice and style and are not centred on the relationships between therapist/client and supervising therapist/supervisee. This might reflect a difference in the pressure to self-disclose between those being supervised, especially trainees, as part of the learning process and supervising therapists and therapists within the context of the therapeutic dyad where there is no apparent pressure to self-disclose.

It would seem that the therapist working with a client or the supervising therapist with a supervisee would not be exposed to the same pressure to disclose. However, another explanation may be that there is a lack of research into the effects of mechanisms such as mutuality on therapist self-disclosure within therapist/client, supervisor/supervisee dyads.

It is interesting to note that alliance is a feature of therapist self-disclosure in the context of supervision. In his theory of counselling and psychotherapy, Bordin (1983) ascribes the energy for change to two factors: the power of the alliance between the individual who seeks change and the agent for change and the strength of the tasks included in the alliance.

A number of the therapist variables that were identified as potential factors influencing therapist self-disclosure could be related to the personal attributes that have been identified as positively impacting on therapeutic alliance (Ackerman & Hilsenroth, 2003). In their review they found that attributes such as openness, warmth, friendliness, respectfulness, honesty and trustworthiness contributed positively to the development of a strong therapeutic alliance. The question that arises from this current review is what features of the alliance facilitate therapist self-disclosure or whether therapist self-disclosure also

enables a strengthening of the alliance. It appears from the review that the alliance is pertinent in many areas of both therapy and supervision.

One of the potential limitations to this current review relates to the idea that theoretical orientation could be thought of as a mechanism of therapist self-disclosure. Although the research suggests that psychoanalytically/psychodynamically oriented therapists would not favour the use of self-disclosure to limit interference with the transference this idea seems outdated. The research related to this finding is quite old and Knox and Hill (2003) argue recently that there has been a noticeable change towards the use of self-disclosure by many psychoanalytic and psychodynamic practitioners. Therefore, the idea that psychoanalytic/psychodynamic orientation might act as a mechanism that inhibits self-disclosure of the therapist is less powerful than it might have once been. Although some practitioners may still adhere to the position of therapeutic neutrality and a blank screen approach it appears that for many practitioners from these orientations the debate has moved to a discussion of what feelings and thoughts might be profitably disclosed (Bernstein, 1999).

Another potential limitation of the studies reviewed is that all of the studies focussed on one side of the dyadic relationship. That is the views expressed about issues such as nondisclosure, alliance and style were only reported on the basis of one half of the dyads. This may limit some of the reliability of the findings. The measures that were specifically developed for some of the investigations were done through qualitative analysis of material generated in pilot studies. There did not appear to be much use of independent raters to enable an assessment of the reliability of the material that was being included in the questionnaires.

Lastly, in terms of limitations, much of the focus of the research around supervisee self-disclosure within supervision is related to trainees and it would be helpful to look at whether the mechanisms for self-disclosure in supervision for qualified therapists are the same as for trainees.

To summarise, this present review has distinguished a number of potential mechanisms that may facilitate or inhibit therapist self-disclosure in both the therapeutic and supervisory relationships. There are also a number of potential areas for future research in this area. There is very little research relating to self-disclosure and cultural factors. There may be different cultural attitudes toward self-disclosure as a whole and within therapeutic and supervisory settings. A specific example where this might be important is within a cross-cultural supervisory dyad.

It might also be helpful to look at how cognitive factors may influence the decisions of therapists and supervisors to disclose and perhaps to investigate whether some mechanisms are more important in influencing therapist self-disclosure. It would also be useful to know how mechanisms operate in the context of specific types of material that therapists might self-disclose for example how clinical mistakes come to be disclosed in supervision. If self-disclosure has important and helpful consequences then understanding what enhances or inhibits it will surely aid both the therapeutic and supervisory environments.

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**Trainee clinical psychologists' intention to disclose
personal clinical mistakes in supervision.**

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Abstract

This paper is an exploratory investigation of the factors that affect the disclosure of personal clinical mistakes within supervision. An 'online' questionnaire study based on the Theory of Planned Behaviour (TPB) was devised to assess trainee clinical psychologists' intention to disclose personal clinical mistakes in supervision and whether intention was associated with the strength of supervisory relationship and team climate. A total of 249 clinical psychology trainees responded to the three questionnaires. The TPB was found to predict intention to disclose personal clinical mistakes in supervision. No other variables were found to add significantly to the model of prediction. However, intention was associated with a number of other variables including supervisory rapport.

Introduction

For clinical psychology trainees one of the most important forums for learning is supervision. The British Psychological Society (BPS) Division of Clinical Psychology (DCP) argues in its guidelines on supervision that the obligations of clinical governance, the anticipated statutory registration and the effects of National Service Frameworks, all have ramifications for the supervision of qualified clinical psychologists and indicate the need for continued supervision of trainees (BPS, DCP, 2003). The policy of the DCP states:

‘It is expected that all clinical psychologists at all stages of their career and in all work contexts, will engage in regular supervision of their own work.’ (pp 2)

They describe supervision as being a central activity in ensuring high quality and effective services and indicate a minimum standard of 60-90 minutes for every 20 sessions worked.

The purposes of supervision

In her book on supervision in the context of the mental health professions, Scaife (2001) argues that there have been many attempts to define supervision, none of which do it justice entirely. Scaife maintains that there is no collective agreement about the objectives of supervision though she suggests that it is useful to remember Inskipp and Proctor’s (1993) model of supervision purposes. They maintain that supervision should be Formative, (focus on development of the supervisee’s counselling skills), Normative, (safeguard the welfare of clients) and Restorative (deal with the emotional impact of client work). Page and Wosket (2001) describe the responsibilities of supervisees that include development of an attitude that is non-defensive and being honest in conveying doubts, difficulties and concerns in relation to client work. The responsibilities described by Page and Wosket imply the need for openness in the supervisory situation.

Disclosure of mistakes in supervision

One important area that may aid development of skills in trainees is analysing mistakes made in clinical practice. Scaife (2001) asserts that supervisors characteristically take the view that they would prefer to know about the errors made by supervisees and are more interested in positively appraising openness as well as development by learning from mistakes. She cites Palmer-Barnes (1998) who defines mistakes as 'an unintended slip in good practice'.

Kramer (2000) argues that therapists learn to take the risks and make mistakes necessary to become a genuine therapist through openness. Wallace and Alonso (1994) argue that disclosure is essential to supervision. This, they maintain, is because the supervisor is dependent on information supplied by the supervisee to gain a breadth and depth of understanding about the client and to facilitate development of the trainee's psychotherapeutic abilities.

In a medical context Allman (1998) found that the self-disclosure and boundary management of physicians in regard to medical mistakes showed that physicians most frequently revealed errors to other physicians to enable learning. However, what evidence there is about psychologists and psychotherapist counsellors suggests that supervisees do not often disclose clinical mistakes.

Ladany, Hill, Corbett and Nutt (1996) in a study of mainly counselling and clinical psychologists found that clinical mistakes were amongst the variables that were most often the subject of nondisclosure by supervisees. Mistakes characteristically included supervisee anxieties about their competence or lack of in performance of counselling and carrying out interventions. Hess (1999) describes reluctant disclosure of perceived mistakes by counselling centre interns within the context of generally good supervisory relationships.

A study of psychotherapy trainees (Yourman & Farber, 1996) found that as many as 30-40% of supervisees withheld information including perceived clinical mistakes at moderate to high levels of frequency. With the ideas of openness and learning from mistakes attached to the development of individuals as therapists (Kramer, 2000) in the context of supervision, the question of whether supervisees intend to bring clinical mistakes for discussion with their supervisors would appear to be of importance.

Mechanisms of disclosure

There may be a number of mechanisms that affect whether supervisees self-disclose clinical errors. Ladany et al (1996) reported nondisclosure due to poor alliances, supervisor incompetence, impression management and fear of political suicide. Webb and Wheeler (1998) found a positive correlation between the extent of disclosure and the quality of supervisory alliance and other studies have indicated relationship quality (Ladany, O'Brien, Hill, Melincoff, Knox & Peterson, 1997; Callis, 1997; Walsh, Gillespie, Greer & Eanes, 2002) as important in relation to the amount of disclosure undertaken. Hess (1999) found that major reasons leading to nondisclosure were concerns about power and evaluation, expectation of negative response from the supervisor and cultural and demographic variables of the supervisor that produced inhibition and negative feelings about the self.

Alonso and Ruttan (1998) argue that shame plays a large part in the development of trainee clinicians and they describe a number of sources of shame within supervision, (e.g. learning regression, patient population) and suggest that this might undermine trainee and supervisor welfare. Other studies have discussed the impact of shame on self-disclosure within psychotherapy supervision (Yourman, 2003; Yourman and Farber, 1996; Yerushalmi, 1992). In Yourman and Farber's (1996) study of psychotherapy trainee patterns of

disclosure led them to report that the shameful feelings of the trainee were most responsible for the nondisclosure of trainees.

Another factor that may moderate the likelihood of an individual disclosing a personal clinical mistake in supervision is how safe they feel to do so in the context of the work team that they are in. This is a construct described by Edmondson (1999) called team psychological safety and is a common and mainly tacit belief amongst members of a team that interpersonal risk taking in the team is safe. A report by the expert group on learning from adverse events (Department of Health, 2000) suggests a positive and measurable effect on the achievements of organisations where open accounting and even-handed analysis are advocated in principle and are modelled in practice.

Edmondson (1999) found in her study that team psychological safety was associated with learning behaviour in teams. In an environment of openness and where risk taking is both encouraged and is perceived as safe and part of the process of learning, an individual may be more inclined to disclose personal clinical mistakes in supervision. One way of examining this is through the Team Climate Inventory (TCI; Anderson & West, 1998) which is a measure of climate for innovation within work groups that includes measurement of participative safety.

As described above there are a variety of explanations as to why supervisees often do not address clinical errors in supervision. Webb and Wheeler (1998) using a modified version of the Supervisory Working Alliance Inventory (SWAI; Efstation, Patton, and Kardash 1990) found a positive correlation between supervisees' perceived levels of rapport with their supervisors and the potential of those supervisees to disclose matters that related to their clients or the counselling.

The theory of planned behaviour

One area which would appear to be material to this are the processes that relate to how the decision is made to use supervision for this purpose or not. One advantageous theoretical framework that can be used to explore this is The Theory of Planned Behaviour (Ajzen, 1985, 1988, 1991). This theoretical framework comes from the field of social psychology and has been applied successfully in predicting a broad spectrum of intentional behaviours including use of clinical guidelines by doctors (Limbert & Lamb, 2002) and suicidal intent (Matheson 2002).

Williams (2002) recounts that The Theory of Planned Behaviour is a development of the Theory of Reasoned Action (TRA: Ajzen & Fishbein, 1980; Fishbein & Ajzen 1975) and evolved out of the difficulty in predicting non-volitional behaviours through the initial model. Williams asserts that the central tenets of the theory are that the closest element of any behaviour {B} is the individual's intention to employ that behaviour. *Behavioural intention* {BI} is itself under the influence of three variables. These are (a) the *attitude* of the individual toward the behaviour {A}, reflecting the positive or negative appraisal of the behaviour by the individual; (b) the *subjective norm* {SN}, reflecting the perception of the social pressure from important others to carry out or not carry out the behaviour; (c) and *perceived behavioural control* {PBC}, relating to the perception of the individual as to the ease or difficulty with which the behaviour may be performed.

Attitudes, subjective norms and perceived behavioural control are in turn affected by other factors. It is thought that attitude towards the behaviour is governed by perceived *behavioural beliefs* {BB} (i.e. beliefs about the important outcomes of a perceived behaviour) and their *evaluations* {Eval(s)} about the achievement or not of this outcome.

Subjective norms are governed by *normative beliefs* {NB} (i.e. the individual's understanding about whether important others/referents believe that the behaviour should or should not be performed by the individual) and the *motivation to comply* {MC} of the individual with the expectation of significant other/s. The presence of internal and external *control beliefs* {CB} is believed to influence perceived behavioural control. Internal control beliefs (e.g. the skills and abilities of the individual) increase the perceived probability of the occurrence of a behaviour and are thus seen as facilitating factors whereas external control beliefs (e.g. available opportunities, the level to which the individual is reliant on others) are thought of as inhibiting factors because they are generally out of the control of the individual.

Perceived power {P} acts as weighting for control beliefs for each of the internal and external control factors. The TPB therefore extends the first model, adding perceived behavioural control to elucidate understanding behaviours where some uncertainty exists and is therefore not under absolute volitional control.

The theory is relevant here, as the intentions of trainees to discuss mistakes in supervision may not entirely be under their control (e.g. opportunity to discuss mistakes openly in supervision may not be presented, individuals may feel that they do not have the skills to present mistakes for discussion). Their attitude towards discussing mistakes and the perceived social pressure from important others to carry out such behaviour may be pertinent.

The present study

Given the apparent paradox of an emphasis on openness and learning from clinical mistakes by trainee psychologists and a seeming reluctance by trainees to disclose these mistakes and given that supervision is the major arena for their discussion, an evaluation of

the cognisances of supervision retained by trainee clinical psychologists would seem appropriate at this juncture. At this time no such investigation exists within psychology.

A study was therefore initiated to examine the trainee clinical psychologist's perceptions of disclosure within the supervisory dyad. The study was devised to address four main aims:

1. To identify issues and areas that are relevant for trainee clinical psychologists in their perceptions about clinical supervision and that effect their preparedness to disclose personal clinical mistakes to a supervisor.
2. To use this information to develop a questionnaire designed to assess the breadth and depth of these perceptions amongst trainee clinical psychologists.
3. To relate this to their intention to disclose personal clinical mistakes, using the Theory of Planned Behaviour (Ajzen 1985, 1988, 1991) as a model.
4. To assess whether intention to disclose personal clinical mistakes in supervision is associated with the strength of supervisory alliance and work team climate.

Method

Introduction

In accordance with the aims of the study the design is in two stages. The principal stage (From now on referred to as Study 2) was contrived to examine the views, beliefs and perceptions of trainee clinical psychologists relating to supervision and then investigating how these might effect their intention to disclose clinical mistakes in supervision using Internet based questionnaires as the methodology. As the research in this area is limited, an

initial study (Study 1) was carried out in order to generate pertinent items for the disclosure questionnaire in accordance with the Theory of Planned Behaviour.

In order to ensure clarity the description and reporting of the two stages of this study will be separately addressed, starting with Study 1 below.

Study 1

Introduction

This preliminary stage of the research was devised to determine the understanding of supervision held by trainee clinical psychologists and pertinent factors for them in relation to the decision to disclose personal clinical mistakes in supervision. It was also designed to produce items in order to construct a questionnaire that explored the intentions of trainee clinical psychologists to disclose personal clinical mistakes in supervision. An unstructured questionnaire of open-ended questions based on the recommendations of Ajzen and Fishbein, (1980) was utilised to garner the required information.

Method

Participants

The participants of the study were the three year groups (2001, 2002, 2003) of a Doctor of Clinical Psychology training course. Other than being from one of the three cohorts no exclusion criteria were used. Of the potential participants for the study 21/57 (36.8%) of the trainees completed questionnaires.

Materials

The ten item questionnaire included eight questions relating to the Theory of Planned Behaviour and was built according to the procedures outlined by Connor and Sparks,

(1996) to develop items for the 'beliefs' sub-section of the main questionnaire. Consultation was also sought with a local TPB expert and the author and research supervisor then made a decision on the questions to be used. The questions examined the advantages and disadvantages of the disclosure of a personal clinical mistake in supervision, feelings related to the behaviour, motivational factors involved, variables that made the behaviour easier or harder and a question related to subjective norms. There were also two further questions about other factors that might influence disclosure and the impact that disclosure of a personal clinical mistake might have on their training. As the study was anonymous no demographic data was collected.

Procedure

Questionnaires were placed in the pigeonhole of each trainee. An information sheet (see Appendix 9a) elucidating the purpose of the study was included in the pack as well as a sheet giving an end date for the completion of forms and an envelope with the authors name on, in which to place the questionnaire. Questionnaires were filled in anonymously by participants and were returned in the envelope provided to a marked box in the clinical psychology unit.

Data analysis

Procedures described by Conner and Sparks (1996) in accordance with the TPB were used to access pertinent 'beliefs' items for the main questionnaire. A qualitative content analysis Semantical Content Analysis (designations analysis) Janis (1965) was applied to the final two questions. Krippendorff (1980) describes this procedure as one where signs are classified according to their meanings and how often certain concepts are alluded to. The method described by Conner and Sparks (1996) entails a standard procedure of analysis, utilised to distinguish and produce items that are specific for the measurement of

behavioural beliefs and their evaluations; internal and external control beliefs; normative beliefs and motivations to comply sub-sections of the questionnaire (Ajzen, 1991; Ajzen & Fishbein, 1980; Ajzen & Driver, 1991; Conner & Sparks, 1996).

Results

This initial stage of the study prior to the main study was designed to investigate factors that trainee clinical psychologist find pertinent to their understanding of supervision and the decision to disclose personal clinical mistakes within that forum and from this to develop a questionnaire for distribution to all current clinical psychology trainees.

The results indicated that trainee clinical psychologists felt that learning, skill development, correcting the mistake and safety were the advantages of disclosing a personal clinical mistake in supervision and that negative assessment by a supervisor and looking incompetent were the disadvantages. Participants thought that such a disclosure might provoke anxiety, relieve anxiety and also be associated with feelings of embarrassment, shame and guilt. Motivating factors to disclose personal clinical mistakes in supervision were wanting to learn from the mistake, supervisor admitting their own mistakes and a good relationship with the supervisor. Decreased motivation was associated with a poor relationship with the supervisor and fear of negative consequences. Factors that made disclosure easier or harder were time limits in supervision and explicit conditions for disclosure. The views of close friends and university/course staff were felt to be important with other trainees being the group most often identified as people whose views would be most important.

Content analysis of the final two questions (Non-TPB) delivered a wide variety of factors, e.g. ethical issues, as well as a number of potential impacts on training, e.g. skill

development. However, none were raised as issues often enough to be considered for inclusion in the main questionnaire.

Discussion

The results of this study from the responses of participants produced a number of advantages and disadvantages to disclosure of personal clinical mistakes in supervision. Factors that could facilitate this behaviour were also identified and others that might prevent disclosure. There was a wide range of responses indicating that the decision to disclose a personal clinical mistake is not necessarily straightforward.

There were a number of limitations in relation to this study including small sample size and lack of demographic information. This meant that, for instance, it was not known whether responses were mainly from one year group or spread across all three. The data from the questionnaires also lacked richness, in that they were often one word answers.

Conclusions – Study 1

The findings in Study 1 match to some level the more comprehensive findings of Ladany et al (1996) in terms of what influences a decision to disclose in supervision e.g. the relationship between supervisor and supervisee. However, Ladany et al (1996) examined a greater number of potential disclosures. In relation to clinical mistakes they found that supervisees generally did not disclose for reasons of impression management and to some degree the responses in the current study accord with these ideas e.g. a disadvantage of disclosure might be 'looking incompetent'.

Study 2

Introduction

The purpose of this part of the study was the distribution via the Internet of three questionnaires designed to explore the views of a comparatively large sample of clinical psychology trainees about their understanding of supervision as a forum for learning and their intention to explore personal clinical mistakes within that context, as well as the relationship with their current supervisor and the style of the team that they worked in at present.

The use of the Internet to conduct research

In an article on carrying out research via the Internet, Hewson (2003) described some of the advantages of conducting research in this way. She suggests that Internet mediated research is cheap, can reduce the time scale for the conduct of studies, participants may be more candid and social desirability effects may also be lessened e.g. it is possible that those who are more likely not to discuss personal clinical mistakes in supervision may be less likely to report their intention not to do so.

After discussion with the technical support team in the Psychology Department of the University of Sheffield the author made the decision that the main stage of the study (hereafter designated as Study 2) was to be carried out by placing the three questionnaires on an Internet website. Also in an effort to ameliorate potential response bias the description of mistakes on the information sheet and questionnaire emphasised their unintentional nature as part of an attempt to carry out good practice.

Measures

Disclosing Personal Clinical Mistakes in Supervision

The 'Disclosing Personal Clinical Mistakes in Supervision' questionnaire consisted of a 50-item inventory that was sub-divided into two sections (see Appendix 4b). Section 1 (questions 1-8) was concerned with basic demographic information including questions relating to year of training, type of placement currently engaged in, preferred theoretical model and number of supervisors experienced.

Section 2 (questions 9-50) investigated participants' perceptions of supervision and explored their intentions or otherwise towards disclosing personal clinical mistakes in supervision. All items in this section related to the Theory of Planned Behaviour components and were designed conforming to Ajzen's (1991) recommendations. The pertinent belief items were derived from the findings that had emanated from Study 1. All the items were calibrated on a 7-point scale, starting with a minimum value of +1.

Supervisory Working Alliance Inventory (SWAI)

As one of the main factors in self-disclosure/nondisclosure appeared to be relationship quality it was appropriate to include this factor in research about intention to disclose. The Supervisory Working Alliance Inventory (SWAI), devised by Efstation et al (1990), is an existing tool that was identified to gauge the quality of each trainee's relationship with his or her current supervisor.

Webb and Wheeler (1998) report that the SWAI was originally designed to evaluate and compare the observations of the supervisory relationship retained by both supervisor and trainee therapist. The SWAI measures two factors on the trainee version of the scale. These are, firstly, twelve items that focus on the trainees' understanding of the supervisor's efforts

to develop rapport e.g. 'My supervisor encourages me to talk about my work with clients in ways that are comfortable for me'. The other eight items were associated with a focus on the trainees' comprehension of the client e.g. 'My supervisor helps me work with a specific treatment plan with my clients.

The concern of the present study is the experiences of trainee clinical psychologist trainees and so in accordance with Webb and Wheeler (1998) 'trainee' replaced the designation of 'supervisee'. The original instrument remained the same in every other facet. The quality of supervisory alliance was assessed and compared with intention to disclose personal clinical mistakes in supervision.

The Team Climate Inventory – Short Form

The Team Climate Inventory (TCI) was originally developed by Anderson and West (1998). The TCI is designed to measure climate for innovation based on the four-factor theory of facet-specific climate for innovation (West, 1990; West & Anderson, 1996). The four factors are vision, participative safety, task orientation and support for innovation. It is argued that vision is made up of four components, clarity, visionary nature, attainability and sharedness. It is asserted that participativeness and safety are a single construct in which the motivation and reinforcement for taking part in decision making occurs within a context that is seen as interpersonally non-threatening (West, 1990).

Task orientation is portrayed as a general undertaking toward excellence in the performance of tasks within a climate that upholds the adoption of developments to policies, procedures and methods that are already established. Support for innovation is described as an expectancy, agreement and support of a practical nature for efforts to bring

about fresh and improved practices within the work environment (West, 1990). Recent work by West (2003) has demonstrated internal validity of the components at $p < .001$.

Participants

The participants for Study 2 were clinical psychology trainees on training courses in the United Kingdom for the years 2001-2003 (No. = 1730 approx.). The course directors for each of the 28 Doctor of Clinical Psychology training courses in Britain were contacted via letter (see Appendix 6), that described the study and its purpose to them. The course directors were asked if they would circulate an e-mail through course administrators to each of the three years of trainees on their course, that contained an attachment containing an information sheet for the trainees and a weblink to a website at the University of Sheffield, Department of Psychology where the three questionnaires were located. Course directors were also informed that a second 'follow up' e-mail containing the weblink would be sent approximately one month after the first in order to access as many possible respondents as possible. Replies were requested for the end of January 2004.

At the end of the deadline for replies 18 affirmative responses had been received with one request to view the questionnaires before approval was granted. The nine courses from which no contact had been received were followed up via e-mail and telephone contact. A request from one of the course directors led to the inclusion on the information sheet that stated that individuals would not be tracked via the use of their computers unless the system was being abused. Finally a total of 27/28 (96%) of the courses agreeing to the trainees being approached.

All course administrators of courses who had agreed to participate in the study were contacted by telephone and then all were sent the first e-mail (see Appendix 7a) with the attachment with the information sheet and weblink leading to the website. Two courses requested the e-mail be sent again as difficulties had been experienced distributing it and one course distributed the e-mail and information sheet on paper to their trainees, as they were not linked to the course via e-mail. Three individual trainees also contacted the author by e-mail requesting the webpage address. Data from trainees who filled in the questionnaires on-line were sent directly to a data file at the University of Sheffield Psychology Department. The follow up e-mail and attachment for trainees was sent a month later.

Overall 321 (18.5%) responses were returned to the data file. This is in line with other studies that have used this methodology. Koch and Emrey (2001) reported 16.4% response rate to an on-line survey of marginalized populations and Sills and Song (2002) reported a response rate of 22% in a study looking at the choice of major subject at college and international students social support network system at an American University.

Of the 321 responses, 72 were not used in the final analysis as only the 'Disclosing Personal Clinical Mistakes in Supervision' had been filled in. This left 249 (14.3%) respondents who had completed all three questionnaires.

Method of analysis

Rationale for selection

Data were analysed using SPSS v.12.0.1. The analysis pertained to assessing within group differences in socio-demographic and other characteristics and to: (a) identify the relationship between the main theory component parts; (b) predict the intention of trainee

clinical psychologists to discuss personal clinical mistakes in supervision in the future; (c) test whether (i) supervisory alliance and (ii) team climate moderate the relationship of TPB individual variables on intention to discuss personal clinical mistakes.

Procedure for data analysis

Data for section 1 was analysed using Pearson Chi-square tests were used to assess the differences in frequencies between male and female trainee clinical psychologists. Means, standard deviations and percentages were presented where relevant.

Exploratory factor analysis was carried out on the TPB attitude component to examine whether more than one factor accounted for the variance within this variable. Independent analysis for TPB constructs were effected in consonance with formal procedures and recommendations illustrated by Connor and Sparks (1996; as shown in Appendix 5).

Alpha coefficients were calculated for all TPB, SWAI and TCI components using Cronbach's alpha. Correlation matrices and hierarchical regression analysis were computed to: (i) identify the relationship between intention and the Theory of Planned Behaviour elements, supervisory alliance and team climate (ii) to identify the relationship between main theory components, supervisory alliance and individual items from the 'Disclosing Personal Clinical Mistakes in Supervision' measure.

Results

Group differences in sample characteristics

Examination of the demographic characteristics of the participants (Table 1) showed that there were no significant differences between male and female trainee clinical psychologists on marital status, placement, ethnicity and theoretical model. It was not possible to compute any differences between ethnicity and other variables due to the small cell sizes. Pearson Chi-square tests did however reveal significant differences between male and female trainees in different age groups.

The mean ages overall were 28.17 (SD 3.58, range, 22-46). The mean age for males was 30.41 (SD 4.78, range 24-46) and for females 27.78 (SD 3.18, range 22-41). There were significant differences between males and females when they were grouped into age bands 22-31 and 32-46 ($\chi^2 = 12.137$, $df = 1$, $p = .001$). In terms of gender and marital status, 37 (14.9%) were male and 211 (69.8%) were female. Of these 21/37 (56.7%) males were married/cohabiting and 16/37 (43.2%) were single/divorced compared to female participants of whom 112/209 (53.5%) were married/cohabiting and 97/209 (46.4%) who were single/divorced.

In relation to the ethnic make up of the sample a large majority were white 229/244 (92%). The make up of the rest of the sample was Asian/Asian British 5/244 (2%), Black/Black British 3/244 (1.2%), Chinese/other 3/244 (1.2%) and Mixed Heritage 4/244 (1.6%). Overall 15/244 (0.06%) came from an ethnic background other than white. In terms of the gender of these groups 1/37 (0.02%) was male and 14/207 (0.06%) were female.

With respect to year of training, 94/248 (37.8%) of respondents were in their first year of training, 79/248 (31.7%) in their second year and 75/248 (30.1%) in their third. In terms of

the type of placement that participants were currently experiencing 28/248 (11.2%) were working with people with learning disabilities and 95/248 (38.2%) were working within adult mental health settings. 51/248 respondents (20.5%) were on child and adolescent placements, 37/248 (14.9%) working with older adults, 12/248 (4.8%) were in health settings and 25/248 (10%) were in other settings.

Regarding the theoretical model that individuals adhered to 89/245 (35.7%) recorded that Cognitive Behavioural Therapy/Cognitive Therapy was their preferred option, 14/245 (5.6%) Psychodynamic and 67/245 (26.9%) Eclectic/Integrative. 16/245 (6.4%) indicated other models (e.g. CAT, Systemic) and 59/245 (23.7) did not specify a model.

As regards the number of supervisors, 63/247 had experience of one supervisor, 35/247 (14.1%) two supervisors, 36/247 (14.5%) three supervisors, 25/247 (10%) four supervisors, 34/247 (13.75) five supervisors, 28/247 (11.2%) six supervisors and 26/247 (10.4%) had experience of seven or more supervisors.

Table 1. Summary table of sample characteristics

Variable	N	Percentage (%)
Age (years):		
22-26	94	38.1%
27-31	113	45.3%
32-36	31	12.4%
37-46	8	3.2%
Gender:		
Male	37	14.9%
Female	211	69.8%
Marital Status:		
Living alone/divorced	105	42.2%
Other (married, cohabiting, other)	141	56.6%
Year of training:		
1 st	94	37.8%
2 nd	79	31.7%
3 rd	75	30.1%
Placement:		
Learning disability	28	11.2%
Adult mental health	95	38.2%
Child and adolescent	51	20.5%
Older adult	37	14.9%
Health	12	4.8%
Other	25	10%
Ethnicity:		
Asian/Asian British	5	2%
Black/Black British	3	1.2%
Chinese/Other ethnic group	3	1.2%
Mixed Heritage	4	1.6%
White	229	92%
Theoretical model:		
CBT/Cognitive Therapy	89	35.7%
Psychodynamic	14	5.6%
Eclectic/Integrative	67	26.9%
Other	16	6.4%
None Specified	59	23.7%
No. of Supervisors:		
1	63	25.3%
2	35	14.1%
3	36	14.5%
4	25	10%
5	34	13.7%
6	28	11.2%
7+	26	10.4%

Theory of planned behaviour items

Factor Analysis

Principal components factor analysis were carried out to explore the variability in the attitude scales (Item 14) to examine whether all five scores were required to explain the variability or whether a smaller number of higher order factors were responsible. An iterative principal axis factor extraction method with an oblique rotation (SPSS “oblimin” command) was utilised. Two factors that accounted for 67.8% of the item variance were obtained. The first factor accounted for 42.9% of the variance (eigenvalue = 2.14) and the second factor accounted for 24.8% of the variance (eigenvalue = 1.24). As Table 2 shows, all of the cognitive items loaded on the first factor and all of the affective items loaded on the second factor. The correlation between the two factors was $r = .25$ and is significant at the 0.01 level.

TABLE 2

Loadings for factor analysis of attitude items

Items	Factor 1	Factor 2
Good - Bad	.808	-.035
Wise – Foolish	.858	-.108
Helpful – Unhelpful	.679	.215
Calming – Distressing	.017	.853
Pleasant - Unpleasant	-.015	.860

Reliabilities

Cronbach's alpha was used to estimate the internal consistency of each of the TPB item scales (perceived behavioural control, subjective norm and the cognitive and affective factors of attitude items) and also scales on both the Team Climate Inventory - Short Version (TCI) and the Supervisory Working Alliance Inventory - Trainee Version (SWAI).

Alpha coefficients for perceived behavioural control scales was .46¹ (N = 237), for subjective norm scales .73 (N = 236), for cognitive scales .69 (N = 249) and for affective scales .65 (N = 249). On the SWAI - Trainee version alpha coefficients for the rapport scales was .95 (N = 246) and for the client focus scales .91 (N = 242).

With regard to the TCI - Short version scales alpha coefficients for the participation scales was .90 (N = 242) for the support for innovation scales .92 (N = 247) for the objectives scales .89 (N = 243) and for the task orientation scales .89 (N = 187).

Assessing the relationship between study variables and the prediction of trainee intention to disclose personal clinical mistakes

A Pearson product moment correlation matrix was computed to evaluate the relationship between the all study variables and participants' intention² to disclose a personal clinical mistake in supervision. The results of the analysis, which are presented in Table 3 (below), show that intention was significantly related to all the theory of planned behaviour component parts with the exception of pbc 1, as well as rapport and age. The cognitive factor of attitude emerges as the strongest correlate of intention $r = .41, p < .01$. Rapport ($r = .14, p < .05$) and age ($r = .18, p < .01$) were also significantly correlated with intention.

Table 3. Pearson product moment correlations of the main TPB component parts

	Int	Cog	Aff	SN	pbc1	pbc2	pbc3	pbc4	Rap	Age	Mean	SD
Int	-	.41**	.29**	.36**	.06	.38**	.27**	.34**	.13*	.18**	6.00	.84
Cog		-	.25**	.41**	.06	.26**	.20**	.25**	.10	.14*	6.05	.67
Aff			-	.14*	.12	.49**	.21**	.25**	.14*	.04	3.71	1.14
SN				-	-.02	.17**	.08	.25**	.00	-.07	5.27	.93
pbc1					-	.03	.35**	.11	.01	.07	4.27	1.79
pbc2						-	.22**	.35**	.13*	.12	4.23	1.60
pbc3							-	.39**	-.04	.12*	5.81	.95
pbc4								-	.18**	.01	6.26	.91
Rap									-	-.10	5.47	1.17
Age										-	28.07	3.94

** $p < 0.01$ level (2 - tailed) * $p < 0.05$ level (2 - tailed)

INT = Intention, COG = Cognitive Attitude, AFF = Affective Attitude, SN = Subjective Norm, pbc1, pbc2, pbc3, pbc4 = Perceived Behavioural Control Items, Rap = Rapport

¹ Given the low reliability rating for perceived behavioural control these items were analysed individually, i.e. pbc1, pbc2, pbc3 and pbc4

² Due to a technical error with two of the radio buttons on the questionnaire data from items 9 (Intention measure) and 50 was lost. Item 12 (Likelihood) was therefore the only measure of intention

Predicting behavioural intention

A four step hierarchical linear regression analysis was performed to assess the predictive usefulness of the significant constructs (see Tables 4-7), with intention as the dependent variable. The cognitive and affective components of attitude, subjective norm, perceived behavioural control components, the total behavioural beliefs and evaluations for cognitive and affective attitude, normative and control beliefs (TOTBB, TOTBBA, TOTNB and TOTCB - see Appendix 5) SWAI components, TCI components, gender, year of training, number of supervisors and age were the independent variables.

Table 4. Hierarchical linear regression analysis of intention to disclose personal clinical mistakes in supervision (Block 1)

Model Predictor	Beta	t-value	Significance
<u>Block 1</u>			
Cog	.185	2.516	.013*
Aff	.074	.994	.321
SN	.218	3.145	.002**
pb1	.015	.213	.832
pb2	.216	2.867	.005**
pb3	.115	1.572	.118
pb4	.119	1.617	.108

*p<.05 **p<.01

N.B. - Cog = Cognitive component of attitude, Aff = Affective component of attitude, SN = Subjective norm, pb1, pb2, pb3 and pb4 = Perceived behavioural control items.

At the first step of the hierarchical regression analysis the cognitive and affective components of attitude, subjective norm and the individual components of perceived behavioural control are entered into the analysis. As Table 4 shows the cognitive component of attitude (Cog), subjective norm (SN), and ease of disclosure (pb2) had significant coefficients in the first equation. The affective component of attitude (Aff), decision to disclose (pb1), control over disclosure (pb4) and confidence in ability to disclose (pb3) did not (all of these, p> .05).

Table 5. Hierarchical linear regression analysis of intention to disclose personal clinical mistakes in supervision (Block 2)

Model Predictor	Beta	t-value	Significance
<u>Block 2</u>			
Cog	.166	2.206	.029*
Aff	.062	.783	.435
SN	.218	3.164	.002**
pbc 1	.005	.069	.945
pbc2	.245	3.047	.003**
pbc3	.123	1.674	.096
pbc4	.091	1.222	.224
TOTBB	.003	.034	.973
TOTBBA	-.026	-.332	.740
TOTNB	.049	.751	.454
TOTCB	.163	2.482	.014*

* $p < .05$ ** $p < .01$

N.B. - Cog = Cognitive component of attitude, Aff = Affective component of attitude, SN = Subjective norm, pbc1, pbc2, pbc3 and pbc4 = Perceived behavioural control items, TOTBB = Total behavioural beliefs and evaluations, TOTBBA = Total affective beliefs and evaluations, TOTNB = Total normative beliefs and evaluations, TOTCB = Total control beliefs and evaluations.

At the second step (Table 5) of the analysis, total behavioural beliefs (TOTBB), the total affective behavioural beliefs (TOTBBA), the total normative beliefs (TOTNB) and the total control beliefs (TOTCB) are added to the analysis. Of these TOTCB has a significant coefficient in the equation. Cognitive component of attitude (Cog), subjective norm (SN), and ease of disclosure (pbc 2) continued to have significant coefficients. All other coefficients are $p > .05$.

Table 6. Hierarchical linear regression analysis of intention to disclose personal clinical mistakes in supervision (Block 3)

Model Predictor	Beta	t-value	Significance
<u>Block 3</u>			
Cog	.178	2.308	.022*
Aff	.082	1.008	.315
SN	.222	3.158	.002**
pb1	.018	.253	.800
pb2	.225	2.729	.007**
pb3	.096	1.237	.218
pb4	.108	1.402	.163
TOTBB	.003	.034	.973
TOTBBA	-.025	-.313	.754
TOTNB	.048	.720	.473
TOTCB	.162	2.189	.030*
rapport	-.084	-.690	.492
client focus	.084	.750	.454
participation	-.001	-.007	.995
support for innovation	.140	1.231	.220
objectives	-.092	-1.071	.286
task orientation	-.098	-.889	.375

*p<.05 **p<.01

N.B. - Cog = Cognitive component of attitude, Aff = Affective component of attitude, SN = Subjective norm, pb1, pb2, pb3 and pb4 = Perceived behavioural control items, TOTBB = Total behavioural beliefs and evaluations, TOTBBA = Total affective beliefs and evaluations, TOTNB = Total normative beliefs and evaluations, TOTCB = Total control beliefs and evaluations. Rapport, client focus = the two factors of the SWAI – Trainee version. Participation and support for innovation, objectives and task orientation = the four factors of the TCI – Short form.

At the third step (Table 6) of the analysis, the factors from the SWAI – Trainee version (rapport and client focus) as well as the components of the TCI – short form (participation, support for innovation, objectives and task orientation) are added. At this stage Cog, SN, pb2 and TOTCB continue to have significant coefficients. All other coefficients are $p > .05$.

Table 7. Hierarchical linear regression analysis of intention to disclose personal clinical mistakes in supervision (Block 4)

Model Predictor	Beta	t-value	Significance
<u>Block 4</u>			
Cog	.152	1.864	.064
Aff	.100	1.211	.228
SN	.256	3.538	.001**
pb1	.020	.282	.778
pb2	.203	2.440	.016*
pb3	.095	1.221	.224
pb4	.106	1.343	.181
TOTBB	.014	.177	.860
TOTBBA	-.061	-.737	.462
TOTNB	.069	.992	.323
TOTCB	.152	2.028	.044*
rapport	-.061	-.499	.619
client focus	.081	.721	.472
participation	-.015	-.147	.883
support for innovation	.130	1.136	.258
objectives	-.104	-1.180	.240
task orientation	-.075	-.674	.502
gender	.011	.154	.878
age	.139	1.823	.070
year	-.084	-.717	.475
No. of supervisors	.107	.916	.361

*p<.05 **p<.01

N.B. - Cog = Cognitive component of attitude, Aff = Affective component of attitude, SN = Subjective norm, pb1, pb2, pb3 and pb4 = Perceived behavioural control items, TOTBB = Total behavioural beliefs and evaluations, TOTBBA = Total affective beliefs and evaluations, TOTNB = Total normative beliefs and evaluations, TOTCB = Total control beliefs and evaluations. Rapport, client focus = the two factors of the SWAI – Trainee version. Participation and support for innovation, objectives and task orientation = the four factors of the TCI – Short form.

At the fourth step of the analysis (Table 7 – see above), gender, age, year of training and number of supervisors was added. At this stage SN, pb 2 and TOTCB had significant coefficients. All other coefficients are $p > .05$.

Table 8. Model summary

Model	R	R Square (R ²)	F change	Sig. F change
1	.574	.330	11.601	.000
2	.597	.357	1.675	.158
3	.608	.370	.555	.766
4	.624	.390	1.207	.310

Table 8 (Model summary) shows that a significant proportion of the variability to predict intention was accounted for by the TPB predictors ($R^2 = 0.32$ $F(7, 165) = 11.60$, $p < .000$). The addition of other variables in blocks 2, 3 and 4 did not lead to any further enhancement in the predictive utility of intention.

Summary

In relation to individual theory of planned behaviour predictors, it can be concluded that perceived difficulty (pbc2), the cognitive component of the attitude scale and subjective norm are the significant predictors of intention for this sample. The affective component of the attitude scale as well as pbc1, pbc3 and pbc4 do not. As far as other variables are concerned, the total cognitive beliefs (TOTCB) and Age were significant predictors of intention but this did not add to the overall model of intention in any significant way, over and above the original model.

Analysis of TPB components behavioural beliefs, and other study variables

There are a number of other significant correlations between components of the model. Ease of disclosure (pbc2) was significantly correlated with the cognitive factor of attitude, $r = .26, p < .01$ and the affective factor of attitude, $r = .49, p < .01$. It was also significantly correlated with total behavioural beliefs (TOTBB) $r = .41, p < .01$, total affective beliefs (TOTBBA) $r = .35, p < .01$ but was significantly negatively correlated with total normative beliefs (TOTNB) $r = -.12, p < .05$. There was a significant correlation between pbc4 (confidence in ability to disclose) and total behavioural beliefs (TOTBB) $r = .31, p < .01$ and a significant negative relationship between pbc3 and total normative beliefs (TOTNB) $r = -.13, p < .05$.

Analysis of Intention, rapport and individual items from the 'Disclosing personal clinical mistakes in supervision' questionnaire

Of the individual items from 'Disclosing a personal clinical mistake in supervision would lead to a negative assessment by my supervisor', ($r = -.17, p < .01$) and 'I have experienced negative consequences in supervision' ($r = -.20, p < .01$) negatively correlated with intention. 'Disclosing a personal clinical mistake in supervision would make me feel shameful', ($r = -.15, p < .054$) approached a significant negative correlation.

The rapport factor from the SWAI – Trainee version was significantly correlated with intention to disclose a personal clinical mistake in supervision ($r = .13, p < .05$). 'I have a good relationship with my supervisor', was also significantly correlated with rapport ($r = .59, p < .01$) and with intention ($r = .21, p < .01$).

Discussion and conclusions – Study 2

The discussion will be divided into two parts. Firstly there will be consideration of the main findings of the study. Following this the limitations of the study will be outlined and areas of caution in relation to the interpretation of findings will be summarised.

The current study examined clinical psychology trainee observations about supervision and investigated their intention or otherwise to disclose personal clinical mistakes in supervision. With regard to the findings from the demographic data, at the time of writing the author is unaware of any published research or statistics on age differences between genders in clinical psychology training to support the observations that male trainees tended to be from an older age range than females. Therefore it is not possible to say whether this reflects a trend within clinical psychology trainees. As far as other demographic variables were concerned, analysis did not reveal any other significant differences and or numbers were too small to carry out analysis e.g. ethnicity.

With regard to the inferences relating to the Theory of Planned Behaviour (TPB), the results of the hierarchical regression analysis showed that perceived difficulty of disclosure (pbc2), subjective norm (SN) and the cognitive component of attitude (Cog) emerged as significant predictors of intention to disclose a personal clinical mistake in supervision. In this study the other components of perceived behavioural control did not correlate strongly within the model in relation to intention to disclose personal clinical mistakes.

However, all components of the TPB correlated individually with intention to disclose except for pbc1 (“Whether or not I disclose a personal clinical mistake in supervision is entirely up to me”). In a meta-analytic review of TPB Armitage and Connor (2001) concluded that self-efficacy accounted for most of the extra variance in intention and

argued that individuals make intentions upon which they are confident they can act. This fits with confidence in the ability to disclose and level of difficulty of disclosure being elements of perceived behavioural control that were individually significantly correlated with intention.

The one element that did not correlate significantly was the item indicating whether or not individuals felt it was up to them whether they disclosed or not. It may be that although individual trainees feel confident and in control in being able to disclose it might be that there is some expectation for trainee clinical psychologists as learners to discuss mistakes in supervision and this might be an inherent part of training somewhat negating some of the choice as to whether or not to disclose.

The cognitive component of attitude was also a significant predictor of intention to disclose a personal clinical mistake in supervision. This would appear to support the contention of some authors (Breckler & Wiggins, 1989; Ajzen, 1991; Trafimow & Sheeran, 1998) that there is a valid distinction between cognition and affect within attitudes. So in the case of trainee clinical psychologists, individuals may recognise that disclosing personal clinical mistakes in supervision may be good, wise and helpful but they may not feel that doing so would be pleasant or calming.

The results from this study also suggest that subjective norm is associated with individual intention to disclose a personal clinical mistake in supervision. In their review Armitage and Connor (2001) assert that there is support for the idea that subjective norm is weak as a concept and does not often predict intention. They argue however that the poor performance of subjective norm was often a function of how it was measured i.e. often subjective norm was evaluated through a single item measure. In the context of the current

study subjective norm was measured through two items. Again there may be an expectation in the context of training and in the profession of clinical psychology as a whole of which trainees would be aware, that individuals discuss mistakes in supervision as part of the learning process creating a professional norm.

In relation to other findings from Study 2 it would seem that both the cognitive and affective attitudes (e.g. how good/bad, how pleasant/unpleasant) of individuals related to how easy it was to disclose a personal clinical mistake in supervision. Ease of disclosure was also significantly correlated with behavioural beliefs, affective beliefs and normative beliefs. So, for example, this might suggest that if an individual felt that disclosing a personal clinical mistake in supervision would enable them to learn and that they would feel safe and that they valued these beliefs more highly than the possibility of a negative assessment by their supervisor then this would make disclosure easier.

Confidence in the ability to disclose a personal clinical mistake in supervision was also associated with behavioural beliefs. So again where individuals believe for example that disclosure would develop their skills and they valued this more highly than some of the more negative beliefs, for instance that it might make them look incompetent, then this would lead to increased confidence in the ability to disclose.

However, there was a significant negative correlation between ease of disclosure and normative beliefs and also a negative association between pbc3 (confidence in ability to disclose) and normative beliefs. These results would appear to suggest that the more that individuals are subject to normative pressure (social influence) the harder disclosure becomes and the less confident they are in disclosing. These findings seem to contradict the finding that subjective norm was positively correlated with intention to disclose a

personal clinical mistake. Armitage and Connor (2001) reported that work has been undertaken on a variety of norms. Cialdini, Kallgren and Reno (1991) differentiate between a number of different norms (personal, descriptive and injunctive). It may be that the different components e.g. intention vs. ease of disclosure map onto different norms. So perhaps ease of disclosure may map onto injunctive norms, which Armitage and Connor (2001) assert relate to subjective norms whereas intention might map onto personal norms i.e. self-identity or moral norms (Connor & Armitage, 1998).

Ladany, Hill, Corbett and Nutt (1996) suggested that negative feelings were associated with non-disclosure and these current findings that items such as 'I have experienced negative consequences in supervision', would seem to suggest that negative feelings are also related to intention not to disclose. 'Disclosing a personal clinical mistake in supervision would make me feel shameful', was close to being significantly negatively associated with intention and this would appear to fit with Yourman (2003) and Yourman & Farber's (1996) assertion of a role for shame in nondisclosure in supervision.

Finally, other studies into disclosure (Ladany et al, 1996; Webb and Wheeler, 1998; Walsh et al, 2002) have argued that the quality of the relationship between supervisor and trainee plays a part in trainee disclosure. It would appear in this study that intention to disclose a personal clinical mistake may also be associated with the state of the supervisory relationship. This is suggested by the finding that both the rapport factor of the SWAI and the 'I have a good relationship with my supervisor', item of the questionnaire were significantly correlated with intention.

As far as team climate was concerned, none of the team climate factors were significantly correlated with intention though each of the four TCI – short form factors were

significantly associated with the rapport factor of the SWAI. This may suggest that a good team climate might foster good relationships generally.

Limitations of the study

Having made some inferences about the results as they stand, the limitations of the current study should be acknowledged and a level of caution added to the interpretation of the findings. The design is correlational and therefore no definitive statement of causality may be made. Although the numbers of respondents to the questionnaires fell within the range for other studies utilising the Internet it would still have been preferable to have achieved a larger sample size in order to increase the generalisability of the findings.

Due to technical problems the data from one of the intention items ('If I make a personal clinical mistake I intend to disclose it in supervision') was invalid. This meant that the measure of intention was an estimation, (i.e. 'How likely is it that if you make a personal clinical mistake you would disclose it in supervision?') Although in a meta-analysis of the Theory of Reasoned Action (TRA) from which the Theory of Planned Behaviour is derived Sheppard, Hartwick and Warshaw (1988) argue that estimation is a better predictor of actual behaviour than intention, it would have been preferable to have had the data from both measures available to make the findings more robust.

The data on intention to disclose a personal clinical mistake from this sample was somewhat skewed (see Appendix 8) and therefore lacked variability. There may be more than one reason for this occurrence. Firstly all three questionnaires lacked variability in their set up. That is, Scales were in most cases set up on a positive to negative scoring system (e.g. good = 1 to bad = 7) and this may have led to a response bias amongst the sample. Another explanation might be that trainee clinical psychologists might be

predisposed toward an intention to disclose personal clinical mistakes in supervision because there may be a level of professional expectation that individuals discuss such occurrences in order to learn from them. Under such circumstances it would be unsurprising for trainees to have the intention to disclose personal clinical mistakes.

Future Research

Areas for potential future research are discussed in greater detail within the critical appraisal.

One area for potential further investigation might be the discrepancy between the apparently wide intention of trainee clinical psychologists to disclose personal clinical mistakes in supervision and the suggestion in the work of Ladany et al (1996) that clinical mistakes is one of the types of material that trainees sometimes do not disclose.

A second area for further investigation might be to look at more serious mistakes or errors. It may be that discussion of fairly simple mistakes is comparatively untroubling to trainee clinical psychologists. However, trainees may well be less likely to discuss, or even have the intention to discuss, more serious errors, for instance those with potential disciplinary consequences.

General Conclusions

To summarise, this investigation has identified specific factors that might predict trainee clinical psychologists' intention to disclose personal clinical mistakes in supervision, utilising a specific social psychological model of behaviour to do so. The study has also detailed some of the elements that may facilitate or inhibit such intentional behaviour. In order for the findings to be more generalisable further more extended research will be required, with an expanded population looking at more specific mistakes. Future research into the area might also include the role that different norms play in an individual's

intentions to disclose clinical mistakes and a focus on the development of good supervisory relationships with strong alliances might be useful as well. One area that may also be potentially profitable to focus on is the nature of the mistakes that individuals would not intend to disclose in supervision and what factors and which individuals might be influential in eliciting them.

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Critical Appraisal

Critical Appraisal

Introduction

The purpose of this critical appraisal is to deliver a picture of the research process from the trainee's viewpoint. This will include an assessment of each step in the research study and will include: the derivation of the study, the designing process, literature review, both parts of the data collection and analysis, as well as the writing up of the research. Through the course of the appraisal there will be reflection by the trainee on the elements that facilitated and hampered the process of research, the maintenance of motivation, the limitations in terms of the methodology of the study and the implications for clinical practice. There will also be a discussion on how the findings and ideas could inform future research.

The origins of the research

Prior to my entering clinical training, I had managed residential and day-care services for people with learning disabilities and one of the roles of management was the formal supervision of members of staff. I had always believed that the best way to ensure that the needs of service users were being met was through ensuring that those directly working with individuals were supported and guided effectively towards the best practices and that their learning and development was facilitated through supervision. A number of authors (Page and Wosket, 1994; Scaife, 2001) have indicated that securing the welfare of clients and improving the services that clients are offered by their therapists is a characteristic of supervision. As a consequence of this, Scaife (2001) asserts that the focus of supervision may be almost entirely on the supervisee's needs and experiences.

In my working life I have always been interested in the supervisory process and what makes for good supervision. This also means an interest in what makes for poor supervision.

On entering psychology as a profession I was aware that clinical supervision was a necessary part of the work. I was interested to learn about the similarities and differences between the supervision that I had practised and experienced within my managerial role within the learning disabilities field and the supervision that I was experiencing in the context of my role as a trainee clinical psychologist. I felt that supervision within both fields was a forum for learning but there was an emphasis on understanding the process in working with individuals and within supervision itself in the clinical psychology context that was not present in my previous experience of supervision.

It was therefore always my intention to try to focus my research on this area and the question then was how to best to approach the subject. My initial ideas were related to counter-productive events and ethical decision making processes in supervision and in the first instance I developed a proposal with my supervisor Professor Hardy around this area. I wanted to carry out a quantitative study using trainee clinical psychologists as participants but I found that I had not managed to develop a proposal that had a clear focus in terms of the question that was being asked. The background material that I had gathered was leading more in the direction of a qualitative analysis, in that I had several questions, all of which were exploratory in nature.

After my initial proposal handed in March 2003 had been peer reviewed and feedback provided in May 2003 I was left with some major changes to make to the study. As a result of this a decision then had to be made about whether I would carry on with the material

that I had garnered and change the methodological approach or whether to reconsider my options and look to develop a much more specific question that could be measured quantitatively. I decided to go back to the beginning, with supervision as my area of interest but with the aim on this occasion of developing a much more focussed question.

It was at this time that my supervisor and I started to discuss the idea of using the Theory of Planned Behaviour as a model to underlie the research. In reading material related to this theory it seemed that it provided a very good opportunity to develop a very definite question related to individuals' intention to carry out a particular action.

I had gone back to the material I had gathered from my initial computerised searches on supervision and had become interested in what training therapists did and did not disclose in supervision. Further searches of the literature led to an awareness of the discrepancy between the apparent importance placed on learning through mistakes within the context of the supervisory process and the suggestion that clinical mistakes were amongst material that training therapists did not disclose within supervision.

Following discussions with Professor Hardy, it was agreed that research into trainee clinical psychologists' understanding and utilisation of supervision and the relationship between the two would be beneficial. It was decided on this basis that these would be the focal point of the research. At this time another discussion took place about the collection of data. The possibility of utilising the Internet to collect data was raised and I decided that some investigation of this option would be profitable, as I believed that it could help speed up some of the research process. Given that I had gone back to the beginning in terms of starting my research, time was of the essence.

Designing the research

Having established a viable research area and formed a specific question, the next step in the research process concerned looking at the practical aspects of implementing the project in order to put in a second research proposal.

There were many aspects to consider in terms of the design of the study, the type and number of participants required, data analysis, how long the process would take and the financial implications. These were carefully considered in consultation with my supervisor and we agreed how best to approach each. I was beginning to be aware of the time pressure that I had put on myself by going back to the beginning but wanted to ensure that when the proposal was finally handed in that there would be as little left to address as possible.

The main area of concern for me at this time was how I was going to run the study via the Internet. This meant some discussions with the computer technical support within the Psychology Department. Ms. Karen Briggs was very helpful and reassuring in her assertions that the study could be hosted online and that I would need to provide the materials. Karen also felt that it would be possible for data to be sent back to an independent data file once it was submitted. These conversations helped ease any anxieties that I had about using this technology.

The research for this second proposal was subsequently finished and handed in to the internal research sub-committee at the University in the summer of 2003. Feedback in September 2003 indicated that approval was given with minor changes necessary. This meant that once I had made the changes my proposal could then be submitted to the Departmental Ethics Sub-committee (DESC) at the University of Sheffield. This was done

in early October 2003 and by the end of November 2003 ethical approval had been obtained.

Data collection

Pre-study questionnaire (Study 1)

The next stage of the study involved recruiting participants to complete the pre-study questionnaire (Study 1) and to begin the process for recruiting participants for the main study. For the pre-study questionnaire I had been allowed to approach the three year cohorts on the University of Sheffield training course. My main concern when designing the study had been how to maintain anonymity. In the end it had been decided that I would leave a collection box in the study area of the clinical Psychology Department that participants could drop their envelopes with their completed forms in. This was left for a set period after which I collected the responses, removed the box and left a memo in trainee pigeon-holes saying that I had completed my collection of responses. I felt pleased with the number of responses that I received especially as the questionnaires had been distributed towards the end of the Christmas term.

At this time, just prior to the end of the Christmas term, I sent letters to all the heads of Doctor of Clinical Psychology training courses in England, Scotland and Wales. I realised that I would be unlikely to receive any responses before the New Year (though in fact six courses did respond very rapidly), but I felt that I need to start the process as quickly as possible in order to maximise the amount of time that I had to carry out the study.

Development of the questionnaire

Once the initial stage of the study had been completed, the next stage was the selection of pertinent items for the questionnaire. The demographic items had been decided upon in

the planning process so it was the items that were relevant to the Theory of Planned Behaviour (TPB), which the data from the pre-study (Study 1) questionnaires provided, which required more deliberation. However, during the analysis I gradually realised that although the questions on the form were open-ended many of the answers given were quite limited and that the data was somewhat lacking in richness. I had, perhaps somewhat naively, assumed that the data would somehow be fuller. Although the data was fit for the purpose for which it was designed I reflected that using another form of data collection e.g. focus group might have provided richer data. In terms of building the main body questionnaire from my analysis I was indebted to the expertise of Dr. Norman whose understanding of TPB was invaluable in terms of enabling me to understand the process of item selection.

Setting up the Internet site

In tandem with the analysis of the data from the pre-study questionnaire and the development of the main questionnaire I had been involved in the process of putting the project onto the Internet. I had eventually received permission from all but one of the training courses to approach trainees. One of the heads of a clinical psychology training course had very usefully pointed out that it would be possible to trace back to computers that were used to fill in the questionnaires possibly compromising anonymity. This led to a change on the information sheet that was to be distributed to trainee psychologists highlighting this and also stating the position of the author and the University that this would not occur unless the University's system was being abused in any way.

Permission for the questionnaires to be hosted via the clinical Psychology Department's website was sought and granted. Once the questionnaires were ready they were given to Mr. Laurence Cornford of the University's Corporate Information and Computing Services

(CICS) section and it was his technical facilitation that enabled the questionnaires to be placed on the website.

In order to avoid anybody other than trainees accessing the pages with the questionnaires on, they were placed on a 'stand alone' web page that could not be accessed by entering the Clinical Psychology Department website. This meant that individuals could only access it if they had the appropriate address. After checks had been made that all the material was correctly assembled on the website and that it could be accessed it was time to proceed with the distribution process.

This was a very exciting and busy time and I had been looking forward to seeing the questionnaire on line. In relation to this part of the project I felt I was mainly project managing, as I did not have the technical know how to carry out the website construction myself. This felt slightly anxiety provoking in that I had to rely on other individuals to complete work for me within the context of their workload although I also felt a great sense of anticipation about what I was about to do. Time seemed to be moving on very rapidly and we had reached the end of March 2004 before the website and the questionnaires were fully functional. However, this did not reduce my sense of excitement when I was able to carry out a test run on the questionnaire to check that it worked.

Distribution of the questionnaires

In order for the trainees to access the questionnaires but for participants to maintain anonymity, I had to send the information sheet that contained a hyperlink connecting individuals to the questionnaires via course administrators on each of the courses. To do this I spent a day ringing round each of the courses speaking to administrators explaining that I had had permission to approach trainees and that I would like to send them an e-mail

with an attachment to the information sheet. The e-mail would then be distributed by the administrators to each of the three year groups on their course allowing trainees to read the information sheet and decide whether they wished to access the website and complete the questionnaires.

I found that all the administrators were unfailingly helpful and co-operative even though I contacted them at a busy time of year in that the selection process for training courses was about to begin or had begun. This meant that the distribution process ran relatively smoothly and it was then up to trainees whether or not they wished to participate. Indeed this response and the technical support I had received reminded me of the human content of the study. I had felt so involved with getting the technical detail right that I had somehow forgotten that there is more than just the material that you present to making a study effective.

Literature review

There seemed overall to be quite a wide range of research in the area of disclosure and some specifically in relation to self-disclosure by therapists. In carrying out my searches I tended to use the main psychological databases until I had a specific focus in relation to the review. Later on I searched more widely using other databases and contacting a leading researcher in the area who suggested further articles of interest.

Overall accessing papers became a matter of travelling on several occasions to the British Library at Boston Spa. Although I could access some of the material that I required through the libraries at the University of Sheffield and Hallam Universities and through the electronic journal database of the University of Sheffield most of the articles that I required were not available through these libraries. I was aware that the cost of inter-library loans

meant that there were restrictions on the amount of these that could be utilised and with that in mind I opted to access the British Library as my alternative resource of choice.

Data analysis and writing up

As I was still collecting data until the end of May 2004 the process of analysis and writing up did not start until relatively late on. However, in terms of the analysis I wanted to be as thorough as I could be as the analysis of such a large data set and the extensive use of SPSS were comparatively new to me. I found completing the descriptive analysis relatively straightforward. For the more detailed inferential analysis I consulted Professor Sheeran whose expertise in the TPB model was extremely helpful in enabling me to get to grips with the data and whose patience with my naïve questions was much appreciated.

The data analysis was also the point where I felt most anxiety because it was here that my blasé assumptions about technology functioning without a hitch were somewhat blown out of the water. It appeared on initial analysis of the data that all respondents had completed the intention question (Item 9) by clicking scale = 1 radio button. This came as rather a shock and it was only after some investigation and completing the questionnaires online several times myself into an empty data file that I discovered that all the radio buttons for that question bar number 7 had scored 1 if you clicked them and for Item 50 none of the radio buttons for that question had worked at all.

In terms of starting the writing up process, apart from the literature review I waited to carry out most of the work during my research block when I felt that I could focus more clearly on the task in hand rather than try to do a lot of it whilst I was still on placement and trying to fill in application forms for jobs.

Methodological limitations of the study

Some of the limitations of the study were addressed within the discussion of the main study (Study 2). These included the correlational nature of the study and the need for a larger number of participants. There were other limitations to the study that will be expanded upon here.

One of the side effects of utilising technology, specifically the Internet, is that technological errors become part of the equation. The fact that two items of data were either rendered invalid or did not register because the radio buttons on those questions did not work has implications in terms of inferences about the findings. Both items were particularly relevant to the study. Item 9 which stated 'If I make a clinical mistake I intend to disclose it in supervision', was a core question in the study. Although intention was assessed through other means, it would have strengthened the findings to have the data from this question. For item 50 'I have a poor relationship with my supervisor', the data did not register at all. The relevance of this question is in the fact that there was a relationship between supervisor and supervisee and whether they intended to disclose personal clinical mistakes in supervision. One might have hypothesised that those with a poor relationship with their supervisor would not have been likely to disclose.

Another limitation of the study was the nature of the measures used. The scales in each of the questionnaires lacked variability in their construction. That is in the case of the Disclosing Personal Clinical Mistakes in Supervision the scales went positive to negative (e.g. Agree – Disagree) in nearly all cases and for the other two questionnaires the scales went from positive to negative (e.g. Disagree – Agree) for all cases. This would seem to make response bias and skewing of the data related to individual intention to disclose personal clinical mistakes, as was the case, very likely.

Another explanation of the bias in responses toward intention to disclose personal clinical mistakes is that trainee clinical psychologists may feel that a philosophy of learning from mistakes may exist within the profession and so make it likely that they respond from a professional standpoint and expectation rather than an individual one. It may have been preferable to focus on trainee psychologist's actual behaviour in terms of disclosing personal clinical mistakes rather than their intention to disclose.

A further limitation of the study was in the context of the TPB components. Responses to the perceived behavioural control (PBC) items were not internally reliable and did not correlate very strongly with each other. Consequently they had to be analysed individually. This might indicate some weakness in the model in relation to some intentions and behaviours. It might be that the components do not work as a coherent whole in some instances. Item 10 'Whether or not I disclose a personal clinical mistake is entirely up to me' was not as strongly endorsed as Items 16 and 17, which were about confidence in ability to disclose and control over disclosure.

Perhaps self-disclosure of personal clinical mistakes is almost entirely a volitional behaviour the theory of reasoned action (Ajzen & Fishbein, 1980; Fishbein & Ajzen 1975) may be a more appropriate model as this applies to volitional behaviour (Sheppard, Hartwick & Warshaw, 1988).

Clinical Implications

There would appear to be a number of clinical implications from this study. Firstly it would seem that there could be discrepancy between what trainee psychologists say in terms of their intention to disclose personal clinical mistakes in supervision and what other research (Ladany et al 1996) suggests, i.e. that clinical mistakes are something that trainees do not

disclose. If trainee psychologists are making clinical mistakes and are not discussing them then this may have an effect on the welfare of clients. A mistake, if it is not addressed adequately, might have an emotional impact on the individual client and may also have other practical consequences e.g. the withdrawal by the client from therapy.

The adequacy of response could well be something better learned from the experience and knowledge of another (the supervisor) than by the trial and error practice of a trainee. In the context of the trainee developing and improving their counselling skills, concealing mistakes would appear to be inimical to therapist growth. In the long run this might affect clients indirectly in that a therapist might not be operating at the optimum level as a result of not learning by the experience of mistakes.

If the therapist does not reveal clinical mistakes then the supervisor is also prevented from supporting the supervisee in dealing with the impact of working with clients and dealing with the emotional stress of making a clinical mistake. This again may have consequences for clients at a later point if the therapist has been unable to process effectively previous difficulties and mistakes.

There are a couple of areas that it might be useful to explore in future. The investigation of Ladany et al (1996) suggested that trainee therapists do not disclose a great deal of material including clinical mistakes. It seems from the present study that it was the intention of many of the trainee clinical psychologists that participated to disclose personal clinical mistakes in supervision. If there is a discrepancy between intention and actual behaviour it might be worth investigating the process between the intention and the decision to disclose. One way to do this might be through a qualitative methodology looking at

peoples' actual decisions and possibly focusing on the kind of cognitions and feelings that are part of that process.

The other focus for study that might be helpful in the future is the nature of the personal clinical mistakes that are being disclosed. It may be that fairly simple mistakes are relatively easy to discuss but that more serious errors would be difficult to bring to supervision, especially those where some kind of sanction may be involved. Although this would be difficult to research in terms of the ethical problems that might be raised by such a study e.g. if someone reveals a serious error that they have not discussed there would be an obligation to take this further.

It would also seem unlikely that individual trainee clinical psychologists/therapists would be prepared to discuss such errors. However, it might be possible to look at this issue through the use of vignettes, looking at a variety of different errors and whether individuals would be prepared to disclose them in supervision or not.

Maintaining motivation

I feel that I had a false start with my initial proposal and because of this I decided to begin again. This meant that the whole research process was shortened in length. The fact that I knew that there was a pressure on me to get things going and keep them moving fairly quickly meant that I didn't feel at any point as though the process was too long or slow. This I found very helpful in keeping me focussed and motivated. I feel that because I managed to keep the research I was doing related to an area that I was particularly interested in also drove me on.

There were large parts of the research process with which I had not previously involved with in such an intimate way, as my previous experiences had been much more directed by others. This sense of control and the freshness of the experience held my interest throughout. Although I had moments of anxiety I genuinely enjoyed the process and I felt that the utilisation of the Internet within my study gave it an innovative feel that reflected some of the creativity involved in carrying out research.

My research supervisor helped with motivation in terms of her own interest in the type of methodology that I was using, the clear, concise and swift feedback that she provided and the general confidence and breadth of knowledge that she was able to use in guiding me through the process.

I also felt that others with whom I had contact to ask for advice, technical assistance and who made comments and suggestions about my study were uniformly friendly, helpful and knowledgeable and that I felt able to trust in what I was being told by them.

I think that I also gained a great deal of motivation from family and friends in the sense that I was always kept grounded in reality and so although I was focussed on the work involved in the research I could always see that there were other parts of my life that were just as important.

Learning points

The first thing that has struck me about the process of carrying out research is the level of detail involved. Until one is involved with a research project at this level it can be hard to understand the level of background work and effort that is required to enable a study to be completed. I think that carrying out the research made me appreciate some of the skills that

I have got e.g. prioritising and time-management and also the many skills that I needed to develop e.g. data analysis and search strategies.

From the literature review I feel that I have learned something about the breadth of the processes involved in self-disclosure by therapists, i.e. the different mechanisms that are involved in self-disclosures by therapists in supervision and within the therapeutic dyad.

In terms of data analysis I learned a good deal about and confidence in the use of SPSS, for example learning how to recode data. I feel that from the responses to both of the questionnaires I have learned much about what influences trainees in their interactions with supervisors and I have learned that the development of a strong alliance between supervisor and supervisee is a key factor in a successful relationship. I also feel that this research has shown me how models from psychology can be successfully applied into real world situations something that I have felt is not always the case. Finally, through completing this research project I feel as though it has allowed me to use and improve old skills, develop new skills and give me confidence to carry out further research projects in the future. The skills e.g. attention to detail, can only enhance my clinical practice.

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Sheffield S10 2TP UK

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Clinical Practice Director: Ms Joyce Scaife
Course Administrator: Carole Gillespie
Prof Nigel Beail

24th February 2003

Rhodri Hannan
Third year trainee
Clinical Psychology Unit
University of Sheffield

Dear Rhodri

I am writing to indicate our approval of the journal(s) you have nominated for publishing work contained in your research thesis.

Literature Review: Clinical Psychology Review

Research Report: Journal of Counselling Psychology

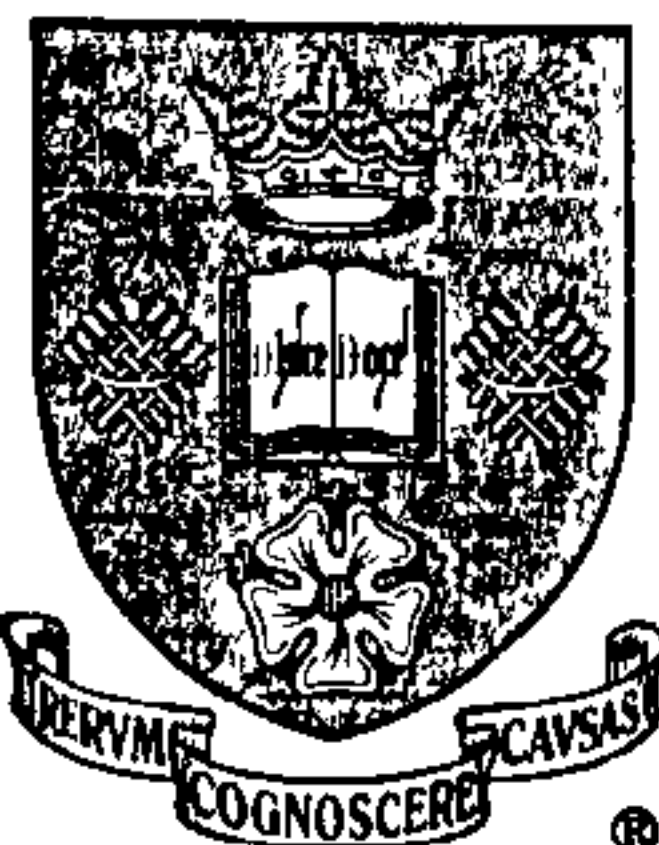
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Yours sincerely

Andrew Thompson
Chair, Research Sub-Committee

Appendix 3

Ethical Approval



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DEPARTMENT OF PSYCHOLOGY

Head of Department

Professor Rod I Nicolson

Psychology Building
Western Bank
Sheffield S10 2TP
Tel: 0114 2226546

Email r.nicolson@sheffield.ac.uk

From: Dr Mark Blades +44 114 222 6549 <http://www.shef.ac.uk/psychology/> m.blades@sheffield.ac.uk

4th December 2003

To whom it may concern,

Dear Sir/madam,

Rhodri Hannon

This is to confirm that ethical approval has been obtained by Rhodri Hannon from our Departmental Ethics Sub-Committee for his project entitled "Trainee Intention to Disclose Personal Clinical Mistakes in Supervision".

Yours faithfully,

Dr Mark Blades
Chair of the Departmental Ethics Sub-Committee (Semester 1, 2003-04)

MARK BLADES
DEPARTMENT OF PSYCHOLOGY
UNIVERSITY OF SHEFFIELD
SHEFFIELD S10 2TP
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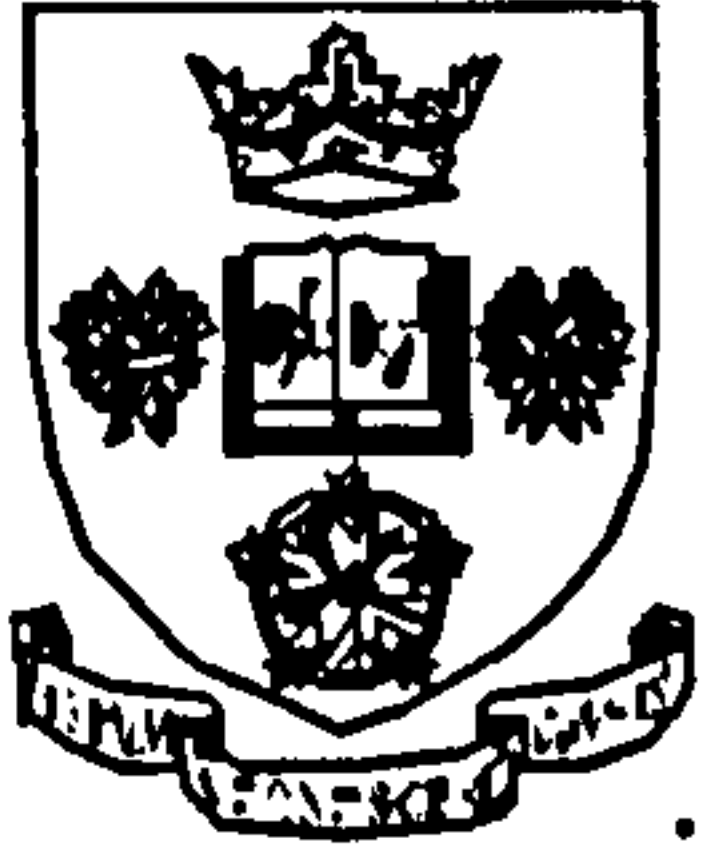
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Study 2

Appendix 4a

Main Study (Study 2) – Questionnaire information sheet



THE UNIVERSITY OF SHEFFIELD
Clinical Psychology Unit
Department of Psychology

Doctor of Clinical Psychology (DClin Psy) Programmes (Pre-registration and post-qualification)
Clinical supervision training and NHS research training and consultancy

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TP UK
Unit Director: Prof Graham Turpin
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Course Administrator: Carole Gillespie
Prof Nigel Beal

Information Sheet – Questionnaire

Disclosing Personal Clinical Mistakes in Supervision

You are invited to fill in the following questionnaire. Before doing so it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Take time to decide whether or not you wish to take part.

THANK YOU FOR READING THIS.

Who is conducting the study?

My name is Rhodri Hannan and I am a trainee clinical psychologist on the University of Sheffield Doctor of Clinical Psychology course.

What is the purpose of the study?

Trainee psychologists as individuals may choose not to reveal many different pieces of information during the course of their supervision. The purpose of the study is to try to understand the factors that may influence a trainee clinical psychologist's intention to disclose personal clinical mistakes in supervision. Mistakes have been described as an unintentional oversight in good practice. For example, not checking all of a client's symptoms, forgetting to follow up on a client referral, making an incorrect interpretation that causes a client some distress, saying something about yourself that you later feel uncomfortable about.

Why have I been chosen?

The study is set up to examine the intentions of trainee clinical psychologists and so I am attempting to survey the trainee clinical psychologist cohort for the years 2001-2003.

Do I have to take part?

The decision to take part is entirely up to you. You may decide to withdraw at any time by exiting the website. However, as the information that you are providing is given anonymously once you have sent the information by clicking the **Submit Data** button on the website, it cannot be withdrawn.

What do I have to do?

All that is required is that you fill in the items in the following questionnaires adhering to the instructions given to you on the website.

Will my taking part in this study be kept confidential?

This questionnaire will be submitted anonymously. The University of Sheffield will not seek to identify users unless it has a specific suspicion that its systems are being abused, in which case an investigation will take place in accordance with the university's normal security procedure.

What will happen to the results of the research study?

The results of the study will be analysed and written up as my research project for the Doctor of Clinical Psychology course at Sheffield University. I will also seek to have the research published in a relevant journal.

What do I do if I wish to make a complaint?

If you have a complaint about the conduct or the content of the study then you should contact Dr. Gerry Kent of the Clinical Psychology Unit at the University of Sheffield by telephoning 0114-2226527 or by e-mail g.kent@sheffield.ac.uk, or my research supervisor Prof. Gillian Hardy on 0114-2226571 or by e-mail at g.hardy@sheffield.ac.uk. You can also use the University of Sheffield complaints procedure by contacting Dr. D.E. Fletcher, Registrar and Secretary, University of Sheffield, Firth Court, Western Bank, Sheffield, S10 2TN.

What if the material in the study leads me to feel upset or concern about my own or other's supervision?

It is suggested that if the material presented in the questionnaire leads to any upset or concern on your behalf either about your own or other's supervision, that you raise your concerns in the first instance with your clinical or personal tutor.

Contact for Further Information

You can contact the author (Rhodri Hannan) at the Sheffield University Clinical Psychology Unit, Western Bank, Sheffield S10 2TP. Tel: 0114-222-6570 or E-mail - pcp01crh@sheffield.ac.uk

Appendix 4b

Disclosing Personal Clinical Mistakes in Supervision Questionnaire

5. Placement Please state the type of placement you are currently on e.g. Older adult, Forensic

6. Ethnicity Please indicate your ethnic group using one of the options below
- Asian or Asian British ()
- Black or Black British ()
- Chinese or Other Ethnic Group ()
 (Please describe other ethnic group).....

- Mixed ()
 (Please describe).....

- White ()
7. Model Please indicate the psychological model that you adhere to (if any)

8. Supervisors Please indicate the number of supervisors you have experienced so far on training ()

Section 2: Perceptions of Supervision and Intention to Disclose Personal Clinical Mistakes

Please indicate your answers by clicking on the number that best represents your position in relation to each statement.

9. If I make a personal clinical mistake I intend to disclose it in supervision
- Definitely would 1 2 3 4 5 6 7 Definitely would not
10. Whether or not I disclose a personal clinical mistake in supervision is entirely up to me
- Strongly agree 1 2 3 4 5 6 7 Strongly disagree
11. Most people who are important to me think that I
- Should 1 2 3 4 5 6 7 Should not
 disclose a personal clinical mistake in supervision

12. How likely is it that if you make a personal clinical mistake you would disclose it in supervision?

Likely 1 2 3 4 5 6 7 Unlikely

13. For me, disclosing a clinical mistake in supervision would be

Easy 1 2 3 4 5 6 7 Hard

14. Disclosing a personal clinical mistake in supervision would be:

Good	1	2	3	4	5	6	7	Bad
Wise	1	2	3	4	5	6	7	Foolish
Calming	1	2	3	4	5	6	7	Distressing
Helpful	1	2	3	4	5	6	7	Unhelpful
Pleasant	1	2	3	4	5	6	7	Unpleasant

15. How much control do you feel you have over disclosing a personal clinical mistake in supervision?

Complete control 1 2 3 4 5 6 7 No control

16. If I wanted to, I am confident that I could disclose a personal clinical mistake in supervision

Strongly agree 1 2 3 4 5 6 7 Strongly disagree

17. Most people who are important to me would

Approve 1 2 3 4 5 6 7 Disapprove
disclose a personal clinical mistake in supervision

The following questions focus on your thoughts about the possible outcomes of disclosing personal clinical mistakes in supervision:

18. Disclosing a personal clinical mistake in supervision would:

a) Enable me to learn

Likely 1 2 3 4 5 6 7 Unlikely

b) Develop my skills

Likely 1 2 3 4 5 6 7 Unlikely

c) Help to correct the mistake

Likely 1 2 3 4 5 6 7 Unlikely

d) Make me look incompetent

Likely 1 2 3 4 5 6 7 Unlikely

e) Lead to a negative assessment by my supervisor

Likely 1 2 3 4 5 6 7 Unlikely

19. Being able to learn would be...

Good 1 2 3 4 5 6 7 Bad

20. Developing my skills would be...

Good 1 2 3 4 5 6 7 Bad

21. Correcting the mistake would be...

Good 1 2 3 4 5 6 7 Bad

22. Looking incompetent would be...

Good 1 2 3 4 5 6 7 Bad

23. A negative assessment by my supervisor would be...

Good 1 2 3 4 5 6 7 Bad

24. Feeling safe would be...

Good 1 2 3 4 5 6 7 Bad

25. Disclosing a personal clinical mistake in supervision would make me feel:

a) Safe

Likely 1 2 3 4 5 6 7 Unlikely

b) Anxious

Likely 1 2 3 4 5 6 7 Unlikely

c) Relieved

Likely 1 2 3 4 5 6 7 Unlikely

d) Embarrassed

Likely 1 2 3 4 5 6 7 Unlikely

e) Shameful

Likely 1 2 3 4 5 6 7 Unlikely

f) Guilty

Likely	1	2	3	4	5	6	7	Unlikely
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26. Feeling anxious would be...

Good	1	2	3	4	5	6	7	Bad
------	---	---	---	---	---	---	---	-----

27. Feeling relieved would be...

Good	1	2	3	4	5	6	7	Bad
------	---	---	---	---	---	---	---	-----

28. Feeling embarrassed would be...

Good	1	2	3	4	5	6	7	Bad
------	---	---	---	---	---	---	---	-----

29. Feeling shameful would be...

Good	1	2	3	4	5	6	7	Bad
------	---	---	---	---	---	---	---	-----

30. Feeling guilty would be...

Good	1	2	3	4	5	6	7	Bad
------	---	---	---	---	---	---	---	-----

The following questions focus on your thoughts about what other people would think about you disclosing personal clinical mistakes in supervision:

31. Close friends think that I

Should	1	2	3	4	5	6	7	Should not
disclose personal clinical mistakes in supervision								

32. Other trainees think that I

Should	1	2	3	4	5	6	7	Should not
disclose personal clinical mistakes in supervision								

33. Course staff think that I

Should	1	2	3	4	5	6	7	Should not
disclose personal clinical mistakes in supervision								

34. With regard to your clinical training how much do you want to do what your close friends want you to do

Not at all	1	2	3	4	5	6	7	Very much
------------	---	---	---	---	---	---	---	-----------

35. With regard to your clinical training how much do you want to do what your other trainees want you to do

Not at all	1	2	3	4	5	6	7	Very much
------------	---	---	---	---	---	---	---	-----------

36. With regard to your clinical training how much do you want to do what your course staff want you to do

Not at all 1 2 3 4 5 6 7 Very much

The following questions focus on things that may make it easier or more difficult to disclose personal clinical mistakes in supervision

37. Limited time in supervision would make my disclosing a personal clinical mistake in supervision

More likely 1 2 3 4 5 6 7 Less Likely

38. A good relationship with my supervisor would make my disclosing a personal clinical mistake in supervision

More likely 1 2 3 4 5 6 7 Less likely

39. The possibility of negative consequences in supervision would make my disclosing a personal clinical mistake in supervision

More likely 1 2 3 4 5 6 7 Less likely

40. The lack of explicit conditions set up in supervision for disclosing personal clinical mistakes would make disclosing a personal clinical mistake in supervision

More likely 1 2 3 4 5 6 7 Less likely

41. Having a supervisor who is open about their own clinical mistakes would make my disclosing a personal clinical mistake in supervision

More likely 1 2 3 4 5 6 7 Less likely

42. Wanting to learn would make my disclosing a personal clinical mistake in supervision

More likely 1 2 3 4 5 6 7 Less likely

43. A poor relationship with my supervisor would make my disclosing a personal clinical mistake in supervision

More likely 1 2 3 4 5 6 7 Less likely

44. I have experienced negative consequences disclosing a personal clinical mistake in supervision.

Strongly agree 1 2 3 4 5 6 7 Strongly disagree

45. There is a lack of explicit conditions set up in supervision for disclosing personal clinical mistakes

Strongly agree 1 2 3 4 5 6 7 Strongly disagree

46. I have a good relationship with my supervisor

Strongly agree 1 2 3 4 5 6 7 Strongly disagree

47. I have a supervisor who is open about disclosing their own personal clinical mistakes

Strongly agree 1 2 3 4 5 6 7 Strongly disagree

48. I want to learn from disclosing my personal clinical mistakes

Strongly agree 1 2 3 4 5 6 7 Strongly disagree

49. I have limited time in supervision in which to disclose a personal clinical mistake

Strongly agree 1 2 3 4 5 6 7 Strongly disagree

50. I have a poor relationship with my supervisor

Strongly agree 1 2 3 4 5 6 7 Strongly disagree

Please continue on to the next section.

Appendix 4c

The Team Climate Inventory – Short Form Questionnaire

The following sections ask about the environment of your current placement. The first section contains questions about the climate of the team in which you are on placement. By 'team' we mean the work group that you are a part of: this may be a psychology department or a community team

Please indicate your answers by clicking on the box that best represents your position in relation to each statement.

1. Participation in the team

This part concerns how much participation there is in your team. Please tick the most appropriate response to you for each question.

To what extent do you agree with the following?

PARTICIPATION	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
3. We have a "we are in it together" attitude.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. People keep each other informed about work-related issues in the team.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. People feel understood and accepted by each other.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. There are real attempts to share information throughout the team.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. There is a lot of give and take.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. We keep in touch with each other as a team.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Support for new ideas

This part deals with attitudes towards change in your team. Please indicate how strongly you agree or disagree with each of the following statements as a description of your team by ticking the appropriate box.

To what extent do you agree with the following?

SUPPORT FOR INNOVATION	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
1. This team is always moving toward the development of new answers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. This team is open and responsive to change.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. People in this team are always searching for fresh, new ways of looking at problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Members of the team provide and share resources to help in the application of new ideas.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Team members provide practical support for new ideas and their application.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Team Objectives

The following statements concern your understanding of your team's objectives. Tick the appropriate box to indicate how far each statement describes your team.

OBJECTIVES	Not at all		Somewhat			Compl etely	
1. How clear are you about what your team's objectives are?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. How far are you in agreement with these objectives?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. To what extent do you think other team members agree with these objectives?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. To what extent do you think members of your team are committed to these objectives?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Task Style

The questions below concern how you feel the team monitors and appraises the work it does. Consider to what extent each of the following questions describes your team. Please tick the box under the response which you think best describes your team.

TASK ORIENTATION	To a very little extent		To some extent			To a very great extent	
1. Do your team colleagues provide useful ideas and practical help to enable you to do the job to the best of your ability?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are team members prepared to question the basis of what the team is doing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the team critically appraise potential weaknesses in what it is doing in order to achieve the best possible outcome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do members of the team build on each other's ideas in order to achieve the highest possible standards of performance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please continue on to the final section.

Appendix 4d

The Supervisory Working Alliance Inventory – Trainee Version

This section contains questions about the type of relationship you have with your current supervisor.

Please indicate your answers by clicking on the number that best represents your position in relation to each statement.

Supervisory Working Alliance Inventory
(Trainee)

	1	2	3	4	5	6	7
	Almost Never						Almost Always
1) I feel comfortable working with my supervisor	1	2	3	4	5	6	7
2) My supervisor welcomes my explanations of my client's behaviour	1	2	3	4	5	6	7
3) My supervisor makes an effort to understand me	1	2	3	4	5	6	7
4) My supervisor encourages me to talk about my work with clients in ways that are comfortable for me.	1	2	3	4	5	6	7
5) My supervisor is tactful when commenting on my performance.	1	2	3	4	5	6	7
6) My supervisor encourages me to formulate my own interventions with the client.	1	2	3	4	5	6	7
7) My supervisor helps me talk freely in our sessions.	1	2	3	4	5	6	7
8) My supervisor stays in tune with me during supervision.	1	2	3	4	5	6	7

- 9) I understand client behaviour and treatment techniques in a similar way to my supervisor. 1 2 3 4 5 6 7
- 10) I feel free to mention to my supervisor any troublesome feelings I might have about him/her. 1 2 3 4 5 6 7
- 11) My supervisor treats me like a colleague in our supervisory sessions. 1 2 3 4 5 6 7
- 12) In supervision, I am more curious than anxious when discussing my difficulties with clients. 1 2 3 4 5 6 7
- 13) In supervision, my supervisor places a high priority on our understanding the client's perspective. 1 2 3 4 5 6 7
- 14) My supervisor encourages me to take time to understand what the client is saying and doing. 1 2 3 4 5 6 7
- 15) My supervisor's style is to carefully and systematically consider the material I bring to supervision. 1 2 3 4 5 6 7
- 16) When correcting my errors with a client, my supervisor offers alternative ways of intervening with that client. 1 2 3 4 5 6 7
- 17) My supervisor helps me work with a specific treatment plan with my clients. 1 2 3 4 5 6 7
- 18) My supervisor helps me stay on track during our meetings. 1 2 3 4 5 6 7

19) I work with my supervisor
on specific goals in the supervisory session. 1 2 3 4 5 6 7

Please ensure that you have completed every question before entering the data. Your time and effort is very much appreciated. Thank you for completing these questionnaires.

Rhodri Hannan, The University of Sheffield (Clinical Psychology Unit)

Appendix 5

Questionnaire measures for the Theory of Planned Behaviour (TPB) items

Theory of planned behaviour items

Introduction:

The exemplars that follow have been taken from Section 2 (items 9-50) of the 'Disclosing Personal Clinical Mistakes in Supervision' questionnaire.

Theory of Planned Behaviour (TPB) Items:

Behavioural intentions (INT) to disclose a personal clinical mistake in supervision in the future were measured by two items: 'If I make a personal clinical mistake I *intend* to disclose it in supervision' and 'How *likely* is it that if you make a personal clinical mistake you would disclose it in supervision?' Answers for each of the questions were measured on two different scales, i.e. definitely would – definitely would not, likely – unlikely. The scores from the 'If I make a personal clinical mistake I intend to disclose it in supervision' scale were omitted from the analysis due to the failure of the radio button for the question to register anything other than a score of 1 and therefore Cronbach alpha's (α) was not calculated for the two items.

Attitudes (ATT) towards disclosing a personal clinical mistake in supervision was measured utilising five semantic differential scales in answer to the statement, 'Disclosing a clinical mistake in supervision would be...': good – bad, wise – foolish, calming – distressing, helpful – unhelpful, pleasant – unpleasant. Principal components factor analysis revealed two factors related to the five scales. These were Cognition (good – bad, wise – foolish, helpful – unhelpful) and Affect (calming – distressing, pleasant – unpleasant). Cronbach's alpha was calculated for both cognitive and affective scales and coefficients were .69 and .65 respectively. Measures of cognitive and affective attitudes were achieved through calculation of the mean score for the three items related to the cognitive scales and the two items related to the affective scales.

Subjective norm (SN) or the level of social pressure to carry out this behaviour was calibrated using two scales, firstly 'Most people who are important to me think that I (should – should not) disclose a personal clinical mistake in supervision. The second item read 'Most people who are important to me would (approve – disapprove) of my disclosing a personal clinical mistake in supervision. Cronbach's alpha for the two items was .73. An overall subjective norm measure was achieved by computing the mean score across each of the items.

Perceived Behavioural Control (PBC) or the level of control the individual perceives him/herself to have over engaging in this behaviour was measured through four different items. These were: 'Whether or not I disclose a personal clinical mistake in supervision is entirely up to me' (strongly agree – strongly disagree), 'For me, disclosing a personal clinical mistake in supervision would be..(easy – hard), 'How much control do you feel you have over disclosing a personal clinical mistake in supervision? (complete control – no control) and lastly 'If I wanted to I am confident that I could disclose a personal clinical mistake in supervision (strongly agree – strongly disagree). Internal reliabilities for the four items were found to be .55. Given the low level of internal reliability and inter item correlation each of the scales was treated individually within the analysis.

Behavioural beliefs (BBs) scales were deduced from responses garnered in Study 1 (questions a and b) that related to the advantages and disadvantages of disclosing personal clinical mistakes in supervision. From analysis of the responses supplied, a total of five belief items were chosen to be included in the final questionnaire, in reply to the question 'Disclosing a personal clinical mistake in supervision would'... enable me to learn, develop my skills, help to correct the mistake, make me look incompetent, lead to a negative assessment by my supervisor. A single response measure (likely – unlikely) was supplied. The *evaluations* (evals) of the belief items were explored through the questions 'Being able to learn would be (good – bad)', 'Developing my skills would be (good – bad)', 'Correcting the mistake would be (good – bad)', 'Looking

incompetent would be (good – bad)', 'A negative assessment would be (good – bad)'. Evaluation item scores were recoded (from –3 to +3) and then combined multiplicatively with corresponding behavioural belief scores. From this five paired BB x evals (BB.evals) scores were achieved (range –21 to +21). These were then summed to provide a total BB+evals (TOTBB) score was then computed.

Behavioural beliefs – affective (BBAs) scales were deduced from responses garnered in Study 1 (question c) that related to the feelings associated with disclosing personal clinical mistakes in supervision. From the analysis of the responses supplied, six affective beliefs were selected for inclusion. In reply to the question 'Disclosing a personal clinical mistake in supervision would make me feel..' safe, anxious, relieved, embarrassed, shameful, guilty. These were all set against the single response measure likely – unlikely. The *evaluations* (evals) of the affective belief items were explored through the items, 'Feeling safe would be (good – bad)', 'Feeling anxious would be (good – bad)', 'Feeling relieved would be (good – bad)', 'Feeling embarrassed would be (good – bad)', 'Feeling shameful would be (good – bad)', 'Feeling guilty would be (good – bad). The identical procedures as for the behavioural beliefs and evaluations were undertaken in order to compute a single TOTBBA score.

Normative beliefs (NBs) were calibrated against three items deduced from the results of Study 1 (question h). The focus of the questions were three significant others 'My (close friends), other (trainees), (course staff) think that I (should – should not) disclose personal clinical mistakes in supervision. The *motivations to comply* (MC) of participants to the views of significant others were measured utilising three questions, 'With regard to your clinical training how much do you want to do what your close friends want you to do? (not at all – very much)', 'With regard to your clinical training how much do you want to do what other trainees want you to do? (not at all – very much)', 'With regard to your clinical training how much do you want to do what other

trainees want you to do? (not at all – very much). The identical procedures as for the behavioural beliefs and evaluations were undertaken in order to compute a single TOTNB score.

Control beliefs (CBs) were derived from questions d,e,f and g of Study 1, relating to factors that would make individuals more or less motivated and factors that made it either easier or harder to disclose a personal clinical mistake in supervision. Seven items were identified and these included both internal factors (e.g. ‘A good relationship with my supervisor would make my disclosing a personal clinical mistake’) and external factors (e.g. ‘Limited time in supervision would make my disclosing a personal clinical mistake in supervision’). The seven items were measured on scales more likely – less likely. The identical procedures as for the behavioural beliefs and evaluations were undertaken in order to compute a single TOTCB score.

Appendix 6

Letter to Directors of Clinical Psychology Training
courses requesting permission to approach trainees.



THE UNIVERSITY OF SHEFFIELD
Clinical Psychology Unit
Department of Psychology

Doctor of Clinical Psychology (DClin Psy) Programmes (Pre-registration and post-qualification)
Clinical supervision training and NHS research training and consultancy

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Telephone: 0114 2226570
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Email: dclinpsy@sheffield.ac.uk

Clinical Practice Director: Ms Joyce Scaife
Course Administrator: Carole Gillespie
Prof Nigel Beail

Dear

My name is Rhodri Hannan and I am a third year trainee clinical psychologist on the University of Sheffield Doctor of Clinical Psychology course. My chosen research project is an investigation of trainee clinical psychologist intentions to disclose personal clinical mistakes in supervision. The model that I am using as the basis of my research is the Theory of Planned Behaviour (Ajzen, 1985, 1988, 1991).

The study involves trainee psychologists on the Sheffield course filling in a pre-study questionnaire from which responses I will develop a larger questionnaire. This questionnaire will then be placed on a website, located at the University of Sheffield, along with the Team Climate Inventory (TCI; Anderson & West, 1998) and the Supervisory Working Alliance Inventory (SWAI Trainee version; Efstation, Patton and Kardash, 1990). These will be completed anonymously by trainee psychologists, 2001-2003 cohort.

The study has received ethical approval from the University of Sheffield Department of Psychology Ethics sub-committee and the request to recruit participants is being made to all Doctor of Clinical Psychology courses in Britain.

As the questionnaires are to be filled in anonymously on a website I would need to send an e-mail (see attached example) through you as Course Director or the Course Administrator, who would then circulate the e-mail to all trainees currently on your course. I would then send a second follow up e-mail approximately a month after the first following the same procedure, in order to maximise the number of participants. I am therefore requesting permission to recruit trainee participants from your course through the route described above.

If you have any queries you can contact me at pcp01crh@sheffield.ac.uk or my research supervisor, Prof. Gillian Hardy on g.hardy@sheffield.ac.uk. I would be very grateful if you could respond to me either way by the end of January 2004.

Yours Sincerely

Rhodri Hannan
Trainee Clinical Psychologist

Appendix 7a

E-Mail sent to Course Administrators

for distribution to Trainee Clinical Psychologists

To:
Subject:
Date sent: **Sat, 13 Mar 2004 15:36:18**

Dear Trainee,

I am a third year trainee on the Sheffield Doctor of Clinical Psychology Course. Attached to this e-mail is an information sheet about a questionnaire study that I am running via the internet. On the information sheet you will also find a weblink that will take you to the questionnaires if you are willing to take part.

Thank you for taking the time to read this e-mail

Rhodri Hannan
Trainee Clinical Psychologist .

Appendix 7b

**Information sheet attached to E-mail
distributed to Trainee Clinical Psychologists**



THE UNIVERSITY OF SHEFFIELD
Clinical Psychology Unit
Department of Psychology

Doctor of Clinical Psychology (DClin Psy) Programmes (Pre-registration and post-qualification)
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Clinical Practice Director: Ms Joyce Scaife
Course Administrator: Carole Gillespie
Prof Nigel Beail

Dear Trainee,

The following introduces a research study to be carried out utilising questionnaires located on a website.

My name is Rhodri Hannan and I am a trainee clinical psychologist on the University of Sheffield Doctor of Clinical Psychology course. I am currently carrying out a study trying to understand the factors that may influence a trainee clinical psychologist's intention to disclose personal clinical mistakes in supervision. Mistakes have been described as an unintentional oversight in good practice. For example, not checking all of a client's symptoms, forgetting to follow up on a client referral, making an incorrect interpretation that causes a client some distress, saying something about yourself that you later feel uncomfortable about.

The study has received ethical approval from the University of Sheffield Department of Psychology Ethics sub-committee and the request to recruit trainees as participants has been made to all Doctor of Clinical Psychology courses in Britain. The responses to the questionnaires are being collected anonymously as there are no questions asking for identification of the individual participant. This page has a weblink that will enable you to access a site containing three questionnaires that can be filled in anonymously. There is an information sheet located on the website that gives further details about the project.

The questionnaires will only take between 10-15 minutes to complete.

It is possible that any act on a computer could be traced to the machine that has been used. The University of Sheffield also has legal responsibilities to collect some data (as do all other UK based Internet providers). However, the University of Sheffield will not seek to identify individual users unless it has a specific suspicion that it's systems are being abused, in which case an investigation will take place in accordance with the University's normal procedure.

If you choose to enter the website but decide that you do not wish to complete the questionnaires you may leave the site at any time even if you have completed some of the questions. Only once you have clicked the Submit button will the information you have completed be sent and only at this point will you be unable to withdraw that information from the study.

If you are prepared to complete the questionnaire please use the following link/address.

<http://www.sheffield.ac.uk/clinicalpsychology/questionnaire>

Thank you for your time and co-operation

Rhodri Hannan
Trainee Clinical Psychologist

Appendix 8

Skewness Statistics for Intention and Theory of Planned Behaviour items

Skewness statistics for Intention and Theory of Planned Behaviour items

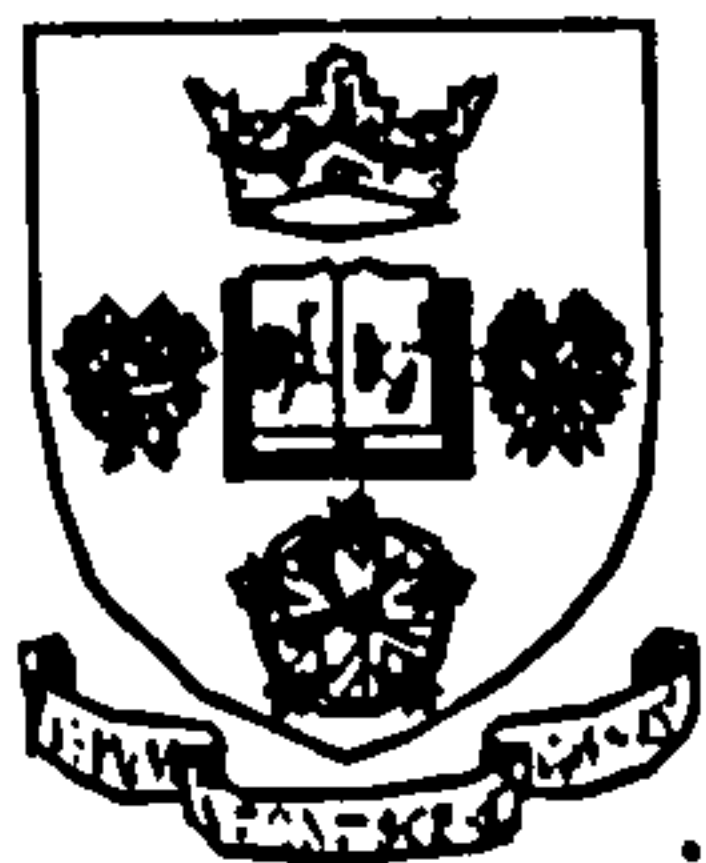
Table (a) Appendix 8

Item	N	Mean (SD)	Minimum - maximum	Skewness statistics	Std Error of Skew
Intention	241	6.00 (0.05)	2 - 7	-1.42	.157
Cog	249	6.05 (0.04)	3.67 - 7	-.665	.154
Aff	249	3.71 (0.07)	1 - 7	.139	.154
SN	246	5.27 (0.05)	3 - 7	-.237	.155
pbc1	249	4.27 (1.77)	1 - 7	.020	.154
pbc2	241	4.23 (1.60)	1 - 7	-.274	.157
pbc3	247	5.81 (0.95)	3 - 7	-.813	.155
pbc4	245	6.26 (0.91)	2 - 7	-1.693	.156

Study 1

Appendix 9a

Study 1 – Questionnaire information sheet



THE UNIVERSITY OF SHEFFIELD

Clinical Psychology Unit

Department of Psychology

Doctor of Clinical Psychology (DClin Psy) Programmes (Pre-registration and post-qualification)
Clinical supervision training and NHS research training and consultancy

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Prof Nigel Beail

Pre-study questionnaire - Information Sheet.

Trainee Clinical Psychologist Intention to Disclose Personal Clinical Mistakes in Supervision

You are invited to fill in the following questionnaire. Before doing so it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Take time to decide whether or not you wish to take part.

THANK YOU FOR READING THIS.

Who is conducting the study?

My name is Rhodri Hannan and I am a trainee clinical psychologist on the University of Sheffield Doctor of Clinical Psychology course.

What is the purpose of the questionnaire?

The purpose of this questionnaire is to explore your beliefs and attitudes about supervision within clinical psychology training as a forum for the disclosure of difficult information. There are **NO** right or wrong answers. Trainee psychologists as individuals may choose **NOT** to reveal many different pieces of information during the course of their supervision. The rationale of the study is to try to understand the factors that may influence a trainee clinical psychologist's intention to disclose personal clinical mistakes in supervision. Mistakes have been described as an unintentional oversight in good practice. For example, not checking all of a client's symptoms, forgetting to follow up on a client referral, making an incorrect interpretation that causes a client some distress, saying something about yourself that you later feel uncomfortable about. Material generated from this questionnaire will be used as part of the design of a larger questionnaire study that will look at the views around the disclosure of mistakes in clinical supervision of the trainee clinical psychologist cohort for the years 2001-2003.

Why have I been chosen?

The main study is set up to examine the intentions of trainee clinical psychologist cohort for the years 2001-2003. Therefore the attitudes and beliefs of current trainees are relevant to the purpose of generating appropriate items for a further larger scale questionnaire.

Do I have to take part?

There is **NO** obligation on any one to take part for any reason. However once you have completed the questionnaire and returned it to the department it will not be possible to return the form as it is completed anonymously.

What will happen to me if I take part?

As the information is completed anonymously there are no implications for taking part unless you have a specific complaint or are concerned in any way about your own or other's supervision. For responses to these matters please see below.

What do I have to do?

All that is required is that you fill in the items in the following questionnaire following the instructions given to you. Return the questionnaire by sending it back to the author in the envelope provided.

What information will be collected?

The questionnaire contains a series of questions that ask about your attitudes and beliefs about disclosing personal clinical error in supervision.*

Will all information be kept confidential?

The questionnaires are filled in anonymously and are to be returned to the author in the envelope provided. All questionnaires will be housed in a locked cabinet and may be accessed by myself, my supervisor (Dr. Gillian Hardy) and accredited examiners only. The questionnaires will be destroyed six-months after the study is completed.

What do I do if I wish to make a complaint?

If you have a complaint about the conduct or the content of the study then you should contact Dr. Gerry Kent of the University of Sheffield Doctor of Clinical Psychology Training Course by telephoning 0114-2226527 or by e-mail g.kent@sheffield.ac.uk, or my research supervisor Prof. Gillian Hardy on 0114-2226571 or by e-mail at g.hardy@sheffield.ac.uk. You can also use the University of Sheffield complaints procedure by contacting Dr. D.E. Fletcher, Registrar and Secretary, University of Sheffield, Firth Court, Western Bank, Sheffield, S10 2TN.

What if the material in the study leads me to feel upset or concern about my own or other's supervision?

It is suggested that if the material presented in the questionnaire leads to any upset or concern on your behalf either about your own or other's supervision, that you raise your concerns in the first instance with your clinical or personal tutor.

*** N.B. In answering the following questions you should not include any information that might identify yourself or others.**

Appendix 9b

Study 1 – Questionnaire

Disclosure of Personal Clinical Mistakes – Pre-study questionnaire

The purpose of this questionnaire is to explore your beliefs and attitudes about supervision within clinical psychology training as a forum for the disclosure of personal clinical mistakes. Mistakes have been described as an unintentional oversight in good practice. For example, not checking all of a client's symptoms, forgetting to follow up on a client referral, making an incorrect interpretation that causes a client some distress, saying something about yourself that you later feel uncomfortable about. There are **NO** right or wrong answers.

Trainee psychologists as individuals may choose not to reveal many different pieces of information during the course of their supervision. The purpose of the study is to try to understand the factors that may influence a trainee clinical psychologist's intention to disclose personal clinical error in supervision.

Thank you for taking the time to complete this questionnaire.

Attitudes and Beliefs about Disclosure of Personal Clinical Mistakes in Supervision

(a) What do you see as the advantages of disclosing personal clinical mistakes in supervision?

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(b) What do you see as the disadvantages of disclosing personal clinical mistakes in supervision?

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(c) What feelings do you think would be associated with disclosing personal clinical mistakes in supervision?

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(d) What factors might motivate you to disclose personal clinical mistakes in supervision?

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(e) What factors might make you less motivated to disclose personal clinical mistakes in supervision?

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(f) What factors would make it easier to disclose personal clinical mistakes in supervision?

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(g) What factors would make it more difficult to disclose personal clinical mistakes in supervision?

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(h) Would anyone else's opinion be important to you when deciding if you should disclose personal clinical mistakes in supervision? (i.e. would you discuss the decision with anyone else and if so whom? e.g. Clinical tutor, fellow trainee, other professional, friend)

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(i) Are there any other factors that you feel need to be considered when contemplating disclosure of personal clinical mistakes in supervision?

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(j) What impact, if any, do you think disclosing clinical mistakes in supervision might have on your training as a clinical psychologist?

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Appendix 10a

Study 1 – Full report

The Complete Report of Study 1

Introduction

The initial stage of the study was devised in order to ascertain the variables that might be relevant to clinical psychology trainees decisions about the self-disclosure of personal clinical mistakes within supervision and also to generate items to build a questionnaire that conformed with the Theory of Planned Behaviour (TPB) in order to examine trainee psychologist intentions to disclose personal clinical mistakes in supervision. The information was gathered using an unstructured questionnaire, that was developed using an approach based on that recommended by Ajzen and Fishbein, (1980, Appendix A). Open-ended questionnaires have been used to examine a variety of variables including assessment of models of inheritance (Henderson & Maguire 2000) and self-talk in exercise (Gammage, Hardy & Hall 2001). Open-ended questionnaires have also been used effectively in order to generate items for further investigation e.g. Deary et al (2003).

Method

Participants

Sampling was carried out using what Coolican (1990) describes as an opportunity sample. Participants were drawn from a Doctor of Clinical Psychology training course 2001, 2002 and 2003 cohorts. No further exclusion criteria were applied other than participants be from one of the three cohorts. From the three-year groups there were 57 trainees available for participation. 21/57 (36.8%) of questionnaires were returned completed.

Materials

The questionnaire was made up of ten items, eight of which related directly to the Theory of Planned Behaviour. Questions (a) and (b) explored the advantages and disadvantages of

disclosing a personal clinical mistake in supervision and question (c) explored the feelings related to such an action. Questions (d) – (g) focussed on factors that might motivate/decrease motivation to disclose as well as variables that made this either easier or harder. These related to the control components of the theory. Question (h) related to subjective norms and asked whether the opinion of someone else would be important in making a decision to disclose a personal clinical mistake in supervision. The last two questions asked about any other factors to be taken into consideration and what impact individuals believed that disclosure of personal clinical mistakes might have on their training.

Procedure

The questionnaire was put in the pigeonhole of each of the trainees. Included in the pack was an information sheet (see Appendix 8a) explaining the nature of the study. No demographic information was required and the questionnaire was filled in anonymously by participants and returned to a marked box in the clinical psychology unit in a pre-addressed envelope. Final collection of completed questionnaires was made five days after they had been put in trainee pigeon-holes. The questionnaire was ostensibly built according to procedures described for the pertinent 'beliefs' sub-section of the TPB (Connor & Sparks, 1996) and through consultation with an adviser who was knowledgeable about the use of the TPB methodology. The project research supervisor and the author then decided on the final set of questions to be utilised.

Method of Analysis

Rationale for selection

Standard procedures (Conner & Sparks, 1996) were used to analyse the questions relating to TPB items whilst the remaining questions were analysed using content analysis. Template analysis (e.g. King, 1998) was considered for the non TPB questions but the depth of this type of analysis was felt to be too detailed for the nature and purpose of this study. Krippendorff (1980) has

described content analysis as a way of investigation into the symbolic significance of messages. He argues that content analysis is able to accept comparatively seminal symbolic communications as data. The form of content analysis used in this context is Semantical Content Analysis (designations analysis) Janis (1965). Krippendorff (1980) describes this procedure as one where signs are classified according to their meanings and how often certain concepts are alluded to.

Data Analysis

The pertinent 'beliefs' items of the TPB (i.e. questions a - h) were analysed using the procedures suggested by Conner and Sparks (1996), Ajzen and Fishbein (1980) and Ajzen and Driver (1991). A list of all the behavioural, normative, control and affective belief items was derived from each of questions a – h. All the items that pertained to outcomes that were semantically akin to each other were coded in the left-hand column under the relevant heading (e.g. Behavioural Beliefs) and the frequencies of each were recorded in the right hand column. The most frequently occurring (modal) salient beliefs were then selected for inclusion.

Questions i-j (Non TPB items) were analysed using content analysis. The analysis involved unitizing the data into thematic units (Krippendorff 1980) and then counting them for frequency of occurrence.

Results

The answers of participants to questions related to the TPB items are recounted and discussed below. The items highlighted in bold are those relating to the theory of planned behaviour scales and will be discussed in the methods section of Study 2.

The advantages of disclosing personal clinical mistakes in supervision

This item produced a number of prominent themes as well as some more minor beliefs. The more prominent themes tended to focus on practical outcomes for the individual. **Learning** featured very widely in the responses of individuals though there was little specificity about what learning might mean. **Skill development** was another area that individuals felt would be an advantage of disclosure including working on different ways to approach similar situations in which the mistake occurred. Several respondents also indicated that it might be possible to **correct the mistake**. A number of respondents indicated that disclosure of personal clinical mistakes would lead to **greater safety** in terms of feeling protected by having admitted to a mistake. Other more minor items that emerged but that were not included in the beliefs items were related to development of the piece of work e.g. enabling improved client care and also associated with helping to understand difficult feelings related to the mistake.

The disadvantages of disclosing personal clinical mistakes in supervision

The two main disadvantages identified were the possibility of **looking incompetent** and that there might be a **negative assessment by the supervisor** as a consequence of disclosure. Again, other factors emerged less frequently and these included the possibility of placement failure, the chance that disclosure might bring about changes in the supervisory relationship and a loss of confidence in the individual making the disclosure.

Participants' beliefs about the feelings that might arise from disclosure of personal clinical mistakes in supervision

There were a number of affective factors that participants perceived might occur as a result of disclosure. A sizeable proportion of the respondents suggested that disclosure might **provoke anxiety** although a smaller number believed that it might also **relieve anxiety**. Several of those who provided responses to the questionnaire were concerned that disclosure of clinical mistakes

might cause embarrassment as well as shame and guilt. Other comments that featured less strongly were emotions such as fear and inadequacy might result from disclosure.

Factors increasing motivation to disclose personal clinical mistakes in supervision

Several of the participants thought that wanting to learn from it (mistake) would increase motivation to disclose. Some felt that if their supervisor admits mistakes this would lead to additional motivation to make a disclosure of a personal clinical mistake. The other factor most clearly distinguished by this question was a good relationship with their supervisor.

Factors decreasing motivation to disclose personal clinical mistakes in supervision

Conversely, in answering this question a large proportion of the participants thought that a poor relationship with their supervisor would decrease motivation to disclose. The other main concern that respondents indicated was likely to decrease motivation was fear of negative consequences as a result of disclosing a personal clinical mistake.

Factors making disclosure of personal clinical mistakes in supervision easier/harder

It appeared that to a large extent participants interpreted the two questions related to these factors as the same or similar to the questions on motivation usually by writing something along the lines of *same as overleaf*.

Time limits of supervision were the main factor to be considered as relevant to this question.

Explicit conditions for disclosure were mentioned less often to this question but had been mentioned by different participants in response to questions on motivation. As the questions on motivation and factors making disclosure easier and harder were examining control factors **explicit conditions for disclosure** was included in control beliefs.

People whose views would be important in deciding to disclose a personal clinical mistake

Other trainees were the group identified most often as the people whose views would be most important. Other people cited were close friends and university/course staff.

Other factors to be considered when contemplating disclosure and what impact disclosing personal clinical mistakes in supervision might have

A content analysis of this data threw up a wide variety of other factors e.g. course view, risk for client and ethical issues as well as a number of potential impacts e.g. skill development and transparency. However none of these apart from learning was mentioned sufficiently often to warrant inclusion in the main questionnaire. Learning had been covered elsewhere in the context of behavioural beliefs and so this was not considered as a further item for the main questionnaire.

Discussion and conclusions – Study 1

In this study the clinical psychology trainees who participated indicated a number of advantages and disadvantages for disclosing personal clinical mistakes in supervision. The responses to the questionnaire also pointed to some of the factors that could facilitate this specific behaviour and indeed others that could prove an impediment. Generally there was a broad spectrum of answers to the questions suggesting that the path toward a disclosure of this nature in supervision could be based on a wide variety of factors and is not a straightforward decision.

The findings in this study fit to some degree with the more general findings of Ladany et al (1996) in terms of what influences a decision to disclose in supervision. However, Ladany et al (1996) investigated a broader range of potential disclosures e.g. personal issues, countertransference. In relation to clinical mistakes they found that supervisees generally did not

disclose for reasons of impression management and to some degree the responses in the current study accord with these ideas e.g. a disadvantage of disclosure might be 'looking incompetent.'

Overall the study provided some useful material in relation to individual trainee beliefs about supervision however, the results are limited in a number of ways. Firstly the data was collected using an open-ended questionnaire and the answers provided tended to be short and to the point and lacking in the richness that might have been brought about using a discursive technique such as a focus group.

The study includes only a small sample and nothing is known about the demographics of the sample due to the questionnaire being completed anonymously. Therefore some important information is not available e.g. whether the data comes from one particular year group of trainees or whether it was spread amongst the three years.

As indicated previously, it seemed that many participants interpreted questions (f) and (g) on factors that made disclosure easier or harder as though they were the same as questions (d) and (e) that focussed on motivation to disclose. However, the questions asked look at different facets of control, for example having an appropriate, private area for supervision might practically make disclosure of a personal clinical mistake easier or harder but is not necessarily a motivating factor. This means again that some potential factors may have been neglected.

In future research it might be helpful to utilise the focus group approach, which would counter both the lack of richness of data and demographic information. Problems encountered with the questionnaire might have been dealt with by perhaps adding some examples to distinguish what was required.

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Appendix 10b

Results for analysis of beliefs items

Analysis for the Beliefs Items of the Questionnaire

Table 1: Organisation of Items for Behavioural Beliefs

Behavioural Beliefs	Frequency	Belief No.
Learning	12	1
Skill development	8	2
Being able to correct the mistake	6	3
Look Incompetent	6	4
Negative assessment by supervisor	12	5
Safety	5	6
Provokes Anxiety	12	7
Relieves Anxiety	8	8
Embarrassment	7	9
Shame	5	10
Guilt	5	11

Analysis for the Beliefs Items of the Questionnaire

Table 2: Organisation of Items for Control Beliefs

Behavioural Beliefs	Frequency	Belief No.
Wanting to learn from it	6	1
Supervisor admits mistakes	6	2
Good relationship	6	3
Poor relationship	9	4
Time limits of supervision	5	5
Explicit conditions for disclosure	5	6
Fear of negative consequences	8	7

Analysis for the Beliefs Items of the Questionnaire

Table 3: Organisation of Items for Subjective Norm Beliefs

Behavioural Beliefs	Frequency	Belief No.
Close Friends	7	1
Other trainees	16	2
University/Course Staff	7	3