Clinical Psychology Training and Therapist Self-Disclosure: the Role of the Supervisor.

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ABSTRACT

There is a wealth of theoretical debate and research on the use of therapist self-disclosure (TSD) within psychotherapy. Research finds that TSD can serve a variety of clinical purposes within the therapeutic relationship, from modelling coping strategies to strengthening the alliance. But findings also indicate therapists need to use TSD appropriately, responding sensitively to the context and with forethought about the purpose of using it. The author knows of no published guidelines or frameworks, specifically regarding TSD, to draw on when working as a Clinical Psychologist in National Health Service mental health settings. This issue is relevant when considering the psychologist-in-training, who makes use of a of variety clinical skills on placement under the supervision of a qualified psychologist.

This qualitative study explores the processes by which supervisors approach self-disclosure with Trainee Clinical Psychologists. Ten qualified Clinical Psychologists were interviewed about their views on TSD and how they discuss it with trainees in supervision. Thematic analysis was used to elucidate four dominant themes emerging from the interviews: The supervisor within context; Process of TSD with trainees, Tensions on placement, A desire for something different.

Findings revealed that supervisors felt there to be a lack of adequate training around TSD for psychologists, and participants expressed a wish for more teaching and systematic thinking on TSD within training and throughout the profession. Experiences of TSD varied according to the supervisor's personal and professional context and how they approached it with trainees in supervision varied from direct proactive approaches to a more responsive stance. This was also influenced by the supervisory relationship and power dynamic, as well as the task of supervising within an evaluative context.

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CHAPTER 1:
INTRODUCTION

"Patients share their lives with us, not the other way around."
Gottlieb (2019)

"We have explored therapist self-disclosure in the literature and more anecdotally, and it is common practice. Everyone is doing it, but no one is talking about it."
Ruddle and Dilks (2015)

1.1 Overview

Therapist self-disclosure (TSD) is a widely debated therapeutic technique that evokes a range of views, depending on the context of the debate and the intention around its use. It is generally defined as verbal statements through which personal information about the therapist is revealed or disclosed to the client (Hill & Knox, 2001), although the definition itself is complex and varied. Acquiring and developing skills in the therapeutic encounter map onto the clinical, personal and professional domains of competence within Clinical Psychology training in the UK. TSD is not explicitly measured or scored within the competency framework (BPS, 2014) that training programmes adhere to and the supervising Clinical Psychologists (CPs) use to assess Trainee Clinical Psychologists (TCPs) on placement. Supervisors therefore hold the bulk of the responsibility for teaching and guiding TCPs in the learning of broader or deeper therapeutic skills such as TSD, in addition to the skills that are covered within the core competency framework.

Research has investigated TSD within the field of Clinical Psychology and psychotherapy, with the focus ranging from the impact of TSD on clients to that on therapists, and also the experience of TCPs using TSD on clinical training in the UK.

This chapter gives an overview of relevant research and theories that explore or investigate the current definitions and function of TSD, including considerations around its appropriate use and clinical application. It will consider this from a variety of perspectives, including the client, the therapist and the therapist-in-training. An outline of current best practice and experiences of supervision for TCPs in training will be presented. It will then cover other psychotherapeutic domains where relevant, given the paucity of research in this area that is specific to clinical psychology training. Finally, it will outline the rationale for this study and the parameters within which it is conducted.

1.2 Literature search strategy

The research literature was searched using electronic databases selected for their wide coverage (PsycINFO, EBSCO and Google Scholar) and variations of key words such as ‘therapist’, self-disclosure’, ‘clinical psychology’, ‘trainee’, ‘clinical psychologist, ‘supervising trainees’, ‘training’, ‘supervision’, ‘supervisory alliance’, ‘therapy’, ‘psychotherapy’, ‘disclosure’, ‘dual relationships’, ‘mental health’, ‘mental health practitioner’, ‘psychotherapy process’.

Relevant papers were identified by title and abstracts, and were included if there was a focus on the practice of TSD within Clinical Psychology, psychotherapy or within services working with related clinical client groups. Snowball searches were then manually conducted through the references of relevant papers to identify other literature. The Health and Care Professions Council (HCPC) and British Psychological Society (BPS) websites and their publications were also searched. To complement the database search, additional search strategies included searching reference lists of relevant articles/books, using Google Scholar. The literature search is embedded within this chapter.

This research project is interested in the practice of TSD and how supervising CPs approach it, specifically within Clinical Psychology. However, much of the self-disclosure and supervision literature is published in North America and is conducted within psychotherapy and counselling settings, so it was necessary to include all relevant published research regarding these subject matters, even

if the setting was not specifically Clinical Psychology in the UK, or the National Health Service (NHS).

1.2.1 Terminology

For the purposes of this thesis, Clinical Psychologist (CP) refers to anyone working in the NHS or third sector who is registered with the Health and Care Professions Council (HCPC) and has trained at one of the institutions offering the Doctorate in Clinical Psychology. Therapist refers to an aspect of the CPs role which is to conduct one-to-one or group therapy with clients or service users in any NHS or third sector mental health organisation. CPs working privately were not included in this thesis.

1.3 Defining therapist self-disclosure

The idea of the therapist revealing or not revealing personal information about him or herself has been around as long as therapy has been in existence. TSD is a complex phenomenon that can be hard to define categorically, making it challenging to investigate empirically.

There are many working definitions of TSD. At its most basic, it is something that therapists sometimes do in therapy, whether the client is aware or not. Hill and Knox (2002) state: “We define therapist self-disclosure as therapist statements that reveal something personal about the therapist,” (page 256) and Goodman and Dooley (1976) describe TSD as “statements in which the speaker reveals a non-obvious aspect of his condition (feelings, thoughts and experiences) through a distinct self-reference”, (page 112). Ruddle and Dilks (2015) define TSD as “the sharing of any aspect of our personal experience” (Page 459). These definitions are broad in meaning, covering a range of possible verbal disclosures within therapy; from professional qualifications to deeply personal experiences. The variety of depth and content of TSD pose a problem for research, in particular to the empirical positivist paradigm, which requires clearly defined variables in order to make claims that are reliable and generalisable.

1.3.1 Subtypes of TSD

To help define what disclosure is in practice, the over-arching, general definition can be sub-divided into different types of self-disclosures in a number of ways. There is no clearly defined cut-off, but many theorists writing on TSD draw a distinction between factual or self-revealing disclosures and self-involving disclosures, also referred to as countertransference or immediacy disclosures (e.g. Farber, 2006). Examples of these are “I am married and have two children” (factual); and “I’m feeling annoyed that you are frequently late for sessions” (immediacy). Hill and Knox (2018) argue that the latter are not truly self-disclosures. In line with this view, this thesis is concerned with factual, self-revealing verbal disclosures but as the extant research literature does not always specify clearly, it has remained open to varied definitions within the literature review.

Ruddle and Dilks (2015) broadly divide their definition into process-based and content-based TSD: the first encompasses in-the-moment thoughts, feelings and experiences, such as the therapist sharing their dilemmas about how therapy should proceed (e.g. Yalom, 2011). The second refers to the disclosure of events, facts and beliefs outside of the therapy room that the therapist chooses to share. Similarly, Linehan (1993), in dialectical behaviour therapy (DBT), distinguishes between disclosure of personal information about the therapist, and disclosure of the therapist’s immediate personal reactions to the client within the therapeutic relationship. However, each therapist is likely to compose their own unique, personal rules around this concept or tool that will vary enormously depending on experience and theoretical allegiances. Decision-making around TSD will also stem from experience-based intuition using heuristic processes that may be or may not be unconscious. Mahalik, Ormer and Simi (2000) propose a continuum of self-disclosure rather than the binary option of disclosing or not disclosing.

There are further ways to subdivide TSD. Zur (2009) proposed the following delineations: deliberate, unavoidable, and accidental or inadvertent. Deliberate self-disclosure is when the therapist intentionally shares some personal information with the client either out of a sense of need, for example the therapist is going on holiday and will be away for two weeks, and judges it

correct to share this with the client, or when a therapist shares something in connection with the therapy to fulfil a clinical function, as discussed below.

Unavoidable self-disclosure includes anything that can be seen by the client – for example a religious symbol worn on a necklace, pregnancy, a wedding ring or a physical disability all convey personal information about a therapist to the client. Accidental self-disclosure might involve a therapist responding with unplanned words or expressions to something the client said that took them by surprise. This can also occur by way of internet searches or, increasingly, social media, or if a therapist and client live in the same community and their paths cross outside of a clinical setting. In some contexts this will be more likely to occur than others, for example working in a residential setting might lead to more unavoidable disclosures than a setting where the client receives weekly individual therapy in the more controlled environment of a dedicated clinic room.

The context of the disclosure is also relevant to the definition: is the disclosure a response to a question asked by the client, or is the therapist consciously using the idea of self-disclosure in line with their therapeutic intervention in terms of the client's formulation? Using self-disclosure as a therapeutic tool may involve not being entirely truthful – the therapist might choose to present a version of reality to achieve an intended outcome, rather than out of an intention to interact honestly and openly with a client. This approach could come under criticism for not aligning with authentic and egalitarian values.

The context of Clinical Psychology: Taking into consideration the varied aspects of the CP's role that stretch beyond being a (psycho)therapist, there is a lack of published research to date exploring or comparing TSD in different Clinical Psychology contexts and how this might relate to its use. Relevant contexts for a practicing CP might be, for example, during a therapy session, in a therapeutic group intervention, during a home visit, or as part of an open meeting with other professionals. Ruddle and Dilks' assertion that "everyone is doing it, but no one is talking about it" at the beginning of this section implies that TSD may be happening 'under the radar' within Clinical Psychology. It is important to understand more about the process and use of TSD within the context of psychology in NHS mental health services, given the potential benefit

to client wellbeing, and the potential harm if used inappropriately. Small and subtle changes may lead to profound impacts, that will benefit clients, and enable CPs to move on from outmoded ideas around self-disclosure that might consider it best avoided given the possible risks.

1.4 Research into efficacy and use of TSD

1.4.1 Clinical application of TSD

The use of TSD is a widely, if infrequently, used clinical tool that can have a positive impact on clients (Hill et al., 1988). In a survey conducted with 456 American psychologists on ethical behaviours in therapy, more than 90% of therapists stated they self-disclose to clients, albeit rarely, (Pope, Tabachnik & Keith-Spiegel, 1987). There is not current data available for use of TSD in UK-based Clinical Psychology.

Some theorists question whether it is a therapeutically useful intervention (Peterson, 2002) and it could comprise as little as 3.5% of overall therapist interventions (Hill & Knox, 2002). Debate around its use focuses on what benefit it can bring to the client, service user or patient. A purist Freudian (Delvey, 1985) psychodynamic approach to TSD viewed the therapist as anonymous and thought that any disclosure might burden the client and transgress professional boundaries (Greenspan, 1986). However, it is now commonly thought that the idea of presenting anonymously to clients is aspirational and unrealistic (e.g. Barnett, 2011) due to, at the very least, the aforementioned unintentional disclosures such as physical appearance (e.g. ability versus disability), clothing, skin colour, or gender. In the 1950s, humanist approaches to psychotherapy advocated a pro-disclosure approach concerning immediate therapy experiences in the belief that it encouraged client disclosures (Henretty, Currier, Berman & Levitt, 2014). Within psychodynamic theory itself, the move towards an intersubjective-relational perspective has also led to a shift away from this strict position. Theorists such as Renik (1995, 1999) and Greenberg (1995) have argued against the ‘‘pretence of anonymity’’ (Renik, 1995, page 476), viewing self-disclosure an inevitable part of therapy.

According to research, there are many reasons why TSD may be intentionally used by therapists during sessions. Table 1 lists principle reasons as presented in Henretty and Levitt's (2010) comprehensive review of TSD research.

Possible clinical motivations for TSD
(adapted from Henretty & Levitt, 2010)

- Promote client disclosure (Jourard, 1964, 1971)
- Foster the therapeutic relationship/alliance (Mahalik, Van Ormer & Simi, 2000)
- Model for clients (Mathy, 2006)
- Validate reality (Hill & Knox, 2001)
- Normalize and promote feelings of universality (Hill & Knox, 2001)
- Equalize power (Mahalik et al., 2000)
- Repair an alliance rupture (Weiner, 2002)
- Assist in identifying and labelling their emotions (Bridges, 2001)
- Show similarities (Audet & Everall, 2003)
- Reassure (Hill et al., 1989)
- Build client self-esteem (Andersen & Anderson, 1985)
- Demystify therapy (Knox & Hill, 2003)
- Reinforce and/or shape desirable client behaviour (Andersen & Anderson)
- Demonstrate alternative ways to think or act (Hill & Knox, 2001)
- Offer authentic human-to-human communication (Geller, 2003)

Table 1: motivations for using TSD

The actual mechanisms of many of the processes listed in table 1 are not fully known, as might be expected when considering research into relational factors that occur within a therapeutic 'conversation'. When comparative studies of psychotherapeutic frameworks found no significant differences between each modality in terms of client outcome – labelled the 'Dodo effect' (Luborsky & Luborsky, 1975; Messer & Wampold 2002), research into the efficacy of therapy moved towards looking at atheoretical common factors. This shift enabled research into psychotherapy to investigate variables previously considered 'confounding' with regard to comparison of therapy type and led to the finding,

for example, that the most significant factor influencing a positive client outcome is the therapeutic alliance (e.g. Messer & Wampold). TSD can be considered within this frame of research. Research into TSD and its benefits or service to the client are hard to quantify and assess, as TSD can link to many other common elements of therapy that span different frameworks, including the therapeutic alliance (Hanson, 2005).

Most of the literature makes a distinction between 'appropriate' versus 'inappropriate' disclosures but there is no agreed rule or definition of these terms due to the complex nature of these processes. Constantine and Kwan (2003) define inappropriate TSD as being "self-indulgent and narcissistic" on the part of the therapist, but this does not tell us what would constitute inappropriate TSD in practice.

Appropriate disclosures are considered to be contextually bound within the specific client-therapist relationship and the situation that gives rise to the disclosure. Effective and appropriate TSD requires "interpersonal skills such as tact, timing, patience, humility, perseverance, and sensitivity. These soft skills cannot be learned from a manual," (Geller, 2003, page 543). Of course, it could be claimed that the only way to know what is appropriate or not, in terms of TSD, is to ask the clients about their experience of the disclosure. But even this is questionable, for example, a client might initially find the disclosure helpful, but after some time has passed may come to realise it was not helpful or appropriate, or vice versa (Goldfried, Burckell & Eubanks-Carter, 2003).

1.4.2 Impact of TSD on client wellbeing

Henretty and Levitt's (2010) systematic review of 85 studies examined the impact of TSD on client's perceptions of trustworthiness, level of regard, empathy, and congruence. It unconditionally found a non-significant effect for these variables. The review did find that TSD could lead to an increased perception of therapist warmth. The authors also compared 30 studies examining the use of TSD versus absence of TSD in therapy. Their finding was that 20 of these studies found that therapists who disclosed were viewed more positively than those that did not. A naturalistic study by Barrett and Berman (2001) found an increase in TSD resulted in a decrease in client symptomology.

It is also theorised that the subject matter of the disclosure is relevant: research has found that clients seem to respond more favourably to disclosure that conveys similarity to, and extends from, what they have just shared with the therapist (Barrett & Berman; Myers & Hayes, 2006). In a case study examining issues around self-disclosure of HIV status, Cole (2006) suggested that TSD could be most helpful when it reveals similarity between the client and the therapist. Hill, Mahalik and Thompson (1989) state that appropriate disclosures "support, reinforce, or legitimise the client's perspective by adding an element of comfortability, and are preferred to those that are challenging," (page 291). From the client's perspective, self-disclosures may make therapists seem more real and human, which in turn strengthens the therapeutic alliance (Knox, Hess, Peterson & Hill, 1997).

There are several qualitative studies that have looked at the impact of TSD on clients, which have small samples but are naturalistic using community samples. Bitar and colleagues (2014) interviewed ten clients whose therapy was court-mandated and found that therapist disclosures were found to normalise the client struggles and lessen the power dynamic between therapist and client. Tsai and colleagues (2010) surveyed 35 clients and found that TSD enhanced their trust and increased equality in the therapy relationship. Audet and Everall (2010) found that TSD facilitated taking risks but could also be overwhelming for the client. Similarly Wells' (1994) findings were both positive and negative – while TSD could validate and empower clients, it also made the therapeutic space feel unsafe, and increased client inhibition.

1.4.3 Methodological challenges of research

As well as the operational issues highlighted regarding defining a concept such as TSD, there are other methodological challenges around researching this field of therapy. As previously stated, much of the published literature on TSD is conducted in North America using experimental research methodology. The analogue or 'pretend therapy' set-ups can be critiqued for not being able to replicate real-life experience of therapy, thereby limiting how relevant their subsequent findings actually are (Henretty & Levitt 2010; Sloan, 2007; Watkins, 1990). Many studies use research participants in place of clients to rate

incidences of TSD in transcripts or videos of therapeutic interactions. It is easy to critique these experimental designs and question whether they truly reflect the client's experience of receiving the disclosure or therefore whether this can be of much use in furthering understanding of use of TSD. The non-clients tend to rate therapists who use TSD more highly than those who do not (Hill & Knox, 2001), but what can that tell those of us practicing as therapists that is relevant to clients who attend NHS clinics today? The studies that use real client-therapist pairs rely on post-event analysis, which suggests possible issues around recall and demand characteristic bias.

Gibbons (1987) outlines the challenge around defining TSD within research. Clients and therapists would be expected to have different understandings of what has been revealed by the therapist in terms of self-disclosure. It may be that a salient and important disclosure as perceived by the therapist goes unnoticed by the client, for example. Therapists are less consistent than clients in their ratings of the helpfulness of TSD, which also raises questions about reliability of findings (Roberts, 2005; Knox & Hill, 2003). A further challenge in research beyond defining TSD and calculating its frequency is posed by the measurement of outcomes to evaluate its effects (Henretty & Levitt, 2010; Knox & Hill, 2003). It is difficult to standardise therapeutic processes that relate to TSD, and the measurement of any outcomes involves post-hoc analysis or interruptive live supervision, neither of which can truly replicate live therapy. TSD is different for each therapist, since each therapist, as an individual, will have a unique group of possible disclosures and potential reactions to different therapeutic events. These will be impacted by their relationship to the client, and moment-by-moment transference and counter-transference processes, as summarised below:

> *"We believe that context is key to determining the rationale for and consequence of any TSD. The same utterance may carry a very different meaning and impact depending on the particular client, therapist and the specific moment in therapy*." (Ruddle & Dilks, 2015)

Because the phrase 'therapist self-disclosure' covers such a potentially broad area, it makes research into the impact and benefits of TSD problematic.

Making generalisable claims from the literature when researchers utilise different definitions can be called into question, and means that overall findings can lack clarity and validity. Thus, in order to obtain a complete overall picture of TSD practices and their effects, researchers are compelled to rely on a range of techniques and sources.

In summary, extant research indicates contradictory findings as to how TSD might be received by clients, and that there are many factors that will influence its successful use, as perceived by the client.

1.5 Implications for therapeutic practice

Hill, Knox and Pinto-Coelho (2018) make recommendations for the judicious therapeutic application of TSD. Based on their qualitative meta-analysis of research on TSD and immediacy events, their recommendations include: “be cautious, thoughtful, and strategic about using TSD”, use disclosure “sparingly” and keep it “brief”, and do not disclose anything that is (emotionally or otherwise) “unresolved” for the therapist. They also include recommendations that place the use of TSD within a client-focussed context – in Clinical Psychology this would fit with formulation-driven interventions: “have a client-focused intention for using TSD”, “keep the TSD relevant to client material” and “evaluate how clients might respond and whether TSD is likely to help”. They also recommend checking with the client to gauge the impact of any TSD after the event: “observe the client’s reaction to the TSD and assess the effectiveness and decide whether it will be appropriate to use TSD again” (page 458). These processes link to the way supervision might be able to help harness TSD as a therapeutic tool; through discussion with a supervisor the supervisee can explore and reflect on their own response to the disclosure and the client’s stated feedback.

1.5.1 Potential risks and negative impact of TSD

TSD could be viewed as either a boundary violation or a boundary crossing depending on the way the therapist approaches any personal disclosure. Boundaries may be described as the ground rules of the professional relationship (Smith & Fitzpatrick,1995), and TSD is an intrinsic part of

negotiating boundaries within the therapeutic relationship. Other boundaries include touch, the managing of the therapeutic space including location and timing, as well as giving and receiving gifts. Appropriate boundaries set guidelines for acceptable behaviour within the therapeutic space, and therefore help to protect clients from unethical behaviour or harm (Gutheil & Gabbard, 1998). It is the therapist's, and not the client's responsibility to set boundaries and to ensure they are not violated (Jorgenson, Hirsch & Wahl, 1997), and CPs are expected to adhere to guidelines set out by the British Psychological Society (BPS, 2018) Code of Ethics and Conduct. The client depends on the therapist to act in their best interest and to be able to develop a trusting rapport and feel safe in what is a vulnerable situation for most people (Smith & Fitzpatrick,1995). Boundaries may be crossed, rather than violated, if it is in the client's interests, consistent with their treatment plan and appropriate given the client's history and not all intrusions of boundaries will be harmful, unethical or inappropriate (Barnett, 2011).

Barnett (2011) sets TSD in the context of boundaries and sets out the need to work within a framework that provides acceptable guidelines for using TSD. The BPS (2018) requires all psychologists to work within ethical guidelines, and self-disclosure falls within this given that we know that inappropriate disclosure can cause therapeutic rupture or distress to the client. Ruddle and Dilks (2015) also argue for the need for clear frameworks for clinical psychologists to be able to use TSD in their clinical practice, with a focus on clients experiencing psychosis. They believe that the lack of an evidence-based or practice-based framework does psychologists and clients a disservice, as it is confusing and could lead to unethical practice.

There exists a wide range of possible disclosures that can be made in a number of voluntary or involuntary ways. Different theorists suggest different ways of approaching this in order to use TSD appropriately. Anderson and Kitchener (1996) suggest the therapist always hold in mind the intent or specific goals that lie behind the disclosure. Others state that TSD can be practiced ethically if it is a thought-through rather than an impulsive act; "impulsive TSD carries risk of violating the client," (Simi & Mahalik, 1997).

Despite the evidence that appropriate and thought-through boundary incursions can be beneficial to the client, some mental health professionals may avoid it all together (Barnett, 2011). This is likely to be partly due to the idea of a 'slippery slope' (e.g. Gutheil & Gabbard, 1993): that all major unethical boundary incursions take place following a gradual progression of boundary incursions (Barnett, 2011). However, attempting to adopt a total non-disclosure stance is also criticised for being unethical (Langs, 1979; Rothstein,1997), given the potential benefit that using disclosures may have if used judiciously. This is supported by evidence demonstrating the ability of psychotherapists to handle boundary incursions without causing harm to clients (Lazarus,1998; Williams, 1997; Zur, 2004).

1.5.2 Disclosure and power

The concept of power between therapist and client underpins the therapeutic relationship, alliance and boundaries; and this is especially pertinent when we consider the context of the service user within Clinical Psychology services in the NHS. There has been a recent and growing shift towards working alongside, and in partnership with, service users, rather than adopting the expert-client stance with mental health disorders increasingly seen as existing on a continuum rather than the traditional diagnostic focused binary stance of 'well' versus 'unwell'. But recovery approaches to mental health problems (Department of Health, 2011; Slade 2009) emphasise that the role of professionals is no longer to 'cure an illness' but instead to work with people towards what they consider a successful outcome. Despite best efforts to make services more accessible and to include the service users as consultants to service provision, there is still a long way to go for equal partnership working.

Respondents to a survey conducted by Simi and Mahalik (1997) into TSD reported the use of disclosures to lessen the hierarchy in the therapeutic relationship and feminist empowerment therapy also values the use of appropriate self-disclosure for this purpose to equalise power dynamics between the client and therapist (Hanson 2005, Mahalik et al., 2000; Tabol & Walker, 2008). This could be because feminist therapists are explicitly open to being seen as human and fallible rather than omnipotent (Hill, 1998). Sharing vulnerability is sometimes a key motivator or function of TSD from the

therapist's perspective, depending on the particular self-disclosure, whilst silence may create distance and work to increase the power imbalance between therapist and client (Tabol & Walker).

1.6 Pluralistic approaches within Clinical Psychology

CPs are in a unique position within mental health settings in the UK. They are qualified to work in a wide range of roles within the NHS, the third sector and privately and can draw from any number of therapeutic frameworks with, or without further specialist training, provided they meet the Continuous Professional Development (CPD) requirements. This thesis is focused on the CP's specific role of 'therapist' in the NHS, within the wider skill set that training prepares individuals for, which includes clinically-related research, indirect consultancy and leadership. However, within the occupation of 'therapist' exists a variety of possible roles.

1.6.1 Evidence-based practice

Beyond the ideas of strengthening the therapeutic bond and deepening the client-therapist relationship, the approach to TSD may vary according to the therapeutic framework and clinical setting. The National Institute for Health and Care Excellence (NICE) offers evidence-based frameworks for how to assess and treat specific diagnoses, presentations and client groups which mental health and Clinical Psychology services will work within. However, this constitutes guidance, rather than a strict set of rules for clinical practice. Patient-centred care is at the heart of the NHS, and individually-formulated interventions based on thorough assessments are widely considered good practice in Clinical Psychology (NHS, 2015). This is in line with evidence-based practice, which combines current best evidence and clinical expertise with patient values and expectations (Sackett & Rosenberg, 1995). CPs are qualified to work in any NHS health setting using any framework, and some will also undertake further model-specific professional training.

1.6.2 Working with different frameworks

The principal therapeutic domains that a CP works with and a TCP can expect to encounter on a training placement are Cognitive Behavioural Therapy (CBT,

e.g. Beck, 2011), psychodynamic (e.g. Lemma, 2015), behavioural (e.g. Eysenck, 1960), systemic (e.g. Fredman, 2004) and narrative and/or community (e.g. White, 2011). There are also many third wave CBT therapies like Compassion-focussed therapy (CFT, Gilbert, 2014) and Acceptance and Commitment Therapy (ACT, Hayes, Luoma, Bond, Masuda & Lillis, 2006) or those that combine elements or different frameworks such as Cognitive Analytic Therapy (CAT, Ryle & Kerr, 2003). There are also supervisors who choose to work using emotion-focussed therapy for example, which takes a more humanistic approach as taught on counselling psychology training programmes. I will now briefly consider the interaction between the different models CPs use and TSD with a specific focus on working in a Clinical Psychology context.

CBT: CBT must be taught by all UK clinical training programmes along with at least one other therapeutic framework (BPS, 2014). CBT techniques are therefore considered a core skillset that CPs are expected to have upon qualifying. There is research around using TSD within CBT which has found that a therapist might disclose in order to strengthen the therapeutic bond, normalise experiences of distress or model effective ways of coping (e.g. Dryden, 1990; Goldfried, Burckell, & Eubanks-Carter, 2003). The decision to privilege CBT within Clinical Psychology is not without controversy, and is also inherently political, given the rise of CBT-specific primary care mental health services (Improving Access to Talking Therapies, IAPT) in the last two decades (Clark, 2011). IAPT is a government backed-initiative, with a foundational aim to reduce time off work related to stress, anxiety and depression in the UK workforce. Some have argued the service wrongly privileges CBT over other therapies due to its short-term, outcome-based methodology (e.g. Timimi, 2018). In reality, it is very rare for a CP to work in uni-modal CBT, and they will usually be drawing on many different theories and models within a formulation-driven practice (Johnstone & Dallos, 2013).

Psychodynamic: Psychodynamically-orientated therapy takes a more boundaried and perhaps clear-cut approach to TSD. As discussed earlier in the introduction, when using a purist traditional approach, personal disclosures on the part of the therapist are considered ill-advised as they can interfere with processes of transference and counter-transference (Freud, 1912/1958).

However, within psychodynamic theory, this rigid position has softened, and some personal disclosure may be considered acceptable within applied parameters (e.g. Greenberg, 1995, Lomas, 2004).

Humanistic: Humanistic, person-centred therapists following in the Rogerian tradition hold client-centred empathic listening as healing in its own right (e.g. Greenberg et al., 1993). TSD may form part of the empathic bond as a means of showing "humanistic congruence" (Rogers, 1961) and "transparency" (Jourard, 1964, 1971) and fostering an equal relationship. Although humanistic therapy is not one of the therapeutic modalities that clinical training programmes cover as a distinct therapy, the core skills of listening and empathising need to be acquired and practiced by any TCP engaging in direct or indirect consultations and therapeutic practice.

Systemic: Different systemic therapy schools take different approaches towards TSD. From Haley's (1976) position of tight boundaries, to narrative therapy's belief that therapists should be "transparent about models of therapy, personal values, and life experiences that inform their practice and beliefs", Roberts (2005). Feminist systemic therapists argue for TSD (Brown, 1994; Mahalik, Van Ormer & Simi, 2000) as a way of "increasing collaboration, decreasing hierarchy, affirming shared and diverse experiences of women, and acknowledging power differentials" (Roberts, 2005, page 45).

Summary: TSD is not conceptualised in detail by many of these theoretical frameworks, for example ACT (Harris, 2009) advocates TSD "if and when it's likely to be beneficial to the client in the service of normalization, validation, promoting self-acceptance, or enhancing the therapeutic relationship" (page 235). This statement seems to make an assumption that deeper thinking about the why, what and when of TSD will be covered elsewhere.

1.6.3 Theoretical allegiance

There is not space within this chapter to cover all of the frameworks' approach to TSD in depth. There is an array of possible theoretical options that exist when considering the use of TSD, which may present a confusing picture for TCPs given the different therapeutic modalities they may be expected to use in

the three-year training period. Research has found humanistic therapists are the most likely and psychodynamic therapists the least likely to self-disclose to clients (Bianco, 2007; Cowan, Hansen, & O'Toole, 2010; Edwards & Murdock, 1994). However, Geller (2003) recognised that "theoretical allegiances" can only account for part of anyone's therapeutic style, and relates this to the use of TSD:

> "…the personal styles and character traits of therapists who share the same theoretical point of view lead to substantial differences in our application of basic principles and techniques, including self-disclosure." (Page 543.)

That is to say, that theoretical allegiance is not the sole factor in the therapist's decision to use, or not to use, TSD. Ziv-Beiman (2013) argues for an integrative conceptualisation of TSD, describing it not as a "therapeutic modality in its own right but rather as an intervention that makes an integrative impact", that can be client driven, technique driven, or theory driven.

1.6.4 TSD's potential as a therapeutic tool within Clinical Psychology

The BPS (2014) states:

> *"*Clinical psychologists are trained to reduce psychological distress and to enhance and promote psychological well-being by the systematic application of knowledge derived from psychological theory and research. Interventions aim to promote autonomy and well-being, minimise exclusion and inequalities and enable service users to engage in meaningful interpersonal relationships and commonly valued social activities such as education, work and leisure. (…) The evidence base tells us that different interventions work for different presentations and groups. It also tells us about the central importance of non-specific therapist factors in outcomes." (Page 5.)

TSD can make claim to be a part of many of the aspects of Clinical Psychology training covered in the above. TSD may: facilitate a reduction in distress by normalising experiences and symptoms; promote psychological well-being by

modelling coping strategies; work towards reducing inequalities via the attempt to equalise power imbalances between therapist and client; and it is, of course, one of the many "non-specific therapist factors in outcomes".

The BPS (2014) Clinical Psychology training guidelines do not outline TSD itself within the competency map. This, together with the lack of any explicit guidance of how to use TSD when working integratively may present as confusing or feel unsafe to the trainee. This may link to why some research has found that trainee therapists sometimes may err on side of caution and not disclose anything at all for fear of transgressing a boundary (e.g. Bottrill et al., 2010). It is also known that early-career therapist may disclose less and for different reasons than more experienced therapists (Simone, McCarthy & Skay,1998) from which we can deduce there is an interrelationship between the experience or knowledge of any therapist and their use of TSD, although this relationship is unlikely to be linear given that it is also possible less-experienced therapists may disclose more readily, perhaps due to lack of knowledge or reflection around the issue's complexities and implications.

Because of the lack of explicit coverage within the curriculum due to the realities of the broad arena that training must cover, nuanced therapeutic skills like TSD are anticipated and expected to be covered on placement. I will now consider supervision within Clinical Psychology training specifically; its framework and the mechanisms for successful supervision.

1.7 Supervision of TCPS

> *"*Despite the divergence in systems of psychotherapy, their goals and varied training practise, supervision remains the one component considered essential to all*."* (Lambert & Ogles, 1997, page 421)

1.7.1 The purpose of clinical supervision

Roth and Pilling (2015) define supervision as "a formal but collaborative relationship which takes place in an organisational context, which is part of the overall training of practitioners" (page 4). Supervision is mandatory for all TCPS and is viewed as an important mechanism by which to maintain practice

standards throughout the profession (Roth & Pilling, 2008; Westefeld, 2009). From the client's perspective, supervision is meant to ensure they receive the best possible therapy experience and in turn, should improve therapy outcomes. For a psychologist-in-training, supervision serves many functions and is an essential component of the doctoral programme. It helps the supervisee learn specific clinical skills as "it links academic input to the realities of clinical work and is the means by which theory becomes linked to practice" (Page 3, Roth & Pilling, 2015). Supervision is also expected to monitor ethical and professional behaviour (Milne & James, 2000; Wheeler, 2004) and offer emotional support to trainee therapists (De Stefano et al.,2007). Positive supervisory experiences have been found to lead to an increase in trainee confidence, motivation and therapeutic perceptiveness (Nelson & Friedlander, 2001).

Proctor (2001) outlines the three functions of clinical supervision: normative – which includes processes like case management, and evaluation forms; restorative – covering emotional processing of client work; and formative which is the development of skills and knowledge, and of particular importance during training. These overlapping and at times, contradictory tasks may be felt more keenly by both parties within the supervisory dyad given the need to pass each placement, thereby making it difficult for a supervisor to be able to adequately cover all aspects of their role. The following quotation captures this sense that being evaluated brings another dimension of feeling to the supervisory relationship: "Both supervisor and supervisee can experience evaluation with discomfort" (Bernard & Goodyear, 1998, page 9).

Supervision training: BPS (2010) outlines guidance on programmes providing regular training workshops aimed at both new and experienced supervisors. It is stipulated that a supervisor should have at least two years' experience post qualification and the London-based North Thames courses, for example, also stipulate completion of a two-day introduction to supervision and one day advanced training, accredited by the BPS (Roth & Pilling, 2015). Inevitably supervisors vary in their ability to provide effective supervision (Russell & Petrie, 1994; Scott, Ingram, Vitanza & Smith, 2000) and yet supervision is considered crucial to trainee development (Binder,1993).

1.7.2 Supervision and TSD

A key role of a placement supervisor is to scaffold the learning of a range of clinical skills within the trainee's zone of proximal development (Vygotsky, 1930-1934/1978). The supervisor has the opportunity to support a trainee in thinking about and making appropriate use of TSD whilst trying it out with clients. But supervision during training is not just about teaching clinical skills within an evidence-based framework and fulfilling the demands of competency frameworks for passing placement. It also fulfils a restorative function (Proctor, 2001) to be emotionally supportive and a space for discussion of professional and personal dilemmas and issues. BPS (2010) Guidelines on Supervision for clinical psychology training programmes states that supervisors "should be sensitive to any personal issues that arise for the trainees in relation to clients and be prepared to discuss these in a supportive way when they are considered to affect the trainee's work," (Page 5). Supervision can enhance a supervisee's awareness of any 'blind spots' (Morrissey & Tribe, 2001, page105) which may in turn lead to an increase in self-awareness. This process is likely to enhance a trainee's ability to distinguish between their clients' and their own emotions (Kumari, 2011) which will help facilitate wider processes around TSD and choosing whether to disclose or not.

1.7.3 The supervisory relationship

Worthen and McNeill (1996) state "the most pivotal and crucial component of good supervision experiences…was the quality of the supervisory relationship" (page 29). The supervisory relationship or alliance is considered integral to the success of supervision and possibly the most important factor (Holloway, 1995; Kilminster & Jolly, 2000; Ladany, Ellis & Friedlander, 1999). In parallel with research findings that the therapeutic alliance is an important factor in positive client outcomes, a good supervisory alliance will enable a trainee to learn in a safe, yet challenging, environment. Furthermore, a weak supervisory alliance is related to supervisees' withholding information (Ladany, Hill, Corbett & Nutt, 1996).

Supervision is not a one-way process, and there are expectations of a TCP to ensure it is a successful working partnership or relationship, a key one being that supervisees need to be open and honest about their clinical work (Roth & Pilling, 2105). Supervisees are more likely to talk honestly and openly with a

supervisor they trust, and the quality of the supervisory relationship is also associated with the level of supervisee self-disclosure (Mehr, Ladany & Caskie, 2010; Webb & Wheeler, 1998). However, self-censorship is a frequent occurrence that occurs in any relationship with a one-down power dynamic and it is known that trainees frequently conceal aspects of their work (Farber, 2006), including clinical mistakes (Ladany, Hill, Corbett & Nutt, 1996; Hess et al., 2008; Yourman & Farber, 1996). This is important because not sharing dilemmas or perceived mistakes is likely to limit a trainee's potential to learn through supervision (Barnett, Cornish, Goodyear & Lichtenberg, 2007) given that supervisors' feedback enables learning and encourages development (Worthen and McNeill, 1996). Disclosures may be viewed as mistakes and this may limit the discussion of TSD within supervision on placement. Daiches (2014) suggests that Clinical Psychology's emphasis of a scientist–practitioner stance may limit supervisee self-disclosure in general.

Accessing supervision during training is vital across all psychological models (Wheeler & Richards, 2007), but it is also important to think about the specific factors within supervision that lead to different aspects of its functioning both positively and negatively that will enhance and support the therapeutic process of TSD for a trainee. However, there is a lack of robust research examining outcomes associated with supervision in terms of the impact on the supervisee's competence (Roth, Pilling & Turner, 2010), and there are no specific studies looking at impact of supervisory practices on TSD on Clinical Psychology trainees.

1.8 Present study

1.8.1 Rationale for this study

Emerging clinical guidelines and an extensive body of research indicates that TSD is an important skill to learn about that can have a positive impact on client wellbeing and therapy outcomes. It can also have a negative impact if used inappropriately, for example without due consideration to the client, the formulation and how they may receive it. Due to the many different types of disclosures and the varied clinical uses it can have, it requires considered reflection by individual therapists and would benefit from being discussed in

supervision. Clinical training is a good place to start these conversations and to open up a relationship to working with TSD in different ways There is a lack of research and framework on TSD within Clinical Psychology and training (Ruddle & Dilks, 2015). The increasing interest in minimising power differentials between professionals and clients, and the relevance of this as a therapeutic skill, mean that it is important this is given prominence in training. Past research (Bottrill et al., 2010) explored this process from the trainee perspective, uncovering where they felt that their supervision or course training may have fulfilled or fallen short of providing necessary support or scaffolding for their learning. Bottrill's findings highlighted a lack of teaching and discussion about the use of disclosure on participants' training programs, consistent with previous findings (e.g., Burkard et al., 2006). Supervision is a key process for trainee development in this area. But, to date there is no research that outlines the process of how this is approached in the clinical supervision of trainees; published papers offer emerging frameworks and a call for more specific research in the field (e.g. Henretty & Levitt, 2010, Ruddle & Dilks, 2015).

1.8.2 Research aims

The aim of this research is to explore the mechanisms by which supervisors guide and scaffold the learning of TCPs in using the clinical skill of TSD. This process supports TCPs to practice competently and ethically, but importantly can benefit the client in terms of the alliance and outcomes. The research will enquire about processes by which TCPs learn about applying this technique appropriately in varied NHS contexts. This study hopes to inform supervisors, Clinical Psychology course centres, trainees and the field of Clinical Psychology in general about the processes that take place within supervision of trainees' use of TSD and how they make sense of it, highlighting areas where different supervisors are either similar or conflicting in their approaches.

Although this research is not asking clients their experience, it hopes that by exploring how supervisors approach TSD in supervision with TCPs it can lend further understanding of how trainee needs are met in this area. The lack of specific or detailed guidance on the issue means there is a need to investigate further the processes by which TCPs experience, practice and reflect on the use of TSD. By interviewing supervisors of trainees, this study aims to deepen

understanding of how this important and, at times controversial, clinical tool is acquired through supervision by the developing therapist. Because of the many, at times conflicting roles of a clinical supervisor in this setting, it is all the more important to have clearer guidelines and best practice outlined to aid trainee learning and guide those in what can be a grey area.

1.8.3 Research questions

The following areas will be covered by the interview schedule:

- What are supervisors' experiences of supervising trainee clinical psychologists in the use of TSD?
- How do supervisors approach TSD in supervision?
- What do supervisors find helpful and unhelpful?
- Is any particular supervisory style or model used in relation to TSD?

1.8.4 My personal motivation for this research

My own position as a TCP is of direct influence in this study. I approach TSD as someone who has an interest in 'basic' human interactions in the therapy room, and who has been asked direct questions from clients that have left me uncertain of how to respond. I have taken these dilemmas to supervision, and while I have found the supervisors to be helpful and supportive, I did not experience the in-depth discussions I hoped to have. In one session, for example, a client asked me if I had ever broken the law, and I was keen to explore the ethical boundaries and potential therapeutic impact of being honest.

As a client myself, I have had experience of a therapist who offers no verbal self-disclosure and a therapist who openly talks about their experience as a means to advise and normalise. These different experiences have made me more aware of the potential advantages, disadvantages and impacts of different positions regarding TSD. It has also shown me the importance of holding the context in mind – in terms of the client, the therapist, the setting, the disclosure itself, the timing in terms of therapy, as well as other socially-imbedded contextual factors.

CHAPTER 2
METHODOLOGY

This chapter covers the research design and methodology employed in the present study. It also considers methodological issues and how they were conceptualised and manualised.

2.1 Rationale for qualitative methodology

As the research question is exploratory in nature, it is suited to a qualitative approach which enables deeper exploration of participants' experiences and views than could be captured with quantitative methods. A qualitative approach also enables the researcher to explore the area of question within a socially- and culturally-embedded context with the aim of gaining an understanding of people's experiences beyond surface value (Thompson & Harper, 2012).

As stated in the introduction, there is a lack of research examining the supervisory processes involved in scaffolding trainees' use and learning of TSD. This exploratory study hopes to deepen understanding of these processes. The aim of this research was to capture in depth personal views of supervising clinical psychologists on TSD and how they approach this therapeutic tool or skill whilst supervising trainees. It was felt therefore that a survey method would be inadequate, given that the process and scope of TSD as complex and rich. Qualitative methods are appropriate for this area of research because they can yield descriptive data as the researcher is able to explore the subject matter more widely with the participant within their own experiential context and gain deeper insight into the phenomena under investigation.

2.1.1 Thematic analysis

Several qualitative approaches were considered for this research, so I will outline why thematic analysis using interviews was chosen as the most suitable qualitative method.

Interpretative phenomenological analysis (IPA, Osborn & Smith, 2008) was considered as it employs individual interviews as its method and the resulting

data is transcribed and analysed for themes. However, IPA is more suited to a research question that is exploring the individual's experience and their "making sense of their personal and social world" (page 53). IPA also requires a roughly homogenous sample, which was in contradiction to the sample desired for this study, as will be discussed below. It might have garnered interesting data for analysis, but the slant of the research would have necessarily shifted, and I wanted to explore the process and means of this subject matter, rather that the psychologists own personal meaning of what they were undertaking in supervision.

Another method that was considered and discounted was Grounded Theory (GT). Green and Thorogood (2010) suggest that the main purpose of GT is to produce new theories that are grounded within empirical data and can also be used for exploratory research questions. Although GT could have been a suitable method, it was decided that for this piece of research thematic analysis offered a more suitable exploratory avenue of analysis.

Discourse Analysis was not considered suitable, as I was interested in exploring themes around TSD across a group of clinical psychologists. Whilst language and expression are important and will be considered as a context in the analysis and discussion, I was not interested in focussing in detail on the participants' discourse or language itself in their construction of reality (Willig, 2009).

A mixed method approach was also considered but it was not thought to be helpful to explore this question in that the quantitative element of the research would not necessarily yield additional information alongside the in-depth data arising from the qualitative interviews. I was not interested in looking at how many supervisors use TSD in supervision, but more at the processes and mechanisms by which this occurs and due to the complexity of the subject matter, it was deemed important to be able to explore these answers as they were given; a process a tick-box answer-style questionnaire is not able to capture.

2.1.2 Approach to analysis

Thematic analysis (TA) is a qualitative method that identified and analyses patterns of meaning in a data set which are then organised and described in detail by the researcher (Braun & Clarke, 2006). As it was necessary to use an exploratory method to investigate the research question, it was a suitable choice of method as it can be used flexibly and with an openness that will be helpful when analysing the participants' responses. The analysis process will aim to generate themes across the data set that can better inform our understanding of how clinical psychologists approach TSD when supervising trainees. A theme can be identified as "a pattern in the information that at minimum describes and organises the possible observations, and at maximum interprets aspects of the phenomenon" (Boyzaris, page 161). The theoretical positioning of the research will be covered below.

2.1.3 Epistemology

This research is rooted in a critical realist epistemology, which means that my position as a researcher assumes that objects and ideas exist independently of the mind even if we may never be in direct contact with them, as their existence is also partially dependent on our beliefs and expectation. Critical realism also questions the positivist position that predictable empirical realities exist (Fletcher, 2017).

From the researcher perspective, I am therefore interested in the complex factors that influence, mediate and underpin decisions and actions taken in relation to TSD and clinical psychology supervision of the trainee. In this process I am endeavouring to take account of filters through which this process of discovery is occurring, that of language, meaning making or individual values and positions, and social context. The constructs of therapy, supervision and TSD are real, even if they encapsulate many different possible definitions.

2.1.4 Ontology

Ontology concerns itself with the nature of reality and this research will also take a critical realist approach falling within the realist-relativist spectrum. Whilst realist ontology makes claims that there is an external reality and that can be measured, relativist ontology states that an objective external reality is not

possible, and realities are created by individual interpretations of the world and experiences within it.

Therefore, in applying a critical realist ontology to this research, I consider TSD to exist as a known entity beyond the participant's accounts and my interpretations of the data. I also accept that a complex, multi-layered concept such as TSD comes to exist through the filter of our own interpretations of it and will approach the data and interpretation accordingly (Fletcher, 2017).

2.2 Research design

2.2.1 Participant selection

I sought to recruit clinical psychologists who fitted my inclusion criteria using a purposive sampling strategy which meant that I accessed networks already known to me and sought recommendations via word of mouth. Diversity was sought in terms of gender, ethnicity, client group they worked with, therapeutic modality and years of experience post qualification.

2.2.2 Inclusion criteria

The inclusion criteria for this study were: a clinical psychologist with over three years' experience supervising trainee clinical psychologists, and by circumstance and necessity this involved psychologists currently working or with experience of working within the NHS. This would mean that the sample would have been qualified for five years or longer, as the British Psychological Society (BPS) stipulates that clinical psychologists should have a minimum of two years' practice post qualification prior to supervising trainees. I was also open to including Counselling Psychologists who supervise trainee clinical psychologists, but my sample did not include these by happenstance, and partly due to my own networking being more thorough in clinical psychology as a profession.

2.2.3 Exclusion criteria

The exclusion criteria were that participants could not have less than three years' experience of supervising trainees, and I did not include anyone who had supervised me during my training due to the fact that the prior supervisory

relationship might influence both the interview process, interactions and responses given.

2.2.4 Recruitment

The study aimed to recruit between eight and 12 participants; as informed by Guest, Bunce and Johnson (2006) on sample sizes and data saturation. Dey (1999) argues that exhaustive coding is rarely used in qualitative methodology and instead data suggest categories rather than saturate them. This was considered a realistic aim given the time constraints of the research project.

The sample consisted of 10 clinical psychologists (5 male and 5 female) who worked in a variety of mental health settings within the NHS using a variety of therapeutic frameworks in their clinical work (See table 2). Eight participants identified as white British, one as white Irish and one as BME but did not wish to be identified more specifically. The possible participants were contacted via email with an attached information sheet (Appendix II) and participants were given the opportunity to contact me or my supervisor to ask any questions about the study and its purpose.

Participant number	Training programme (University)	Years super-vising TCPs	Gender	Service setting (NHS)	Preferred Model
1	1	20	M	Adult LD	Psychodynamic/ Integrative
2	2	4	M	Adult LD	CBT / Systemic
3	3	4	F	CAMHS (Neurodev)	CBT / Systemic
4	4	7	M	Adult forensic	CBT / Integrative
5	2	6	M	Adult inpatient	Narrative / Integrative
6	1	15	M	Adult Recovery	Family Therapy / CBT
7	1	11	F	Adult Recovery	Family Therapy / Integrative
8	5	24	F	Adult recovery	CBT / Narrative
9	1	6	F	Adult Community MH	Psychodynamic
10	3	6	F	Adult Psychosis	CBT / Systemic

Table 2: participant demographics.

2.2.5 Considerations on recruitment

I was aware that by using a purposeful sampling strategy, I was in danger of biases entering my sample. For example, I was often suggested recommendations of people to contact from people who were known to me or were already taking part. This could lead to bias in the data as I might unknowingly recruit a sample of very like-minded participants who do not fulfil the diverse range of theoretical frameworks that are available to clinical psychologists working in the NHS. This led to me shutting down avenues of recruitment if I were to end up only recruiting from one service or related services, even if it made recruitment lengthier. However, I recognise this was in some ways an arbitrary process and one that I could not fully control but I could aim to be transparent and reflective about.

2.3 Data collection

2.3.1 Developing the interview schedule

The first draft of the interview schedule (Appendix IV) was produced after an initial literature review and considerations of what would be interesting to explore within the research area, in discussion with my research supervisor and also with peers. I conducted a pilot interview and took feedback from the participant at the end to gain feedback. As a result of this feedback I revised the schedule and amended and added some further prompts (Appendix V), again checking in with my supervisor for coherence. As discussed previously, collecting data through interviewing in of itself is changing me as the researcher and I felt it is appropriate to be reflexive and reactive whilst going forward with interviews which mean that as I progressed with the interviews, I inevitably found myself exploring certain areas of the participants' responses that I might previously have overlooked. To maintain transparency, I attempted to capture this evolving process in my reflective journal. It is seen by some researchers as appropriate and even important to be reflexive in this way and "departures from the guidelines [interview schedule] are not seen as a problem but are often encouraged" (Silverman, 2013).

I developed my interview schedule on the understanding that whilst there was a need to cover basic general information with all participants and the same areas

of interest, there was no 'one size fits all' and a more flexible approach was needed (MacNamara, 2009) to gain nuanced and rich data from each participant. It is a balance of being flexible without being so informally conversational that there is a danger of not covering the same topic with each participant.

2.3.2 Interview style and positioning

I wanted to create an opportunity and atmosphere in which my participants felt relaxed and as open as possible. I was aware that due to the nature of the research, and my role as a trainee asking questions to qualified psychologists, that participants might feel like they were being put on the spot, or tested on their skills as supervisors, by someone who has experience of supervisors. I found that tone of voice and keeping it conversational without being overly informal was the most likely way to garner rich responses (Legard, Keegan & Ward, 2003). It is important as the interviewer to recognise that I am not the centre of the research – I wanted to privilege the participant's story through my actions as researcher/interviewer (Seidman, 2006). I considered how my approach would influence the research. I found a useful frame to work within was to think about the many selves I brought to the interview (King & Horrocks, 2018). In the case of this research, my professional self – both as trainee and as aspiring clinical psychologist – was of particular relevance.

2.3.3 Individual interviews

Ten conversational face-to-face one on one interviews were conducted to gather data. The semi-structured interviews were guided by an interview schedule with open questions followed by prompts when required. The interviews ranged in length from 38 to 70 minutes, with an average time of 48 minutes. Each interview was recorded on a dictaphone and took place at the participant's place of work or home at a time convenient to them. Confidentiality and the right to withdraw at any time were explained, as was the possibility of excluding any part of the interview from the transcription should the participant feel concerned about anonymity or confidentiality of the trainee or clients discussed. This was introduced after the second interview when a participant expressed concern during the interview and was possibly not giving examples as a result of anxiety over accidentally giving identifying features of either the

trainee or the client. It felt to have potentially shut down the richness of the interview due to this concern.

The decision to conduct individual interviews is worth consideration. Trainee/supervisory dyads would have been advantageous to explore and consider the dual perspectives of being supervised and needing supervision on TSD. However, this was discounted as being beyond the scope of this thesis given the issues that recruitment would entail. Focus groups could also have been considered but there can be disadvantages to this as each participant would be affected by what the other might say and discussions can stray away from the topic under investigation (Freitas, Jenkins & Popjoy, 1998).

2.3.4 Transcription

The recordings of the interviews were transcribed manually by the researcher using an orthographic transcript style, verbatim as this is suitable for thematic analysis (Braun & Clarke, 2006). To preserve anonymity, all identifying details were redacted and all participant names converted into P1, P2, P3 and so on.

Although recognised as “time-consuming, frustrating, and at times boring” (Riessman, 1993) I found the process of transcription an invaluable way to familiarise myself with the data (Phase 1, identified by Braun & Clarke, 2006). It also enabled me to reflect on my position within the interviews and what I was following in terms of exploration and the avenues I was leaving unexplored. It also helped me to recognise that qualitative research is by its very nature an iterative process that cannot help but change me, the researcher, and expand my knowledge as the process unfolds.

2.4 Data analysis

The data analysis process largely followed the fives phases set out by Braun and Clarke (2006) as their expertise was felt to be a useful guide.

2.4.1 Phase 1 and 2: Familiarisation with the data and coding

Having familiarised myself with the data I moved on to phase two, generating initial codes. Codes are used to identify a feature of the data that seems

meaningful to the researcher. Boyatzis (1998), describes them as “the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon” (page 63). As this research is data-driven rather than theory driven, the themes that arise from the coding process will be drawn on the data itself, rather than searching for specific themes within the data. I chose to undertake this process manually rather than using a specialised software programme. Whilst coding I took the advice of Braun and Clarke to code for as many potential patterns as possible whilst also retaining some of the context of the coded item, to enable the identification of themes.

2.4.2 Phases 3,4, and 5: Searching, reviewing and naming themes:

After completing the coding of the data, I began the process of sorting the codes into broader themes, collating all relevant data extracts into different potential themes. I began this process within each data set and then across the whole. I then reviewed the themes checking they were distinct entities, and not merely different descriptions of similar ideas. This process involved merging any that overlapped and splitting those that seemed distinct. Super-ordinate themes and sub themes were conceptualised to capture the essence of the meaning within the coded data extracts.

2.5 Ethical considerations

2.5.1 Ethical approval

Ethical approval was applied for and gained from the University of East London’s research committee, (Appendix I).

2.5.2 Informed consent

Participants were given the opportunity to ask any questions about the research before and after the interview was completed. They were also reminded of their right to withdraw up until February 2019 as after that date the data analysis was underway making it difficult to extract specific coded excerpts from the analysis. The right to withdraw is a basic ethical component of all biomedical research (Kaye et al., 2015).

2.5.3 Confidentiality

At the end of each interview participants were reminded that the data would be confidentially stored and when transcribed all identifiable details would be removed. Any questions regarding confidentiality were explored and answered at this point if required. Some of the participants raised concerns about being identified. For this reason, the reported demographics (see table 2) were kept to a minimum in terms of detail. To facilitate open conversation during interviews, I reassured participants that they could ask me to remove any examples of details from my transcription should they feel uncomfortable and concerned that a trainee they worked with or a client could be identified. Two asked me to redact the transcript prior to analysis. Following completion of the viva and the Clinical Doctorate training programme, all recordings and consent forms will be destroyed. The anonymised transcripts will be deleted after seven years.

2.6 Reviewing the quality of qualitative research

Ritchie and colleagues (2003) outline four principles that underpin evaluating and maintaining quality of qualitative research: contributory in advancing wider understanding of the area under research and contributing to policy, practice or theory; defensible in design, that is the strategy can claim to adequately explore the research question; rigorous in conduct by collecting analysing and interpreting data systematically and transparently and finally, plausible in the claims it makes. Further considerations around evaluating and appraising a qualitative study will be covered in the Discussion chapter.

This study has been conducted with the intention of fulfilling these four guiding principles. In terms of contribution, the interpretation of the analysis has covered implications for training courses and supervisory practices including supervision training of how TSD might be thought about for the clinical psychologist in training.

Triangulation is an important technique to help ensure findings are plausible, provide inter-rater reliability and internal coherence. Triangulation refers to the use of multiple methods or data sources to help develop a comprehensive understanding of what is being studied (Carter & Little, 2007). Due to the

context to this research full triangulation methods were not possible, but coding and themes were discussed with the research supervisor for coherence. The findings are also context dependent, and as such will always be subjective and filtered through the lens of researcher reflexivity. This is in line with Elliott, Fischer and Rennie (1999) who assert that to attain high quality qualitative research it is imperative to own your position as researcher.

Another conceptualisation of rigour in research is reliability, which is difficult in the context of qualitative research. Although the method could be replicated, it would not be possible to replicate the findings as all interviews are context-dependent and interactional between interviewer and interviewee (Potter & Hepburn, 2012). However, Spencer and Ritchie (2012) propose that reliability be viewed as reflexivity to account for the researcher's subjective bias.

2.7 Summary

This chapter has detailed the design of the present study, and the rationale for selecting a qualitative methodology and specifically thematic analysis, along with a framework for how the data were analysed.

Chapter 3:
RESULTS

3.1 Overview

This chapter will present the themes that emerged through TA of interviews with CPs about how they approach self-disclosure as a therapy skill or tool with TCPs who they supervise on placement. As outlined in the previous chapter, initial codes were organised into superordinate themes, which were sub-divided to capture the nuanced content of each theme. These themes are briefly introduced, presented and illustrated with verbatim interview excerpts, below.

3.2 Reflections on TA

Given the nature of the interview and the fact that the over-arching subject is of supervision, whilst analysing the data I have had to pay keen attention to seeking relevant TSD-related responses that inform on this particular aspect of training, rather than presenting an overall review of the approach to the supervision of trainees or the approach to TSD in therapy in general. It has been a fine balance to tease out the themes and has inevitably meant the process of coding and analysing has not been purely deductive as there has been a necessary intentional seeking of data relevant to both TSD and supervision.

3.3 Introduction to themes

3.3.1 Outline

Meanings from the data were captured by four main themes, each divided into relevant subthemes, outlined below.

The supervisor within context

- Beliefs about function of TSD
- Responding to context
- Working within frameworks
- Feeling ill-equipped

Process of TSD with trainees

- Taking a declarative approach
- Reactive and unplanned approaches
- Reflecting after the event

Navigating the push and pull of placement

- Personal and professional dilemmas
- Power dynamics on placement
- Developing as a psychologist

A desire for something different

3.3.2 Summary of themes

The first theme looks at the process and thinking on TSD as it takes place within different contexts, from the supervisor's individual experiences and beliefs, to the influence of the service setting and client group and the theoretical models and frameworks employed. The multi-layered nature of these contexts is explored with the subtleties and nuances that inevitably accompany a concept as multi-layered as TSD.

The second theme captures how the process of TSD plays out on placement between supervisors and trainees, looking at proactive, reactive and reflective approaches described by supervisors. It considers the many different ways TSD may arise on placement.

The third theme encapsulates how TSD on placement links to the supervisory relationship, taking into account personal and professional dilemmas of TCPs, power dynamics within clinical psychology and the intersection of TSD with a trainee's development within supervision.

The fourth theme looks to the future, with the participants' expressed aspirations for how training courses could better teach TSD.

Underlying all the themes and running through the interviews as a thread, was the sense of appreciation and respect supervisors had for working with TCPs.

3.4 Theme One: The supervisor within context

This theme brings together ideas discussed by participants about what influences, and experiences have led to their approach and thinking regarding TSD. It encompasses a broad scope of topics given the range of possible influences on an individual psychologist's approach to the concept of TSD, and how these factors will in turn influence or impact on the supervisor-supervisee relationship in terms of process and content. It is divided into three sub-themes covering different aspects of their experience that hold importance within the context of supervising trainees around TSD. These include: work history, CP training and their current setting and client group. Their beliefs on the function of TSD is another key driver and potential influence in their supervisory practice. It also covers the theoretical frameworks the supervisors work with and how these interact with the idea of TSD.

3.4.1 Beliefs about function of TSD

A fundamental driver as to how a supervisor might approach TSD when supervising trainees originates from their beliefs and values about what function it might have in clinical situations. All participants covered this aspect of TSD,

but the function itself was described in many different ways depending on the individual's own clinical and personal experience, beliefs and the theories they are drawn to using in their work:

> "*If we're going to self-disclose we always need to check out with ourselves first, am I disclosing this because I think it would be useful for the client to know that […]. Either in terms of relationship building or just knowing that I've had a particular experience, and this is what it meant to me and this is how I got through*." (P1)

This describes P1's way of thinking about the usefulness of TSD from a client's perspective. It brings into play the idea of TSD as being useful for building an alliance with a client (e.g. Fitzpatrick et al., 2006) and also that sharing experiences can be of value to a client. These particular 'rationales' for using TSD with clients came up with some other participants; one described supervising a trainee who was able to use disclosure around being of a similar ethnic background with a client whom previous members of the MDT had found difficult to engage in the service. In considering the meaning of their similar backgrounds and the assumptions they might make about each other, the supervisor helped forge trust in and form an alliance where others had failed.

Other functions of TSD present in the data concerned the therapy relationship, therapeutic change, and empathising with clients: "trying to get a better relationship and trying to get a therapeutic change "(P7); "*it was just about trying to help people feel less anxious in sessions*" (P7); "*to support an understanding*" (P3). Not all participants were able to call up detailed examples of TSD where a therapeutic change had been achieved or the relationship improved; it seemed to be an intuitive process of using TSD in these examples.

An important factor to consider with the process of engaging clients is the power imbalance between CP and service user and in these instances TSD is described by some participants as a means by which to redress power imbalances and thereby enable an alliance:

> "…*so I suppose the first point is about how stigmatised they are, and how powerless they are in our society, and the second point is about the actual nature of their experiences as such that they are unlikely to want to form a trusting relationship so you need to do everything you can to build trust and be open and honest*." (P10)

It was felt that disclosing some of the professional's own personal views or experiences could break down the barrier between the two 'sides' and encourage trust.

In terms of finding out if the TSD used by trainees was of value to a client, only P10 talked about explicitly encouraging trainees to check in with clients after a self-disclosure to ask what impact it had, how did it feel to the client and advocated that they discuss any disclosures immediately afterwards or at the next session. Whilst the benefit to the client was held in mind with most of the participants, the viewpoint of the process was from the position of the supervisor or trainee. The fact that this was not a common theme in the data is likely to do with issues around the time-limited nature of supervision, which makes it impossible to come back to every single case in detail but raises the possibility that the client's voice or feedback risks being silenced in supervisor-supervisee interactions when trainee learning is being privileged.

The extract below gives the only explicit questioning of whether this process is necessary or helpful to 'engage' service users:

> "*I think there is an idea that disclosure, self-disclosure is important for engagement for people seeing you as a person rather than as a powerful figure or as a therapist with no life themselves that I'm not sure I agree with, I think we have so many resources for connecting*." (P5)

The above reference to the therapist as a figure viewed as powerful or expert by participants was also a common thread running through a majority of interviews. P5 feels that there are many other ways to engage people and self-disclosure is not therefore the sole tool for this – he made reference to body

language, tone of voice and general manner as being very important in making clients feel at ease.

Several participants expressed the idea that the function of TSD is not clear-cut or straightforward; it will depend on the situation, client and of course the personal opinion of the therapist:

> "*I don't think there should be hard and fast rules about whether you should use therapist self-disclosure or that you shouldn't use therapist self-disclosure, and I don't think it's as simple as that*." (P8)

> "…*it's a personal choice what you think is going to be useful when working with someone*." (P4)

This raises the possibility of a broad range of ideas and guidance coming from supervisors to trainees and that the use of TSD is governed by heuristic judgments that occur in a specific context and moment in time.

In this relatively small sample of clinical psychologists, we are presented with a broad range of ideas on what the function of TSD might be. Although many of these functions can coexist and do not preclude each other, this sub-theme conveys how potentially confusing TSD can be to the psychologist-in-training. And, as with many psychotherapy processes, TSD takes place as an in-the-moment decision based on intuition rather than objectively known facts or evidence-based knowledge.

> "…*we operate with people which is at a fairly deep, intuitive connected level so there's a kind of energetics in a conversation we respond to as human beings, we might call that intuition we might call that amassed experience*." (P1)

3.4.2 Responding to context

Nearly all of the participants named their current work setting or previous settings and client group as influences on their practice in relation to using TSD and how they might think about TSD with trainees. Given the spectrum of

settings and diversity of approaches there was no single idea about the mechanics of what might be considered suitable or advisable, but there was a common idea of responding to context appropriately and thoughtfully.

P4 reflects on the realities of working in a prison and how the nature of the client's history of offending might make a trainee or therapist think ahead of disclosing:

> "*I think it makes it a bit more acute, cos you know yeah we work with people who've committed violent offenses and so I think it makes some people much more aware and it makes some people much more boundaried*." (P4)

As the only participant working in a forensic setting, P4 reminds us that using TSD is not only risky for clients in terms of boundary violations but can also represent a very real risk for therapists. It is appropriate professionally and therapeutically to be very clear about how boundaries are navigated within forensic settings, and trainees will be expected to understand and work within this. P4 does not suggest that TSD should be avoided; but recommends it be thought about within the context of the additional risk factors.

Several participants working in psychosis services, CAMHS and Learning Disability all felt that using TSD could not only be actively beneficial for these particular client groups but is an essential part of the clinical work.

In response to direct requests for personal information from the client:

> "*But to do nothing in psychosis work for me just fuels paranoia and makes people feel very, very nervous*." (P10)

> "*When I'm asked direct questions about self-disclosure I'll have a little bit of a thought in my head before I answer it …in a learning disability setting where you don't want to sit in silence, and you don't want to not respond to what people are saying because people with learning disabilities are used to not having their voices heard*." (P1)

The last excerpt returns to the theme of power and the idea that making personal disclosures puts the therapist 'alongside' the client, rather than in the role of an expert with an undisputed opinion. Without the participants voices to agree or disagree with these statements, and with a paucity of research looking at the impact of TSD on marginalised or specific client groups, it is difficult to provide evidence for this.

Of the participants working with psychosis and severe and enduring presentations, there was a strong sense that TSD will come up on placement; and is almost unavoidable. Reasons for this as mentioned by these participants included clients coming from difficult backgrounds with complex or troubled, family relationships and also due to being socially isolated. These factors meant CPs felt it important for a therapist to be warm and offer an experience of a safe and trusting human relationship, and TSD is a way of achieving this. (This resonated with me as the researcher, as it was experiences during my first-year placement working with people with a diagnosis of psychosis, that ultimately led to the conception of this thesis. I found that working with younger people with diagnosis of psychosis, being able to reveal a bit more of myself and step outside of the clear boundary within appropriate parameters was helpful for the therapeutic alliance.)

> "*It's definitely come into every relationship I've had with a trainee, both in terms of our relationship but also the clinical work that they've been doing and that's partly because I'm supervising psychosis work*." (P10)

A common thread within this sub-theme was supervisors wanting trainees to think about the motivation for the request for personal information – and the client's presentation in relation to that.

> *"And there are some people I don't use self-disclosure at all with deliberately because of concerns about preserving a boundary in the relationship and that it needs to be very clear that I'm in a professional relationship with the person, that this is not friendship."* (P8)

This sub-theme has encapsulated some of the issues that face trainees during training itself – having to switch to different setting at least four, if not six, times over the course's duration and quickly settle in at a new setting that may be with a newly-encountered client group.

3.4.3 Working within frameworks

The theoretical frameworks and therapy models which the supervising psychologist draws on in their work inevitably interlink with how TSD may be approached with their clients and trainees.

As background to this subtheme, it is helpful to note that all participants talked about working integratively to varying degrees – combining different therapeutic frameworks with clients – in varying degrees. (See Table 2).

The excerpts below illustrate the idea that the framework through which someone is working may influence how they think about disclosure, in this case with reference to working using a psychodynamic approach.

> "*I suppose I take a psychodynamic frame. I would perhaps be more reluctant than some other people to self-disclose, with the idea that if we, especially if a client asks a question like "Are you married?", or "Do you have children?" or even "Where are you going on holiday?" or whatever, if we automatically, if we just answer and fill that gap we've lost an opportunity to explore*." (P9)

P9 is suggesting that automatically disclosing is not necessarily the right course of action, and that when working psychodynamically, alternative approaches are more suitable. P9 works in a recovery service, so this view is perhaps at odds with other participants who felt that people with psychosis diagnosis find non-disclosure stances off-putting. This highlights the intersectionality of framework, client group and the individual therapist's way of interpreting theoretical frameworks – whether in a purer way as inferred above, or in a more integrative way.

> "*And I guess it comes from a dynamic perspective somewhere in there in that it is saying that your emotional response as would-be psychologist is absolutely part of the work, so we need to look at it and feel ok about looking at it and we need to create a safe space for it to be there, validated and explored, witnessed*." (P1)

> "*I don't buy into the sort of the being a blank slate and, and I guess that's probably my therapeutic orientation, but that to me can seem a bit aversive potentially*." (P4)

P4 is rejecting of the traditional psychodynamic 'blank slate' approach of not disclosing personal information, rooting the reasons within their own broader therapeutic values and beliefs, rather than tying themselves to one model's approach.

> "*I like the freedom of the systemic work to be more of a sense of sharing that we all go through life experiences*." (P7)

P7 and P6 speak about the freedom of working in a team in family therapy, and how systemic work enables self-disclosure within its core processes; working in reflecting teams and speak through the 'lens of self (P6).

In contrast to this, P1 believes the different models are in a sense irrelevant, and that what underpins all therapeutic work that CPs undertake is the relationship with the person which is transtheoretical:

> "*My sense is that the therapeutic modalities on the one hand can look like they're quite different, but when you get it down to the core part, there are some core things that are really similar across all of them, and it comes down to the relationship with the person doing the work*." (P1)

3.4.4 Feeling ill-equipped

This theme covers the commonly expressed idea that the supervisors did not feel that their background has given them adequate support in thinking about TSD. The overall message from participants is to express disappointment and

regret that TSD was not thought about, either in terms of skills-focussed or opportunities for in-depth reflection and discussion were lacking.

The majority of participants cited their experience of exploring and thinking about TSD during their own training. P3 and P8 convey doubt at the 'traditional' message on self-disclosure given by the respective courses:

> "*I know when we're in training we had quite a few discussions about if people asked direct questions how do you respond, you know do you say, "I wonder why you're asking me that?", and that just doesn't work, it doesn't sit comfortably with me*." (P3)

> "*…trainees were still getting the message from course which I got which is that you don't say anything so if someone says to you "Where are you going on holiday?" you say, "Why do you want to know?" which always struck me as completely bizarre*." (P8)

Both these excerpts are implicitly referring to the 'traditional' psychodynamic approach of presenting as a 'blank screen'. These participants describe finding this way of being with clients as "bizarre" and causing them discomfort because it is at odds with their own personal style and the frameworks they use (CBT and Systemic).

P10 also expresses disappointment that the issues surrounding TSD were not given due thought and attention and that the teaching that touched on it was not detailed enough to be personally or clinically pertinent:

> "*But there was nothing like this when I trained, maybe it was just my course, but we certainly didn't get any teaching on it. There was a lecture on professional ethics that kind of thing, but it was like don't have sex with your clients, or whatever, it was like really, really basic stuff, there was not the subtlety and the nuances we're talking about*." (P10)

Two other participants mention their disappointment at the lack of coverage of this topic, in the latter's case it having a direct causal effect on how they broach the area in their supervision of trainees.

> "*I think it's definitely something looking back on training I would have liked to spend more time on*." (P2)

> "*I bring that [use of self] as part of my supervision because that's something that I've found really personally useful, but I guess that's something that didn't really exist during training for me*." (P6)

Others were influenced by subsequent training in other domains, such as in the following case where qualifying in family therapy opened up opportunities to think more deeply about use of the self:

> "*I did the family therapy training erm about ten years later and that very much talks about um use of the self for therapeutic reasons*." (P7)

These extracts expose an issue that is at the core of clinical psychology training: the depth of an individual trainee's experience of nuanced clinical skills like TSD is gained on placement, and therefore the responsibility of clinical supervisors. Lectures on boundaries in therapy will inevitably include issues around TSD, but unless topics are covered systematically and with in-depth reflective processes within programmed lectures this can lead to a gap in knowledge for some trainees.

3.5 Theme Two: Process of TSD with trainees

This theme covers the processes by which TSD comes up or is brought into supervision and the supervisory relationship during placement. This is of direct relevance to how a trainee may experience talking about or using TSD during training. There are four sub-themes which cover the different stances used by supervisors, covering proactive and reactive approaches as well as reflection after the event.

3.5.1 Taking a declarative approach

How supervisors approach TSD is pivotal to how a trainee might experience and learn about it during placement. There are two main ways that agenda items are raised in supervision – by the supervisor or the trainee, but the background as to why they are raised will vary enormously. Time constraints, service setting, and supervisor / supervisee alliance will all interact with these. This sub-theme covers elements that are explicit in raising TSD with trainees. Nearly all participants talked about it coming up in supervision with most trainees during placement.

In the following two excerpts, the participants describe how they actively bring up the concept of TSD with trainees early on in the placement, in different ways.

> "*It is something that I will talk about with my trainees in the first month, and I'll have in on my list of things to talk about in the first month of them taking clients on because it's something they need to be thinking about from the very beginning*." (P9)

This is in fact the only example of TSD being approached in a systematic way. Other supervisors describe actively bringing it up, but not in an agenda-based way which could of course mean that it does not come up with every trainee.

> "*About that I guess we'd probably have a conversation early on in supervision around how they would feel comfortable with dealing with self-disclosure, what level of self-disclosure like in terms of…they…may have clients asking about their sexuality, some trainees will be happy to speak to that others will not*." (P6)

Both these supervisors emphasise the idea of TSD within their placement for trainees as a key factor to be thinking about when working with clients. P9 is holding it in mind from the moment a trainee begins placement as she expects it to come up in sessions with clients and believes that preparing for this is important. P6 is encouraging trainees to actively consider what kind of disclosures they might feel comfortable with should it arise while recognising that it is a personal choice, and there is no right way.

Nearly half of the participants made reference to taking a conscious decision to encourage using TSD via modelling and similar teaching techniques as part of their supervision. Modelling can occur in different ways, these include accidental modelling when a supervisor is observed by a trainee in a session, modelling supervisor self-disclosure within supervision, or role play. The below extracts described some of these aspects of modelling:

> "…*me modelling that it's ok to share and try and understand feels quite important I think there's, a, I think there's an important role in it and quite a normalising role and I guess one of the things that sometimes comes up in supervision thinking about it*." (P3)

> "*Firstly I would model it with clients, and they would watch me, and I would often share with them stories of where I'd done this with my clients*." (P10)

These supervisors are giving trainees permission to try TSD with clients by demonstrating it in front of them and both then think about it in supervision afterwards.

> "*I think it's modelling, you know they look at my tree [of life] and they see what I'm doing and how I'm responding to when people ask me questions about things, again it's not an explicit conversation that we might have*." (P5)

P5's excerpt comprises parallel processes of modelling which might be viewed as an explicit directive process, but in this instance is viewed by the supervisor as an implicit process that the trainee can observe, but not necessarily comment on, and nor would they necessarily have a conversation about it. This could be received differently by different trainees – some might feel unable to question a supervisor whilst others may not reflect on it without guidance.

P10 summarises how important they feel the alliance between supervisor and trainee is:

> *"I just think you can't distract from the importance of the supervisor-supervisee relationship and the modelling of self-disclosure generally – not just about what they're doing but that self-disclosure and openness is crucial to the supervisee's ability to go off and use that as a skill."* (P10)

Here the supervisor is making explicit the links between modelling self-disclosure with clients and within the supervision itself to give the supervisee the confidence to try it out in therapy, having experienced it first-hand themselves. Research shows that such disclosures by supervisors are met very positively by trainees (Farber, 2006).

Supervisors also viewed placement as a chance to experiment with different techniques like TSD as a way to learn and for the trainee to find what fits with their own personal style.

> "…*particularly during training you know play around, find the bit that's right for you, cos that's when you've got a bit of space to do that and some space with regular supervision*." (P1)

> "*I've not had a trainee that hasn't by the end of placement been comfortable putting some things on the tree [of life] most trainees are happy to do it*. "(P5)

3.5.2 Reactive and unplanned approaches

An alternative approach that was also spoken about was to be less directive in bringing the topic of TSD into discussion with trainees; to treat it in the same way as other clinical or case material that might come up in supervision and respond accordingly.

> *"it probably comes up more as a response usually if someone is resonating with a piece of the work – or it might even be that I've resonated with something through the work and then it might come into a conversation (…) But yeah it tends to be more reactive I guess."* (P2)

> "*…it's not a technique that you bring in like a thought record, it's something that organically comes up and for me I guess, that's then about the focus on the relationship and what comes up in the relationship between you and the trainee or me and the client so yeah, it wouldn't be something that you'd kind of incorporate from the beginning but if it came up*." (P4)

These excerpts from P2 and P4 outline the supervisors' approach being reactive and responding to trainees, rather than proactive on this topic. Both participants express some doubt about the exact mechanisms of this approach, possibly because being questioned on it means they are being called to think about it in a new way given it is normally an intuitive and organic process within supervision.

In the excerpt below, P2 describes being influenced by his own experience of discomfort at being pushed into an area he does not want to go, this has in turn influenced his approach to supervising trainees around this area.

> "*You have that conversation with a supervisor who pushes you into that uncomfortable area to talk about some of these things but also feeling I don't want to go there if I'm being supervised by someone and it's really tough, so I guess I probably do opt on the side of inviting*." (P2)

The use of the word 'tough' brings up the area of discomfort that issues of a personal domain can bring when interacting in the professional arena of clinical psychology. The idea of the therapist revealing something of themselves to a client as being uncomfortable or unsafe is a common theme in the literature on TSD although this idea is not usually fully expanded on in terms of how safety or comfort is constructed.

> "*So I've waited for it to come up, for it to have a reason to come up so when it's first come up in a piece of clinical work I've been supervising then it starts a conversation, and then it usually leads to quite a rich conversation that they go away and act on in the clinical work but also it becomes a thread then maybe throughout our supervision later."* (P10)

Because perhaps this supervisor conveys avoidance or discomfort around this issue, the trainees in turn have not bought these examples.

3.5.3 Reflecting after the event

This sub-theme captures the thinking that takes place between supervisors and trainees after a TSD event of some nature has occurred and is brought to supervision. It encapsulates the reflexivity that is necessary in order to learn and also links to the function of TSD as the reflection considers how a real or potential disclosure may have been received and what it would have served in the context of the work and the client's formulation.

> "*It will come back up again when something's happened so the trainee will say oh, so the client asks me this and I handled it in this way like what we talked about type of thing and we'll talk through whether that felt ok and what the meaning was of that and how that fits into the formulation*." (P9)

> "*I would always be encouraging trainees to come to me and talk about it in supervision. We'll think about it together and then you go back to the client and have a think about it afterwards, and often it leads to big shifts in therapy*." (P10)

It's not about having right answers or one way of 'doing it', but discussing it in supervision can be a useful way to process what happened and give the trainee ideas going forward for how to handle similar situations in the future, as discussed below:

> "*And, of course there are no answers to that, but if we think about it in supervision then we might begin to get some pointers in the right direction*." (P1)

Reflection after the event gives the supervisor space and opportunity to think about what the intended purpose and outcome of the disclosure might have been, thereby scaffolding the trainees learning on this subject:

> "*If a trainee bought an example of something that they'd done I'd be thinking why, what was that about, what were you hoping to achieve from that*." (P5)

P1, below describes using supervision to reassure the trainee that a disclosure perceived as an error need not cause anxiety, as it can be openly addressed with the client and that so long as basic ethical boundaries are observed, if an authentic approach is taken there is no such thing as a 'mistake':

> "*You know, it doesn't matter, you might have self-disclosed and think oh actually that wasn't such a good idea, well you can address that with the client you can find some way around that you can have the conversation around the disclosure*." (P1)

This links to the idea of trainees needing the support of a trusting alliance in supervision in order to feel able to bring perceived therapeutic 'mistakes for discussion with their supervisors. It follows that if a trainee does not find the supervisory relationship a place that is safe from judgment (beyond needing to pass the placement) where uncertainty around clinical judgments can be raised, then it is unlikely that topics of this nature will be discussed.

In this sub-theme, participants have discussed how TSD can be raised in supervision for reflection – encompassing consideration of what happened, why it happened and what the trainee might do in the future.

3.6 Theme three: Navigating the push and pull of placement

This theme covers the tensions that supervisors recognised as salient for coping with working around TSD with trainees on placement.

3.6.1 Personal and professional dilemmas

In this subtheme, supervision represents a space for reflecting on navigating the tension between the personal and the professional, and what this means for

an individual who is forging their own path as therapist. Supervisors also reflect on their own experiences during their training and career of coping with this process. All of the participants touched on this theme in some way. TSD and the issues it brings are linked to the interaction involved with dilemmas of a personal and professional nature. All of the participants discussed issues pertaining to the intersection of personal and professional identities that are formed during clinical training and beyond that need to be covered within the supervisory relationship.

P6 describes the unfolding process of balancing the personal and the professional that TCPs have to grapple with during training:

> *"…that classic dilemma of personal versus professional identities, and how to marry those two things up together, and I think it's more something that's a bit more present when you're training because you haven't fully bought into the idea that you are a psychologist in terms of seeing yourself as a clinical psychologist, so you're trying to match images of what it is and what it isn't to be a psychologist in your mind."* (P6)

Above, the idea of training representing a shifting of identity that is not yet fully developed. Imbedded within this is an idea that there could possibly be a categorical difference between what it is to be a 'trainee' and what it is to be a 'qualified psychologist'. That is, P6 believes the trainee is viewing themselves as not qualified, and not a psychologist, which inevitably leads to a lack of confidence and identity confusion which could make decisions about nuanced aspects of therapeutic encounters such as TSD all the more daunting.

> "…*I would always encourage trainees to bring as much of themselves as they can into supervision and into the clinical work*." (P1)

> "…*I talk to trainees about how we are going to manage that distinction between the personal and professional in supervision and in terms of what they say and bring about themselves or not and how we check that feels appropriate*." (P8)

The use of ‘appropriate’ is wide-reaching: what is appropriate for the trainee in terms of discomfort, but also what is appropriate professionally and for the client; a reminder that it is not as simple as bringing ‘the personal’ unthinkingly into the clinical space – it requires thought. These excerpts exhibit a recognition of the potential discomfort for trainees with disclosing in the therapy relationship and within the professional domain.

Linked to this, participants also reflected on their own dilemmas and personal journey of finding the balance between their professional self and their personal self, which will have an influence on their supervisory relationship with trainees:

> “*It’s very much an interest of mine since when I started as a trainee, where basically I found the first year of training in terms of my personal professional development quite a challenge, and a very steep learning curve and the thing I found hard about it was kind of knowing how to be sufficiently myself in therapy without losing my integrity, but being sufficiently professional.”* (P10)

The following excerpt is an example of a supervisor using their own self-disclosure, which encompasses modelling with bringing the personal into the professional arena:

> “*And I’ll usually share, I’ll, maybe give an example of self-disclosure in a way with trainees and I’ll talk a bit about if it’s appropriate and they’re ok with that you know I’m perfectly, you know I’m very, very open about my own life experience*.” (P1)

It will depend on the trainee’s own personal style as to how this might be received and responded to, but the idea of the supervisor leading the way in being transparent is likely to foster an openness on both sides, as exemplified by the below:

> “*I think that’s sort of my style of supervisor is to try and give something of myself so that it feels there’s a relationship*.” (P3)

3.6.2. <u>Power dynamics</u>

Some of the participants viewed TSD as a means to break down the power differential between service user and professional:

> *"I think sometimes clients can ask questions about therapist as a way of re-evaluating the power differential that's happening in sessions and as a short cut to that and that might lead to some in the supervision after those sessions, to think about how they maybe want to give, you know, allow for the client to feel in a more powerful position*." (P6)

> *"That particular client was trying in my view to erode the power of the therapist or take control of it, be quite threatening so I asked the trainee to feedback that it was making them feel threatened."* (P7)

The two excerpts above cover different aspects of power within the client-trainee relationship from the perspective of the supervisor as it relates to TSD. In the first quote, TSD is conceptualised as an available tool for the client to activate by asking a personal question of their therapist, which might go towards enabling the client to gain power within the therapeutic relationship. This is not a straightforward, linear process, but requires 'negotiation' within the therapy dyad. The second instance refers to a different TSD event, one mentioned by half of the participants – where the client makes a direct request for personal information about the TCP and it requires intuitive thinking within context to know whether this is a straightforward communication or a more subtle manipulation of the therapist.

> *"I mean I think inevitably it's always hard to have, it's hard for trainees to feel like they can do that because of the power differences, to really say to a supervisor you know, actually, that was really unhelpful when you said that but I think you can try as a supervisor to say you're open to having those conversations and then keep returning to thinking about that."* (P8)

P8 is aware of the impact of power within the supervisory relationship and attempts to return to this issue in the hope that a trainee will feel able to speak up about something they may disagree with or not want to do.

Participants were aware of the evaluative aspect of being on placement and impact this can have within supervision on openness and honesty:

> *"I really want trainees to understand there will always be a temptation, particularly when trainees are being supervised, to censor your work, but if we can step back from that and really bring as much as possible including the stuff you don't feel great about 'cos that's where the learning will be, and it's often where the therapy is*." (P1)

The above excerpt shows the links between the power of 'being supervised' and the danger of self-censorship. That is, omitting to discuss clinical issues with the supervisor which in turn impacts the possibility for exploring the tougher bits of therapy which P1 believes can give the greatest learnings.

3.6.3 Developing as a psychologist

The idea of the TCP developing through training was present in two thirds of the interviews, with a hypothesis that, when considering a nuanced issue like TSD, supervision needs to respond to the point the trainee is on in their training.

The excerpt below presents the idea that process-type skills like TSD, rather than technical therapy skills such as completing a thought record, are less in demand with first year trainees.

> *"I think there's greater demands for this, I think as you acquire some skills, I think with first year trainees this way of working is experienced as being less relevant an issue because what they really want is tell me what the technique is, tell me what the model to follow, and I guess there's a greater sense of wanting safe certainty."* (P6)

The mention of 'safe certainty' calls to mind the idea of TSD therefore being viewed as an unsafe or uncertain domain for a trainee to enter, whilst CBT-type manualised techniques may give the psychologist-in-training more confidence.

The following excerpt also brings in the idea that trainees are being pushed to the limits of what they feel capable of, and how TSD is somehow something

extra or outside of the general therapy techniques trainees are trying to learn rather than being part of an integrated whole, as yet.

> *"I don't know if it's more anxiety provoking for trainees than it is for qualified staff, because obviously as a trainee you're in the situation where you're working the limits of your confidence the whole time and […] …and you're trying to think about how self-disclosure fits in with that when you're busy trying to learn particular therapeutic approach."* (P8)

If you are 'busy' learning, then attending to process-focussed aspects of therapy such as TSD alongside acquiring the 'basic skills' may be overwhelming. The supervisor's awareness of this will likely influence how far they would go to explore this with a first-year trainee or one that they feel needs to learn therapy skills. However, the process of learning is inevitably not a simple linear trajectory; it depends on what interests your supervisor may have and what the individual TCP's own experience is.

P10 shares the idea that it is important that a process such as TSD should be learnt carefully and relates to the confidence of the developing therapist:

> *"And if you just did a straw poll of first year trainees, you know, how would you feel if you were to share x, y or z, and you give some sort of examples they would probably be on the side of probably not, probably not, and I think that's right to start with because I think that people should develop the confidence and the skill to know to use it judiciously and to know when and how to use it."* (P10)

So in this case, P10 views it as the supervisor's role to ensure trainees can explore using TSD 'judiciously' as a skill or therapeutic tool. The implication of this is that if a supervisor does not scaffold a trainee's learning on this, they will either continue to not disclose, or use it without appropriate thought or judgement.

3.7 Theme Four: A desire for something different

A majority of the participants expressed a desire for change for how TSD is taught on the training courses given that they all cited minimal experience of teaching around TSD. They also talked about the process of the research interview itself leading to a shift in their thinking and in turn, their intended way of approaching TSD with trainees in the future.

> *"It's just been helpful even just thinking about it now, it's something that definitely comes up in every supervision at some point, there will be a discussion about it [...] …it's been nice to think about it again and thinking about where it might have come from in my practice."* (P3)

> *"I actually, through the conversation, it's really highlighted how important this area is […]. It's certainly something that has made me think about being more specific about when I supervise people."* (P2)

These two excepts refer to thinking about it in more 'concrete' and 'specific' ways, which contrasts with the idea that some supervisors have of letting TSD arise organically within supervision. This idea maps onto the different supervisory styles that people have, but with an intention to bring something to an agenda that can override a more relaxed less systematic approach.

In the context of wondering why more specific examples have not come to mind, P5 makes the commitment to bring this to the forefront of their supervision.

> *"It's on the agenda every supervision now!"* (P5)

Whilst P9 found that expressing certain ideas and a train of thought about her reasons for using TSD with clients led to a desire to share that with trainees.

> *"No, I haven't every really had that sense about vulnerability versus curiosity but yeah I would share that with my trainees in future, I would say this is what I find, what do you find*." (P9)

Several of the participants made suggestions, both vague and specific, about how training courses might ameliorate provision of teaching on TSD in order to better prepare the trainees.

> *"I think it would be incredibly important to have a lecture or day on how different therapies approach that idea of self-disclosure and then you know I'm pretty sure when I was doing the course they had a day - I don't think it was very good, half day maybe."* (P5)

P5 acknowledges that they were taught about it, but cannot recall it being very beneficial and suggests it should be integrated into course teaching. The below excerpts continue on this theme, but take it a step further, suggesting a more systematic approach with the idea of frameworks and it being added to the competency map to 'force' supervisors to think about it, thereby removing the element of luck or chance that is prevalent in the placement system currently.

> *"I think professionally we do trainees a disservice by not helping them think more systematically about it and that's what I mean by having a framework to understand what therapist self-disclosure, you know, means." (P8)*

> *"So yeah I think it should be certainly part of the teaching and then something that gets discussed and monitored as a competency through placements and that forces supervisors to have to think about it and talk about it."* (P10)

Whereas P7 below is thinking more along the lines of opening up reflective spaces in training for people to show vulnerabilities which links to TSD.

> *"There isn't an encouragement to talk about your own vulnerabilities on that course so how can you disclose something that might feel vulnerable to you if you haven't processed that on your training, so my feeling is that some people don't because the training didn't encourage them to."* (P7)

The participants express dissatisfaction with the current situation of training for learning about this kind of topic, and look to the courses to provide a base level of teaching which speaks to the idea that supervision is a rather random experience from the trainee perspective and unless things are systematised by the courses they are in danger of being left out of a trainee repertoire or experience altogether.

CHAPTER 4.
DISCUSSION

4.1 Overview

This thesis explored how the use of self-disclosure in the therapeutic relationship is approached by supervising CPs with TCPs on placement. In this chapter, the findings will be discussed in the context of the research questions, the evidence base and Clinical Psychology training frameworks. A critical review will consider all aspects of the research, from methodology to the researcher's position. Implications for the theoretical understanding and practical implication of TSD within the context of Clinical Psychology will be discussed. Pragmatic implications and recommendations for training courses will be presented, along with suggested future research avenues.

4.2 Relevant features of participant demographics

Representing 50% of the sample, male psychologists were over-represented compared to the clinical psychology profession as a whole. The majority of participants identified as white British, in line with most recent demographic data (Daiches, 2010; BPS, 2016;). The participating CPs represented a broad range of therapeutic frameworks that they drew on in clinical practice, as would be expected in a random sample of CPs. Through analysis, commonalities emerged across different approaches that are likely to influence and guide supervision of TSD.

4.3 Findings within the context of research literature

4.3.1 Research questions

The research questions explored by the interview schedule were:

- What are supervisors' experiences of supervising trainee clinical psychologists in the use of TSD?
- How do supervisors approach TSD in supervision?

- What do supervisors find helpful or unhelpful with regard to this topic in supervision?
- Is any particular supervisory style or model used in relation to TSD?

This section will expand upon the novel and relevant findings pertaining to the research questions, examining the commonalities and differences between participants, within the context of the existing evidence base for TSD.

4.3.2 Experiences of TSD in supervision

Ideas concerning experience were intrinsic to all the emergent themes and there was a wide range described, as might be anticipated by exploratory research of this nature using a randomly selected sample. This research question overlaps and intersects with the other research questions. All but two participants reported overall positive experiences around TSD and supervising TCPs. This could relate to findings that show supervisees hesitate to bring mistakes to therapy in favour of only reporting positive experiences (Yourman & Farber, 1996). Or it could be that when TSD is discussed in supervision it is viewed as an opportunity to explore and learn, rather than it be allocated a binary categorisation of ‘good’ or ‘bad’. Despite guiding frameworks outlined by the BPS (2010), experiences of supervision can vary enormously on training which is both a strength and potential weakness of training. The variety brings breadth of experience, but it also means an inevitable lack of systematization. This variety of experience will likely be magnified when considering an issue as nuanced as TSD as indicated by the findings in this study. There can be inconsistencies in how much time is made available or how well supervisors are able to support a trainee in thinking about the subject (Bottril et al, 2010). Supervision is considered a crucial aspect of trainee development; most clinical skills are learnt on placement (Binder,1993) and supervision can also influence client outcomes (Gray, Ladany & Ancis, 2001). If a supervisor is mostly taking a reactive approach to material bought to supervision by a trainee, it raises the possibility that trainees are not be bringing important material to supervision. This could lead to issues around TSD not being disclosed at all in supervision, even if the trainee were grappling with them in their clinical work. At an extreme, it could mean that inappropriate boundary transgressions are being made in

therapy, unbeknown to the supervisor. Hill and Knox (2001) speculated that 'beginner' therapists may over disclose. Their findings highlight the importance of a supervisor bringing difficult topics into supervision if they are not arising organically through a trainee's own disclosures.

One of the study's most striking findings was the lack of experience that many of the supervisors reported in terms of thinking about or discussing specific TSD events with trainees. This was directly related to the main theme Process of TSD with trainees but was also explored in the sub theme Feeling ill-equipped and a Desire for something Different. It was not always easy for participants to recall detailed examples of 'TSD supervision events', which could reflect a possible limitation of the single interview method to gather this genre of data, given limitations of recall and lack of prior knowledge of the interview schedule. Two participants explicitly stated that they had found it difficult to think of any specific examples regarding trainees, even if TSD within their own work was something they had thought about in some depth.

However, most participants did talk about giving space for reflective issues with trainees on any aspect of their clinical work, which would include TSD. However, Bottril, Barker and Worrall (2010) found that some trainees felt they had been given no space to reflect on the issue of TSD, either in supervision or on training, leaving them with insufficient support to evaluate and make decisions. Such research concurs with two participants in this study who mention their disappointment at the lack of coverage of the topic in their training. One admitting it had a direct causal effect on how they broach the area in their supervision of trainees. Bottril refers to a process of "reflection-on-action"; after the event in supervision, leading to trainees being more able to "reflect-in-action" and make a "live" decision to use TSD in a client session. If the opportunity to reflect is missing, as it might be if TSD is not explicitly drawn into the supervisory agenda, it follows that trainees may find it harder to make decisions in session. Such a scenario could lead to a possibility of inappropriate disclosures, or adhering rigidly to a non-disclosure stance. Not giving space for reflection does not equate to an evaluation of a supervisors' ability; the factors involved in supervision are complex, and given its time limitations within busy services, not every aspect of each clinical case can be covered in detail.

Supervision needs to strike a balance between the procedural requirements and the organic, responsive aspects that are required of a professional relationship (Proctor, 2010).

4.3.3. Approaches to TSD

There were three sub-themes that emerged regarding the approach to TSD (Taking a declarative approach, Reactive and unplanned approaches Reflecting after the event). All participants described taking a responsive approach to TSD with trainees in supervision, as would be expected given the supervisor's role. Some also described taking a more proactive approach, alongside a responsive one. Regarding those that did not; there could be a number of reasons why some supervisors may not actively bring TSD to supervision. It may be considered uncomfortable for trainees; one participant described it as "tough" in terms of navigating the personal and professional dilemmas when making decisions around self-disclosing. However, it was also described in terms of the supervisor's own discomfort, which could account for why some supervisors choose not to actively bring it up. And this discomfort may then result in a hesitation in making a trainee feel uncomfortable, particularly in the context of an evaluative situation such as a training placement, given that a supervisor's role is to be an empathic, supportive figure (Donovan et al. 2011).

It follows that if a supervisor broadly adopts a reactive stance in supervision – that is what supervisees bring is what will be discussed – the onus is on the trainee to bring the issue of TSD to supervision to get it on the agenda for discussion. This process will likely interact with power and the supervisory alliance. There is an inherent power dynamic between supervisors and trainees that participants were aware of, which also effects how TSD might be discussed in supervision. Research has found that supervisees respond to the power dynamic by being selective about what they choose to tell supervisors about in client sessions (Bernard & Goodyear, 2009). If there are issues with hierarchy and power dynamics, such as a particularly dominant supervisor and an unassertive trainee it may be harder for trainees to bring queries or clinical issues concerning TSD to supervision. A similar process may unfold if the

supervisory alliance is poor. Research into supervision has found that supervisees need to feel that they are in an open and trusting environment if they are to take risks by bringing material to supervision that could be considered 'wrong' or having made a mistake (Donovan et al, 2011). There is also evidence that supervisees hide their mistakes from supervisors (Yourman & Farber, 1996). Although supervisors will likely be alert to any trainee whose work seems surprisingly smooth and presented in a positive manner, it is inevitable that there will still be much material that never makes it into supervision due to a number of factors, such as limited time. TCPs often report high levels of concern about their capacity to be effective therapists, and use supervision as a key learning space to help mitigate such feelings (Scott et al., 2011). Without guidance and openness on the issue, raising TSD may be viewed as risky within the remit of supervision (Bottrill, 2010).

Taking a declarative stance on the other hand may give the opportunity to explore issues such as TSD. This will likely facilitate the trainee's confidence in being honest and thinking broadly about the use of TSD in therapy, in turn circumventing or reducing the power dynamic.

The supervisor's style and personality will inevitably dictate the supervisory practice, as well as each interview within this research. Some participants gave responses that were framed as previously thought about, others seemed to be thinking-in-the-moment. These different approaches reflect how TSD itself can be conducted within therapy: as an intentional goal-orientated act, such as might be used for modelling coping and normalising distress within CBT type frameworks, or as a 'live' decision based on intuition and experience. Participants were not necessarily divided between the two, 'live' responses are given by supervisors who elsewhere might reference declarative approaches to TSD.

The diversity within the sample may be interpreted as an indication of how TSD may be encountered by the psychologist-in-training (Bottril, Barker & Worrall, 2010). The participants varied in how much prior thinking they had described giving this and TSD in general, in line with research findings that TSD may be an intuitive, heuristic process (e.g. Audet & Leverell, 2010). However, there was

inevitably a spectrum of developed thinking on the interactions between TSD and context, with some participants able to describe a clear picture while others were thinking through ideas during the interview. Such examples are important as they likely mirror how TSD might be broached in supervision with a trainee. Such experiences could be related to lack of memory but could also indicate an absence of explicit discussion of TSD in supervision. Using disclosure in therapy involves a personally influenced process and often a spontaneous or live decision in a therapy session. Supervisors may also avoid the topic (consciously or unconsciously) in supervision in order to give a trainee the opportunity to develop their own relationship to TSD.

Several participants talked about using self-disclosure within supervision as a means to model TSD with clients, as well as serving the additional function of enhancing the relationship with the trainee. These experiences can be seen as a parallel process whereby processes in supervision reflect process in the therapy room, in a conscious directed manner. Such a process is perhaps in contrast to unconscious parallel processes within supervision, where the supervisor-supervisee transference mirrors the client-therapist transference (Morrissey & Tribe, 2001).

4.3.4 Influences on approach and experience

The different themes that emerged in this study reflected interactions with salient personal factors such as work history, values and beliefs. Not all participants had ‘readymade’ responses regarding their beliefs around TSD’s function and their approach, and some made use of the interview to reflect on this fact. A range of factors can influence a CPs approach to TSD, within their own clinical practice and in supervision. It is relevant to note that trainee supervision is only one part of a CP’s role. Leadership, indirect consulting and organisational aspects are also important, and every CP will have strengths in different areas that their supervisees, trainee or otherwise, will benefit from.

Influence of setting and client group: All of the participants spoke in varying amounts of depth about the setting and client group as an important influence on their decision-making regarding TSD. Research exploring interactions

between specific settings on working with TSD is currently lacking, due in part to the focus on the pan-theoretical common factors aspects of TSD (Ziv-Beiman, 2016).

In this study, the work setting seemed to be particularly salient for those working in recovery/psychosis services. In psychosis services, the thinking around TSD raised issues around engagement and working with clients who may be paranoid, socially isolated or have impoverished experiences of supportive, empathic relationships. Those working with psychosis presentations are perhaps more likely to have an interest in TSD because of the nature of their work and the relational needs of the client group (Chadwick, 2006). The cluster of symptoms that are associated with a label of psychosis is linked to this observation: paranoia and delusions are likely to interact strongly with the professional figure of a therapist, in that certain questions, if unexplained without context, may lead to feelings of mistrust. Being open about intentions and sharing one's own experiences appropriately is one way to build trust (e.g. Ruddle & Dilks, 2015). In these settings, participants presented TSD as a means by which to reduce isolation and give a more positive and empathic experience of care.

Several participants felt that presenting as a 'blank screen' might be perceived as intimidating and off-putting to this particular client group. Therefore it was viewed as important to think carefully about how you might respond to client questions about personal information or whether making small talk of a less personal nature is something a trainee would welcome in order to build an alliance. This involves sophisticated skills: from being empathic, yet not responding in an uncontained manner, to meta-cognitive processes that enable a therapist to remain observational of the process in which they are part.
The setting was also discussed in-depth by the only participant working in a forensic setting. Here, there is a strong discourse that disclosures may transgress boundaries, which could be putting the professional at risk, and the client in a position that they are unable to navigate. Lamb and Catanzaro (1998) cite disclosing personal information as possible harmless boundary violations or 'boundary crossings' within forensic settings. However, given the vulnerability of forensic populations, there is concern. Schoener's (1998) findings suggest that

TSD is the most common ‘boundary violation’ that precedes sexual involvement with a patient. Schoener is not referring exclusively to psychologists or therapists working using TSD, but any staff member. There is an important distinction between inappropriate self-disclosures and violating one of the critical ethical principles of any caring role, but boundaries and TSD within the forensic population are imbued with additional concern over risk.

The findings suggest there is a need to think about the impact and benefit of using TSD, both because of and regardless of, the client group. It could be that different settings will have unspoken rules guiding decision-making around TSD. If these implicit rules are not made clear to trainees they may risk causing themselves or clients harm. Given that the participants in this study advocate for thinking about TSD carefully, it would be of benefit that further advice and guidance in this area is developed and accessible to all. There can be a strong discourse available to the training therapist that self-disclosure is the first step on a ‘slippery slope’ to Schoener’s gross boundary violations. This relates to the way supervisors approach TSD in supervision, as it indicates that if it is not openly discussed by the supervisor, there will be a risk that the TCP is aligning their working practice with this view without perhaps questioning or considering the implications.

Influence of theoretical frameworks: the subtheme ‘Working within Frameworks’ covers how TSD interacts with different therapeutic models. There is a lack of specific research on this topic for the practicing CP. There was not always a clear-cut relationship between the participant’s preferred theoretical framework and decision to disclose or not disclose. However, nearly all participants framed their thinking around TSD as being influenced either directly or indirectly by their therapeutic leanings. Research suggests that there are significant differences between therapists and how they work depending on what type of therapy they are using (Castonguay & Goldfried, 1994). Ziv-Beiman (2013) proposes a model of TSD as an ‘integrative intervention’ to be used across therapies. Using a common factors approach, TSD can enhance non-specific relationship factors, but also be a tool to encourage insight and facilitate change (Wampold, 2015). TSD is being practiced in this way by some of this study’s participants, who may encourage trainees to do the same.

Many supervisors, like the CPs interviewed in this study, work integratively, even if they aim to supervise trainees on 'theoretically pure' pieces of work for the purpose of learning. Such an aim could confuse the relationship to TSD further for TCPs. How participants interact with their chosen therapeutic frameworks and using TSD were not always explicitly communicated in supervision. This could indicate a gap in learning for the trainee if there is no systematic approach to TSD. Trainees learn and benefit from supervision that is both supportive and didactic, with clarity around theory-practice links (Roth & Pilling, 2015). But in contrast, supervision is also a responsive, fluid relationship and systematic approaches are not always appropriate. These processes relate to, and are explored in, the interpretation of themes two and three.

Context has been of central importance to participants in this study. In their proposal for a framework for using TSD within clinical psychology, Ruddle and Dilks (2015) explain that context is vital in determining the rationale for, and consequence of, any TSD. "The same utterance may carry a very different meaning and impact depending on the particular client, therapist and the specific moment in therapy," (Ruddle and Dilks).

4.3.4 <u>What do supervisors find helpful or unhelpful in supervision?</u>

There were a number of factors raised indirectly in the interviews that can be defined as helpful and unhelpful. This research question may suggest that these factors are binary and mutually exclusive, when in fact the findings report that TSD is nuanced, complex and rarely gives rise to straightforward answers.

Managing competing demands of placement: Clinical training placements offer the opportunity for a trainee to use theory-practice links in the 'real-life' world of mental health service provision in the NHS. Within the scientist-practitioner model and context, TSD is embedded in other relational, professional and developmental tasks related to placement. The theme 'Navigating the push and pull of placement' brought to light these tasks and subsequent tensions which interact with TSD on all levels. The subthemes centred around personal and professional identities, power dynamics and the training trajectory of the developing psychologist.

The concept of personal and the professional identities is imbedded within Clinical Psychology and training (BPS, 2010). TSD encapsulates the intersection of the personal and the professional in terms of a therapist bringing something of themselves into the therapeutic encounter. This will vary in terms of the level of intimacy of the disclosure (Henretty & Levitt, 2010); there is a marked difference between telling a client that you suffer from claustrophobia to sharing that you have suffered a miscarriage, for example. Such variety was reflected in the participants' accounts of supervision – one reported that among trainees it varies how much of the 'personal' they bring to supervision. However, another participant described a gradual shift in attitude, remarking that in recent years trainees seemed more equipped to be reflective about their own personal experience and what they bring to the therapy room. Such a shift is likely to be, at least in part, a result of changing attitudes to mental wellbeing in the workplace. TSD can sometimes be conflated with a therapist disclosing their own mental health struggles to a client. But this sub-type of TSD did not emerge as a theme within the study.

Ideas around the trainee's developing identity were thought about in context of the supervisors' approach. It is inevitable that a supervisor will treat a first-year and a third-year trainee differently, given the different expectations of experience and learning. However, it is useful to think about the linearity of this assumption; there was an awareness in the interviews that trainees will vary in ways other than the trajectory of training itself, but also according to individual traits, interests and prior experience of supervision itself when relating to TSD.

Research suggests that disclosures tend to increase as the therapist gains experience (Simone et al., 1998). While the choice to disclose, or not, will be individual, it may logically follow that experience could lead to a therapist thinking more deeply about their stance on disclosure. However, the evidence base is not clear on the relationship between experience of therapist and type and frequency of TSD (Henretty & Levitt, 2010).

Power: Power dynamics between supervisors and supervisees are an inevitable outcome of the hierarchical structure of supervision (Porter & Vasquez, 1997). It is incumbent on the supervisor, as the more powerful figure, to attend to the

inherent power differentials from the outset of supervision (Cook, McKibben & Wind, 2018) to minimise power imbalances and ensure supervisees feel supported in being able to speak openly about any issues that arise within their clinical practice. Neglecting to address power can place supervisors at risk of providing ineffective supervision (Ellis et al., 2014) and will also inevitably impact issues pertaining to self-disclosure, both in terms of supervisor-supervisee and client-therapist relationships.

The conflicting demands of supervision place potential strain on these relationship. Several participants drew attention to the evaluative aspect of supervising trainees, the so-called 'normative' aspect (Proctor, 1988). Research indicates that the supportive element of supervision is the most important in achieving a successful alliance. Research has found that the quality of the supervisory relationship is associated with the level of trainee supervisee self-disclosure (Mehr et al., 2010; Webb and Wheeler, 1998).

The concept of power dynamics between the dyads of supervisor and supervisee, and therapist and client is long-standing and much discussed in psychotherapy literature (e.g. De Varis, 1994). Power was a key theme of this study, and is relevant to the supervision of TSD. In addition to the usual power held by a supervisor over a supervisee, is the evaluative power held by the supervisor over the TCP on placement. This compromises a 'normative' function of supervision, which is in conflict with the other 'restorative' and 'formative' roles that require empathy and understanding within an educational framework (Milne, 2009). Some participants stated that expressing some of their own personal views or experiences of TSD could break down the barrier between the two 'sides' of the supervisory dyad and encourage trust. This view chimes with research findings (e.g. Hill, 1989) that therapist disclosures can help equalise the relationship.

Greater emphasis on teaching of TSD: The majority of participants expressed a desire to see more directed teaching and reflection given to TSD, with many comparing this to their own experience of training. Such views are consistent with the findings of Bottrill and others (e.g. Burkard, Knox, Groen, Perez &

Hess, 2006), which highlight a lack of teaching and discussion of TSD on training programmes.

Half of participants reported that the research interview was a useful opportunity to think about TSD in more depth. They found they could not recall relevant detailed teaching or discussions. Some participants responded to this absence by seeking training or peer support. In nearly all cases, there was a reaction to the lack of teaching, and space for reflection, which prompted discussion of future changes to training provision.

4.3.5 Is any particular supervisory style or model used in relation to TSD?

This research question relates to the interaction between supervision style and theoretical frameworks. Two participants spoke explicitly about the influence of their chosen framework (psychodynamic and family therapy) on their disclosure, and how they would relay this clearly to trainees in supervision. The study found that the majority of the participants did not use an explicit supervisory style or model in relation in TSD. They did, however, draw on a range of theoretical influences, either explicitly or implicitly, that informed their approach, as covered earlier in this chapter. This finding is of interest and it perhaps runs counter to established discourses around TSD and therapeutic style or practices being closely linked to theoretical leanings. I certainly anticipated finding a more explicit link, given the emphasis on theory-practice links made during training. It calls to mind Ziv-Beiman's (2013) conceptualisation of TSD, describing it as "an intervention that makes an integrative impact". The reason for this finding can be hypothesised to be due to the uniquely pluralistic approach of Clinical Psychology as a profession, sitting within (or alongside) the more specialised or focussed psychotherapies. Or can it be that TSD is a means of navigating the human relationship that forms the basis of the therapeutic contract and therefore theory is not at the forefront of its purpose or practice.

4.4 Summary of findings

4.4.1 Overview

This research provides an in-depth perspective on the process of supervision on training for TCPs with regard to TSD. It provides insight into the process of

supervision in clinical psychology training from the supervisor's perspective. The research was conducted by a trainee with lived experience of the phenomena being explored, and has uncovered gaps in knowledge of supervisors, both through their work and from training. It has identified that this is an important area of research, warranting more information and training at all points of a CPs career including during the training process whilst on placements.

4.4.2 Novel findings

The key findings of this study that will inform the implications and recommendations are: the way that TSD may be approached in a responsive rather than proactive way in supervision by supervisors; the lack of provision of sufficient teaching and training on TSD; the related importance of covering this issue in supervision training; the impact of context on use of TSD for the trainee and qualified CP; and considerations around a CP's theoretical positioning and how this may or may not influence their approach and use of TSD. It also raised important issues concerning supervisory dyad including power dynamics, the supervisory alliance, as well as individual values, traits and interests of individual supervisors and supervisees.

What is of particular interest for this study's recommendations, is that those working within the field of Clinical Psychology (trainees and qualified) do not necessarily feel equipped to handle this issue, and have not always felt they have received clear guidance on how to approach it in different settings. People slip into ways of being without necessarily explicitly the process or benefit to the client through. The client and outcomes of therapy are not always at the forefront of the considerations when supervising trainees, and this could be taken into consideration more when approaching TSD in supervision in a systematic way. The findings suggest that a proportion of clinical supervisors wait for trainees to bring up issues in supervision and then respond to them, this has raised considerations around how this might play out on placement for trainees who either have not thought about this issue, or are uncomfortable about disclosure for any number of reasons. It can also mean it gets overlooked amidst all the other tasks of supervision and placement during training and that

trainees are making judgments unsupported by guidance from a more experienced clinician.

The findings add to the current body of research by giving a unique perspective on the supervisors' approach to TSD when considering the needs of TCPs on training. The multi-faceted relationship to context within Clinical Psychology and training extends our current knowledge within this specific frame of reference that is currently lacking. The varied approaches to process give insight into how TSD may be thought about and used – or not used – by trainees and supervisors. The desire for change and further provision on this topic in training reflects the lack of certainty regarding TSD, despite evidence indicating that it can be of benefit to clients. The study was able to confront and explore assumptions regarding this issue, and open it up for examination. As indicated by this quote: "Everyone is doing it, but no one is talking about it," Ruddle and Dilks (2015) this study aims to get people talking about it in more depth and with more thought to how this skill can be harnessed by clinical psychologists in all settings, and covered in training programmes with greater depth.

4.4.3 Concluding summary

This thesis explored how CPs approach TSD in their work with explicit links to the supervision of TCPs using semi-structured interviews and thematic analysis. Four themes emerged from the data that revealed that supervisors are influenced by a number of contexts in how they conceptualise and operationalise TSD, and that the approach to TSD within supervision varied. There were a number of tensions and dilemmas within training that interacted with how TSD was treated and 'used' with trainees and their clients. A desire for further knowledge and training was expressed. The findings suggest that greater focus on TSD within training curricula and on placement would benefit trainees and clients. Setting-specific research could inform guidance on harnessing TSD as a beneficial therapeutic tool and a means to equalise power imbalances between client and therapist and parallel the societal shift that mental health and ill-health exist on a spectrum of experience.

4.5 Critical review of the design

This section will first consider the methodological aspects of the study, discussing any potential issues or limitations.

4.5.1 Methodology

Qualitative research cannot be evaluated on the same basis as quantitative research. Given the critical realist epistemological stance, these findings do not aim to establish general truths. The process of analysis and interpretation is conducted through the lens of the researcher, and is therefore subjective, influenced by my own context and experiences. There are multiple possible alternative perspectives that may draw different conclusions from the same interview data. To account for this, I have outlined my position as a researcher in the reflexivity subsection in this chapter, in line with Spencer and Ritchie (2012), who proposed that reflexivity is a way in which to affirm reliability in qualitative research.

To evaluate this research I have referred to Yardley (2000; 2008), who suggests the following 'open-ended, flexible quality principles' on which to assess qualitative methodology:

Sensitivity to context: To achieve this principle, the research needs to be responsive to the socio-cultural context in which the participants and researcher are embedded. To achieve this, I asked open-ended questions so that participants could respond freely to express their viewpoint. When analysing the data, I took care to consider comments in context (see Appendix VIII), both of the interview itself, and also of the participant's context rather than impose my own meaning without allowing for inconsistencies or nuance. As an example, I held in mind the context of the setting the CP worked in and tried to allow it to enrich the interview process while also give it space to flow regardless of context. Such a process also needs to be situated within relevant theoretical and research literature, which this research has achieved with a review of relevant published literature on TSD, and drawing from wider theoretical literature as relevant.

Commitment and rigour: I have attempted to show commitment and rigour to this topic through thorough data collection and attempts at saturating themes. Methodological competence has been attempted by attending to the process of data collection and analysis with care and in the context of relevant literature (Braun & Clark, 2006). I was able to check themes and coded sections for coherence with my research supervisor before interpreting the data more deeply.

Transparency and coherence: Transparency requires that researchers reflect on the influence of personal assumptions, values, intentions and actions, and show how these affected the products of their research (Yardley, 2000). I'm hopeful that my analytic argument has clarity and is persuasive. I am also satisfied that the methods and critical realist position I have taken along with my interpretation are aligned in a coherent manner that will be clear to the reader.

Impact and importance: I believe this research has fulfilled its aim to explore a specific process of TSD within supervision of trainees. Given it is an important, but at times overlooked area of clinical skills development, it may be used to guide and influence training programmes, and Clinical Psychology as a whole. It also aims to understand and fulfil the needs raised by supervisors and trainees who lack necessary guidance in this nuanced area involving relational boundaries within therapy (e.g. Bottril et al. state trainees are tentative in raising TSD in supervision). I am hopeful that it will have practical and applied use to doctorate training programmes and placement supervisors, regarding the teaching of TSD and the way it might be actively approached in supervision. Ultimately, however, the aim is to benefit clients who are receiving therapy from TCPs and CPs in the NHS – a core purpose of supervision is to provide better therapy or treatment to clients, and the core aim of TSD is to benefit the client in some way.

Reflexivity: I have strived to recognise my active role throughout the research: that as researcher my values, beliefs and interests will inevitably shape my approach to, and treatment of, this current study. To reflect on my role, and in an attempt to gain awareness of my own influences on the research, I kept a reflective account after each interview (see Appendix IX). I discussed aspects of

the research and my role with my supervisor and I sought to question assumptions I had made during the interviews (transcribing proved a useful exercise in this regard) and analytic process. For example, I became aware of my belief that there was some kind of categorical shift of identity between the trainee and the qualified psychologist, but as the research (and my training in parallel) progressed I realised this idea was misleading and called it into question.

Positioning: My position as a trainee conducting interviews with supervisors about the supervision of trainees, meant my role felt interlinked with the research. Considering my identity, I was aware of the possibility of a mirroring or parallel process occurring in the interviews; that I would treat a participant as if they were 'my' supervisor, or they might treat me as if I were a trainee and these roles would 'play out' in the interview. I was aware of the possibility of self-censorship by not following up on issues raised that seemed to create discomfort to the participant, and of the participant preferring to not being entirely honest should they fear presenting themselves as 'ignorant' or in a negative way. Such demand characteristics can be at play in all research, but it felt especially salient given the supervisor-trainee dynamic within the interview and any perceived power imbalances. I noticed that my own sense of discomfort in assuming the more powerful role of the person asking the questions; a reversal of the power dynamic that usually exists between supervisor and supervisee. Yet I was also aware I held a less powerful position than participants, and so I did not always feel completely comfortable probing further on areas that seemed to be causing discomfort. I wanted to put people at ease by building a good rapport, which is an essential component of the interactive interview process in order to encourage disclosing of information (Reinharz, 1993), but in doing so may have at times subconsciously avoided pursuing certain themes. My reflective diary was a useful tool to develop these thoughts. For example, I noticed that in an interview with a participant who struggled to give examples readily of TSD, I found myself reluctant to pursue requests for examples, in the way that I might with another interviewee. As the research progressed I feel my meta-awareness honed my interview skills to be more alert to such potential, aided by the reflective process of keeping a diary.

Reflexive interviewing: The participants were necessarily aware of my 'insider' status (Braun & Clarke, 2013, page 303) which may have influenced their responses, and equally I was responding to the interview and analysis through the lens of my own personal experience as a TCP. My own experience of satisfactory or unsatisfactory supervision was also triggered within the interviews. I noticed myself more drawn to the participants who approached the research topic in a way that I would have appreciated in my supervision. This was perhaps inevitable given that the research was inspired and influenced by my own experiences on placement. It was not explicit theoretical underpinnings but more the manner in which they thought about it which drew me, and I question whether this meant that I was blinded to other aspects of the interview and missed opportunities to follow up on important areas as a result. As the research continued I became mindful of how the study was also a personal journey of discovery to find my path as a future supervisor of TCPs. As the interviews continued, I became aware that my questions themselves were inevitably having an influence on some of the participating psychologists, in particular those who may have given less structured thought to the way they approach TSD in supervision and with trainees in general on placement. The interview process is an active and mutually reflexive one, where both sides are inevitably changed in some way by the event. This fascinated me, as it meant that by conducting the process alone I had potentially already highlighted this area that I considered important to a sub group of supervisors who would then potentially alter their future supervisory practice. This is comparable to interventive interviewing (Tomm, 1987), which views questions themselves as possible interventions that elicit change even if the therapist is trying to maintain a neutral stance as the questioner.

Linearity: Qualitative interviews inevitably represent a snapshot in time, which does not reflect the whole reality of the participant's world and their views, despite an interviewer's best attempts. There are many aspects of this research that are not linear or static: "relationships, disclosures, and awareness all change over time" (Gibson, 2012), which therefore limits the applicability of any such findings as one fixed truth.

Alternative methodology: I was aware that by taking a thematic approach using a critical realist epistemology, I risked losing some of the constructed narratives and richness of the language within the interviews. A narrative approach (Etherington, 2004), for example, would have enabled a more contextualised focus to the analysis, as it necessarily brings with it ideas of people's accounts of themselves being storied both on a personal and socially-bound level, and it involves ideas of some kind of transformative journey. Both of these ideas felt relevant to the themes that emerged. Given that TSD is contextually-bound itself, it felt important to shine a light on these factors as I coded and thematised the data. While my epistemology enables and encourages a critical approach to the reality presented in the data, it still maintains that a static reality exists, and that the concept of TSD is one that exists. P6, who works using predominantly narrative approaches in his clinical work, struggled with the words 'therapist self-disclosure' and felt them to be wholly inadequate to describe such a social process of building stories that is therapy. I also questioned the limitations of participants' recall as required by the interview methodology. If resources of time and manpower were greater, analysis of recorded supervision sessions discussing use of TSD could have resulted in rich 'live' data to analyse.

4.6 Limitations

4.6.1 Overview

The farther-reaching aim of this study – beyond exploring the process of supervision around TSD – is to benefit clients by adding breadth and depth to its debate in the specific setting of Clinical Psychology and training. The ultimate goal would be to understand more about whether TSD can be a useful therapeutic tool in this field, how its benefit and use can be maximised in diverse settings, and most relevantly how the skill of using it can be taught and learnt to the best outcome. This study focusses on a particular voice – the qualified CP/supervisor – and therefore other important perspectives are missing. Such focus risks silencing an already disempowered group: the service users who may benefit from and be able to inform on best use of TSD.

4.6.2 Interview process

Exploring the specific mechanisms of how TSD was approached was not always possible. The study relied on participants' memory of events and, therefore is subject to the shortcomings of retrospective recall (Giorgi & Giorgi, 2003). The majority of participants could either not recall in enough detail TSD events in supervision with trainees or stated that they were not sure they had even occurred. One participant stated, "*I don't know if it's answered your questions about trainees or not, it's made me think I know more about the way I'm doing it*" (P7). This risked a circular argument: of finding out more about the views and positioning of supervisors who already regard this issue as a salient factor in working with trainees, while those that did not were not always able to give richly detailed answers given their lack of memory or experience of such events. (Initial participants expressed discomfort with speaking in detail about trainee cases due to anonymity, but I took steps to address this by encouraging participants to share cases in detail that could then be redacted from transcribed files).

4.6.3 Participants

This research sought to recruit participants who were practising CPs with at least three years' experience of supervising TCPs. These participants were relatively easy to identify, which meant that it could have been beneficial to the research to impose further limitations on the sample such as requiring experience of supervising a minimum number of trainees (rather than a time period). Although every effort was made to interview a balanced spread of CPs across service settings, there ended up being a larger number who worked in recovery services predominantly with psychosis diagnoses. As the findings of this study indicate, the context of the service inevitably interacts with the approach and use of TSD.

A strength of the participants is the variety of theoretical frameworks used in their work. This was an intended strategy, to reflect both the reality of Clinical Psychology training in the UK and to be open when recruiting and not stipulating adherence to particular models. There was a risk that the participants could have been weighted towards one or two particular models, which may have restricted the results and limited the usefulness of the findings to training.

4.6.4 Defining TSD

The definition of TSD was kept open, which may compromise the relevance of findings as each participant will be interpreting it in subtlety different ways. Henretty and Levitt's (2010) question non-standardised definitions of TSD within research literature, as it can be difficult to draw meaningful analysis from findings. However, as this was an exploratory study it was important to keep the definition of TSD open to the interpretation of the participant as this in itself could – and did – yield relevant data. However, because concrete examples of TSD events with trainees were not in abundance, there is a risk that participants are thinking about very different aspects of TSD when answering questions. It is hoped that this was countered by sensitive and responsive interviewing.

4.6.5 Conceptualisation of training

I realised while analysing the data, that I had been conceptualising the position of trainee and qualified CPs as distinct roles – each one either side of the dividing line of qualification itself. This fed into a sense that training is in some ways a finite learning process, by the end of which 'everything' important should be known. However, as my progress through the research and analysis process continued, alongside my development as a trainee, my awareness that training is only the beginning of the learning, and there is no discrete identity demarcation between 'trainee' and 'qualified', deepened. With regard to TSD specifically, training can offer opportunities to begin conversations, ensuring that there are reflective capabilities to continue thinking about such issues after qualification. The BPS (2014) recognises the vast scope of Clinical Psychology and that training cannot possibly cover all of the skills, knowledge and expertise in the profession, considering the vast array of specialisms that can be entered once qualified.

4.7 Implications and recommendations

The findings in this study have theoretical and applied implications for Clinical Psychology, training and for supervisors working with trainees. This includes implications for how TSD might be broached by relevant stakeholders such as course leaders, the BPS and all those involved in training future psychologists.

Findings also feed into wider research and debates on TSD and its use with, and mechanisms of, benefit within clinical populations.

4.7.1 Theory-based implications

The findings in this study indicate that TSD is an important and relevant therapeutic tool that is not always clearly defined as such within Clinical Psychology. Findings suggest that more clarity and guidance would be useful for practicing CPS, TCPs and all those working within NHS mental health services. Through its absence from systematic discussion and explicit coverage in curriculums, TSD risks being situated as an advanced skill or a concept that is 'not for everybody' – leaving it to individual CPs and TCPs 'to take it or leave it'.

If the definitions and processes of TSD can be examined in more depth within the current cultural, social and political context of Clinical Psychology in the UK, this could lead to improved harnessing of its benefits to clients in terms of outcomes and alliance. In turn, it could also lead to greater understanding of the mechanisms of using TSD in different contexts, thereby granting more nuanced insight into the perceived risks. In relation to training, TSD could be examined and reflected upon at different stages in line with the findings that it links to a trainee's developmental stage. If practicing psychologists can begin to reflect on their relationship to TSD from the beginning of training, it will likely to lead to a greater confidence around its use, which could lead to increased egalitarianism within client-therapist relationships. Such a move would correspond to a wider societal shift towards mental health symptoms being viewed on a spectrum and mental illness as a response (e.g. Johnstone et al., 2018), rather than in terms of discrete diagnostic categories.

For CPs to have a clear and developed idea of who this can benefit and why it can be of benefit, more explicit and detailed thinking about its relationship to the divergent settings needs to be undertaken. By defining these concepts with greater clarity, training and placement can then reflect this knowledge, to enable TSD to be used within the pluralistic and varied settings and theoretical frameworks that uniquely characterise Clinical Psychology.

4.7.2 Practice-based implications

Training and supervision: It is both a strength and a weakness of the Clinical Psychology Doctorate programme that each trainee will qualify with a range of different experiences and skills under their belt. As a result, the NHS will be able to recruit from an appropriately diverse cohort to match the varied needs of newly-qualified jobs needing to recruit. However, depending on the quality of supervision experienced and the specialist focus of each training programme, there is a risk of a deficit in process-based skills such as TSD (as well as other specialisms), if they have not received useful supervision in this area. More detailed guidelines focused on the teaching of TSD in lectures and on placement would mitigate the issue.

One of the participants expressed concern that a lack of in-depth supervision training can lead to CPs with experience of lower-quality supervision going on to supervise trainees, running the risk of propagating poor-quality supervision. Given that experiencing good supervision furnishes a supervisor with the necessary learning to form a good working alliance (Cutcliffe & Proctor,1998), it is important that the profession does all it can to ensure supervisors are well trained. Proctor (2010) emphasises the importance of the supervisee being a recipient of training, reinforcing the idea of a two-way process to form a successful supervisory alliance.

Recommendations for clinical training: The findings from this study suggest the need for a more systematic approach to the teaching of TSD on clinical training programmes to impact both university- and placement-based learning.

It is helpful to have a baseline teaching on TSD, as with any important aspect of clinical work, to ensure that all trainees have an opportunity to develop their thinking about their own position in the ‘safety’ of their peers. It is likely to be beneficial and safer for clients, given the research on the negative impact of inappropriate disclosures, if trainee therapists are able to think about this in places other than live in the therapy room.

This could be achieved through updating and extending guidance within the BPS (2014) framework. One participant also wondered if it is worth adding TSD

to the competency skills map that supervisors use in reviewing trainees on placement, as this would offer a systematic prompt. Ruddle and Dilks (2015) praise Henretty and Levett's (2010) TSD guidelines but ask for clearer guidance that can be more pertinently applied to specific settings within Clinical Psychology. However, generalised guidance should not outweigh client-specific factors and clinical judgement regarding TSD (Farber, 2006), as decision-making needs to be made within context, as supported by these findings.

Recommendations for supervisor training: In response to findings that supervisors vary in their ability to provide effective supervision (Scott, Ingram, Vitanza & Smith, 2000), Australia requires that CPs complete a minimum of three years professional experience along with training that involves demonstration of key supervision competencies (Psychology Board of Australia, 2010). They must take part in training every five years to retain accreditation. In the UK no such system is currently in place, which could be considered a disadvantage given the impact that positive supervisory experiences can have on professional wellbeing and client outcomes. A more comprehensive mandatory training and accreditation could be introduced, comparable to the current system of Continuous Professional Development (CPD) that requires qualified CPs to undertake and record a minimum number of hours of relevant training in order to maintain their registration with The Health and Care Professions Council (HCPC). While this would entail administration and governance, as well as additional duties for CPs to undertake, the potential benefits would be widespread.

It is also a recommendation from this study that current supervision training ensures there is teaching on and discussion of TSD, emphasising the importance of exploring the complexities with trainees in supervision. Supervisors can be advised that actively introducing and modelling thinking on TSD, may help create a trusting environment for trainees to feel able to share issues around self-disclosure.

Another important recommendation arising from this study's findings is that supervisors can be encouraged to model self-disclosure themselves within supervision. This includes their own personal disclosures or TSD with clients, including events that they perceived as 'mistakes', as this provides a learning

opportunity. Research into this ‘dyadic effect’ (Jourard, 1964) has shown that disclosure from one person may encourage disclosure from the other (e.g. Jourard & Richman, 1963).

Research into TSD: This study suggests that research exploring using TSD within specific frameworks and settings would offer useful information to help compile tailored recommendations for using TSD. For example, I could find no guidance or published research that considered the implications of TSD when using Narrative therapy, and specifically the Tree of Life (Ncube, 2006). The latter was mentioned by one of the participants in this study, given the implicit need for therapists to disclose personal information on their tree, and to think about what they do not want to disclose. Much research and theoretical writing on TSD is pan-theoretical or psychodynamically-oriented and focusses on the processes within therapy and the therapeutic relationship. Research methodology could include recorded sessions of client-therapist with TSD events, and interview clients and therapists on their experience and perceived outcome of TSD occurrences.

4.7.3 Wider implications

This thesis highlighted how little research specifically looks at the mechanisms of supervision on Clinical Psychology training courses in the UK, both from the perspective of the trainee and the supervisor. Assumptions made about the benefits and important of supervision, but without more in-depth knowledge into the realities of the experience of it, mean it is not possible to know if the current system is adequate for furnishing trainees with necessary clinical skills training.

All courses have placement reviews and assessment paperwork, as well as processes by which trainees can give feedback about the supervisors they work with. However, only the more negative or extreme cases are likely to be raised; the majority will fulfil the necessary criteria, with the trainee passing placement. There is a vested interest for trainees to ‘get through training’, which means that invaluable information may be lost about the experiences of acquiring therapeutic skills such as TSD. But it means that little detail is recorded about supervision as a process and whether client outcomes are improved. Trainees and supervisors are each under pressure from academic and professional

duties, which leaves less time for thinking about issues such as TSD if they are not built into compulsory frameworks. Further quantitative survey-based research to investigate experiences of supervision on training that are not aligned to university assessment procedures could provide data on trainee and supervisor experiences. Qualitative research would also be useful to explore these processes in depth, preferably with supervisor-supervisee dyads, to gain perspectives from both sides.

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6. APPENDICES

6.1 Appendix I: Ethical Approval

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Rachel George

SUPERVISOR: Paula Magee

COURSE: Professional Doctorate in Clinical Psychology

STUDENT: IMOGEN AYLEN (name since changed to Kearns)

TITLE OF PROPOSED STUDY: Clinical psychology training and therapist self-disclosure: the role of the supervisor.

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

Approved

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐	HIGH
☐	MEDIUM
x	LOW

Reviewer comments in relation to researcher risk (if any): na

Reviewer *(Typed name to act as signature)*: Rachel George

Date:16.6.16

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

PLEASE NOTE:

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here: http://www.uel.ac.uk/gradschool/ethics/fieldwork/

6.2 Appendix II: Participant information sheet

Information Sheet to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study. This study is being carried out as part of a Doctorate in Clinical Psychology at the University of East London.

Researcher
Imogen Kearns
Trainee Clinical Psychologist, University of East London

Project Title
Clinical psychology training and therapist self-disclosure: the role of the supervisor.

Project Description
The aim of the project is to investigate clinical psychologists' experiences of managing the supervision of therapist self-disclosure in clinical psychology trainees. This is with a view to gaining a better understanding of how trainees learn about using self-disclosure as a clinical skill with clients.

It is hoped this research will inform people working in the field of psychology about current practices and in turn contribute to a better understanding of trainees' learning needs in this area.

Taking part in this study will involve taking part in a one-one-one interview with me asking questions about your experiences of supervising trainee clinical psychologists and your opinions and experience of using therapist self-disclosure. The interview will last up to one and a half hours and will involve answering questions such as: What has been your experience of issues around therapist self-disclosure and supervising trainees?

There are no risks involved in taking part in the study and taking part is unlikely to cause you any distress. However, if for any reason during the interview you needed to take a break, wanted to reschedule or terminate the interview that is possible.

Confidentiality of the Data
The interview will be conducted with me [my name] and recorded on a digital recorder. The recording will only be listened to and transcribed by me and potentially but examiners of the final thesis. Any names or other identifiable information will be changed in the transcripts to ensure anonymity. The data will additionally be accessible to my research supervisor [name] at the University of East London and by the examiners who will be assessing my thesis. The audio recordings and transcripts will be stored securely on a computer in a password-

protected file and deleted from the digital recorder immediately after being transferred.

Following completion of the examination the audio recording will be deleted. The anonymised transcripts will be deleted after three years following completion of the study and might be used for additional articles and publications based on the research.

The thesis and subsequent publications will include quotes from the interviews and all extracts will be made non-identifiable.

Location
Interviews will take place at the University of East London or at a location convenient to participants such as their place of work.

Disclaimer
You are not obliged to take part in this study, and are free to withdraw at any time. Should you choose to withdraw from the research you may do so without disadvantage to yourself and without any obligation to give a reason. Should you choose to withdraw from the study after the interview, the researcher reserves the right to use your anonymised data in the write-up of the study and any further analysis that may be conducted by the researcher.

Researcher contact details: Imogen Kearns, tel: email: u1438288@uel.ac.uk

Supervised by Dr Jenny Jim, Clinical Tutor, School of Psychology, The University of East London, Stratford Campus, Water Lane, London E15 4LZ. Tel: 020 8223 4414, j.jim@uel.ac.uk

Ethic
If you have any questions about how the study has been conducted, please contact the study's supervisor Dr Jenny Jim as above,
Or
Chair of the School of Psychology Research Ethic Sub-Committee: Dr Mary Spiller, School of Psychology, University of East London, Water Lane, London E15 4LZ.
Tel: 020 8223 4493. Email: m.j.spiller@uel.ac.uk.

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please retain this invitation letter for reference.

Thank you in anticipation.

Yours sincerely,

Imogen Kearns,
Trainee Clinical Psychologist

6.3 Appendix III: Consent to participate

Consent to participate in a research study:

CLINICAL PSYCHOLOGY TRAINING AND THERAPIST SELF-DISCLOSURE: THE ROLE OF THE SUPERVISOR

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study, which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw after my interview has been transcribed and analysed, the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher.

Participant's Name (BLOCK CAPITALS)

…….

Participant's Signature

……..

Researcher's Name (BLOCK CAPITALS)

……..

Researcher's Signature

……..

Date: ……..…….

Researcher contact details: Imogen Kearns, tel: email: u1438288@uel.ac.uk

Supervised by Dr Jenny Jim, Clinical Tutor, School of Psychology, The University of East London, Stratford Campus, Water Lane, London E15 4LZ. Tel: 020 8223 4414, j.jim@uel.ac.uk

6.4 Appendix IV: Interview schedule

Interview Schedule

The interview schedule provides a guide to the questions that participants will be asked in the interview. However, this is not an exact representation of all of the questions as the interview will necessarily be guided by the participant's responses.

Introductions

Introduce myself, remind participant of confidentiality and the right to withdraw at any time during the interview and the length of the interview (between 1 and 1.5 hours). Have a brief chat to promote an open atmosphere, e.g. How are you doing today, how was your journey?

Information gathering

1. How long have you been a clinical psychologist?
2. Where did you train?
3. What service are currently working in?
4. How long have you been supervising clinical psychology trainees?
5. What client group/s do you have experience of supervising trainees with?

Therapeutic models

6. Which therapeutic models do you draw on in your work?
7. Which do you mostly use/keep in mind with trainee clinical psychologists?
8. Do you draw on any particular models of supervision to guide the placement supervision sessions?

Therapist Self-Disclosure

9. How do you define therapist self-disclosure?
10. Do you think therapist self-disclosure is an important skill to acquire in Clinical Psychology Training? And to use as a practicing therapist in the NHS?
11. How do you handle therapist self-disclosure when it arises in supervision?
12. Is it something you would actively suggest if it doesn't arise? If so, when, why and how?

13. What kind of situations can you recall where it results in a positive result for the client?
14. What kind of situations can you recall where it resulted in a less positive result for trainee, client or other?
15. What factors govern your decisions around therapist self-disclosure?
16. Is there anything else you would like to share with me that you think is important in relation to this research or the questions that I have asked you?

Prompts

Would you be able to tell me more about that?

How did it affect the situation/the trainee/you?

Why do you think that was?

Could you give an example?

Debrief

How do you feel?

Is there anything that concerned you about this interview?

Do you have any questions?

If you have any questions after today, please contact me using the details provided on the information sheet.

Thank the interviewee

Remind them of confidentiality

Appendix V: Revised interview schedule

Interview Schedule V2

The interview schedule provides a guide to the questions that participants will be asked in the interview. However, this is not an exact representation of all of the questions as the interview will necessarily be guided by the participant's responses.

Introductions

Introduce myself, remind participant of confidentiality and the right to withdraw at any time during the interview and the length of the interview (between 1 and 1.5 hours). Have a brief chat to promote an open atmosphere, e.g. How are you doing today, how was your journey?

Information gathering

- Age, ethnicity
- Where did you train and how long have you been a clinical psychologist?
- What service are currently working in? (Client group)
- How long have you been supervising clinical psychology trainees?
- What client group/s do you have experience of supervising trainees with?

Warm up question:

I would be interested to hear your views before I ask you some more detailed questions. Is self-disclosure in the therapeutic relationship something you have given much thought to?

Therapist Self-Disclosure

1. How would you define therapist self-disclosure?
2. Do you think using therapist self-disclosure is an important therapeutic skill to acquire in Clinical Psychology Training? And to use as a practicing psychologist?
3. How do you handle or approach issues around therapist self-disclosure when it arises in supervision?

4. Is it something you would actively bring up or suggest if it doesn't arise? If so, when, why and how?
5. Can you think of any (more, *if some already mentioned*) specific examples of working with a trainee and dealing with issues around therapist self-disclosure?
    a. What kind of situations can you recall where it resulted in a positive result for the client and the trainee?
    b. What kind of situations can you recall where it resulted in a less positive result for trainee, client or other?
6. What factors govern your decisions around therapist self-disclosure?

Therapeutic models

7. Which therapeutic models do you draw on in your work?
8. Which do you mostly use/keep in mind with trainee clinical psychologists?
9. Do you use any particular models as a framework to guide trainee supervision sessions?
10. Is there anything else you would like to share with me that you think is important in relation to this research or the questions that I have asked you?

Prompts

Would you be able to tell me more about that?
How did it affect the situation/the trainee/you?
How did you make the decision?
How did you reflect on it afterwards?
Why do you think that was?
Could you give an example?

Debrief

How do you feel?
Is there anything that concerned you about this interview?
Do you have any questions?
If you have any questions after today, please contact me using the details provided on the information sheet.

Thank the interviewee; Remind them of confidentiality

Appendix VI: List of initial codes

1. Absence from training courses
2. Absence of TSD (trainee)
3. Acknowledge/open up
4. Advice to not use TSD
5. Age and disclosure
6. Anxiety around TSD
7. Assessment and supervision
8. Assumption of competence/no negative experiences
9. Background / prior experience and influence on TSD
10. Being a trainee and TSD
11. Being human
12. Boundaries
13. Complexities of TSD
14. Context
15. Deciding not to use TSD – linked to boundaries
16. Decision making
17. Deeper thinking
18. Definition of TSD
19. Developing an identity
20. Developmental trajectory of trainee
21. Discussing in supervision
22. Effect on therapist of TSD
23. Encouraging trainees to do TSD
24. Ethnicity
25. Experiences / influences from training itself
26. Experiencing/trying out on placement
27. Explaining to trainee
28. Formulation context
29. Function of TSD
30. Guiding a trainee to reflect or make decisions about TSD
31. Hiding information /not bringing to supervision
32. How is it discussed/brought into supervision
33. How it comes up

34. Ideas for future
35. Identity
36. Impact on client work when trainees use TSD
37. Interview itself leading to new learning
38. Just comes up
39. Lack of teaching on it
40. Learning and developing as a psychologist (trainee)
41. Learning by doing
42. Learning from the trainee
43. Life stage of the trainee
44. Link to setting/client group (Forensic; Psychosis)
45. Making decisions in the moment about TSD
46. Modelling
47. Modelling to trainees
48. Negative experience
49. Not being human
50. Not covered in supervision
51. Not disclosing
52. Personal and professional interaction
53. Power - general
54. Power being taken away from trainee therapist
55. Power dynamic within therapy
56. Power within supervision
57. Process of deciding
58. Process of TSD
59. Recognition of /dealing with discomfort of trainee
60. Reflecting on TSD
61. Religion
62. Role of supervision/thinking through TSD
63. Safe versus unsafe sharing
64. Self-reflection
65. Shifting arena
66. Skill/tool of TSD
67. Society and power
68. Stigma and TSD

69. Sub-types of TSD
70. Supervision relationship
71. Supervision as a two-way process
72. Supervision gives a space to think about TSD
73. Supervision style
74. Supervisor being observed
75. Supervisor regrets
76. Supervisors trajectory as a trainee
77. Supervisors' prof/personal identity
78. Supervisory style and TSD
79. Teaching TSD
80. Telling stories in supervision
81. Tentative approach
82. Themes that come up between trainees and clients
83. Theory-practice links
84. Therapeutic orientation
85. Therapeutic relationship
86. Trainee (TSD) competence
87. Trainee dilemmas
88. Trainee response to TSD
89. Trainee style and personality
90. Trainee-supervisor alliance
91. Training and teaching TSD
92. Transparency/authenticity
93. TSD Discouraged by courses
94. TSD within supervision
95. Unable to recall examples/not at the forefront of minds
96. Unclear/unsure/doubts
97. Who leads it
98. Working in teams and TSD

Appendix VII: Initial code example with excerpts

Number	Initial code	Extract
21.	**Discussing in supervision**	I would invite that into supervision and that in a way then invites the question around self-disclosure because we're self-disclosing in supervision. P1 I think the first thing to think about kind of understanding how the issue even kind of came about what is the context leading up to it and then trying to understand what is the intention behind it. What would be the kind of - in the context of the work that someone's doing, what would be the - what would that be around? P2 I um I remember with one of my very early trainees having a really open discussion about it, she, I haven't given the game away, most trainees are female, um had ah asked why I'd told a family something about me, I think that felt quite alien and I was then trying to explain this idea of how it sometimes brings you on side together, particularly if there's a difficulty there it can be quite helpful positioning yourself next to each other. P3 I'm just trying to think of times it has come up, yeah I mean I think it would be with trainees trying to open up to a reflective space because I think that sometimes there's there unsaid rules that we kind of just accept that we don't disclose and that often there's this narrative around that and that maybe it isn't questioned so. P4

		I think that then asking in terms of checking in. in terms of how their week has been actually affecting how they've been in the room, or if they've had, if the trainee is having something that's quite stressful at the moment, it could even be an assignment and may be less available so exploring that with them so to bring themselves into the therapy so yeah. P6 I think in terms of the feedback that we've got, it's about that actually, um, using a supervision space which isn't about what to do next, but actually what it makes you feel and what it makes you think um has felt an awful lot more useful because I guess if you tell someone do this with this client that's something that works in that one instance perhaps but actually being able to work using their own lens of self, and linking that to theory and what have you if something sticks with them and I guess it's a process that they'll probably be doing the rest of their career. P6 It's that real learning of how to pick up on people's body language and tone of voice and all of that to know what you need to give back so I just talk about that from the word go with all the trainees so they're some people who will be asking you a lot about yourself and you just stop and say that's really interesting you've asked me a lot about me and I just wonder why quite a general way of saying why are you doing this versus you just pick up straight away that it's quite benign if someone's very nervous they're just making conversation. P7

		I guess it's only bring it and talk about it we'll talk about where it seems safe to disclose and use your sense of self or where it seems like there's something else going on with this person as I've said might be intrusive might be controlling might be trying to back the therapist into a corner. P7 because I like having frameworks and models for understanding I developed one for myself in my own head effectively and er through discussions with colleagues and then I've shared that with trainees as I've gone along to try and help them think about it with er kind of caveat that their still their own person and they have to make their own decision about what they do or don't feel comfortable, yeah, self-disclosing but that having some parameters for themselves about what they might feel comfortable self-disclosing to give someone more of a sense of themselves as a person in working with psychosis is helpful I guess my message with trainees has been I don't think you can get away with not saying anything about yourself if you're working with this client group so basically you need to think about it. P8 How to try and communicate to the client um that he would be doing his best you know to set aside his own experiences and to you know to pay attention to the client's experiences, the meanings his own experiences growing up had for him you know that kind of thing um that's springs to mind in terms of engagement. P8 And I suppose what we do is we think about what happens if they ask what it means to be a trainee

		because my trainees need to know how to field that kind of question, and what they're ok about sharing and what they're not, because like I said I'm very straightforward if someone asks you about your qualifications you just answer and you kind of in that way, if trainees are going to answer they need to think about what they're going to say that feels alright rather than feeling put on the spot. P9 So I think having much more conversation about it, even if it's just to raise self-reflection about it – to get people thinking a bit more about it, noticing when it's happening, noticing when an opportunity comes up and being much more careful to think about why you might do it, and what the reasons might be and then to think about what the impact might be if you do chose to do it and then to reflect on that with the client afterwards. P10 So we would talk about the TSD generally about I think some of it came about because of his confidence / arrogance erm that he felt that he could just share this stuff and it wouldn't have much impact or it would only have a positive impact on people so I was like what are you doing, why are you doing it, what impact is that going to have, how do you think that client might receive that, did you look to them? P10 So that's another theme is being able to model that humility and acknowledge when you've done something that might not have been helpful, without necessarily meaning to, to the therapeutic encounter, I think that can help along the therapeutic encounter. P10

Appendix VIII: Excerpt of marked-up transcript

TRANSCRIPT	CODES	THEMES
I: *Um and um you've kind of touched on this from your own experiences of training and beyond but do you think it's important like it's an important skill or tool for trainees themselves to be thinking about and using and developing during training?*		
P10: Yeah massively yeah very much I think it's a massive gap which I only realised after sort of training um yeah I think it is I think there's not much erm kind of consensus out there about how much is right and what to do and some models of therapy talk more about it than others, none of them talk about it that much, but regardless, I think developing it as a sensitive skill firstly to open up the conversation because I think for a long time in training it just hasn't even been a conversation and by it being absent there's an assumption that you shouldn't do it or you should be very cagey about it and if you just did a straw poll of first year trainees you know how would you feel if you were to share x y or z and you give some sort of examples they would probably er on the side of probably not probably not and I think that's right to start with because I think that people should develop the confidence and the skill to know to use it judiciously and to know when and how to use it, but I think people often don't ever get that skill developed, so they're missing out on something and, or people use it too much inappropriately and	Lack of coverage in training Different approaches Important tool Ignored in training Approach Trainee development Developing TSD as a skill Negative experience, Inappropriate	Desire for something different Working within frameworks Function of TSD Desire for something different Tensions on training Trainee development

I've had that experience when I supervised trainees as well, and I was probably one of those people to start with, so I think having much more conversation about it, even if it's just to raise self-reflection about it – to get people thinking a bit more about it, noticing when it's happening, noticing when an opportunity comes up and being much more careful to think about why you might do it, and what the reasons might be and then to think about what the impact might be if you do chose to do it and then to reflect on that with the client afterwards. All of that, I would be wanting to encourage much more conversation around, as a core skill, both in the teaching but also in placement as well. Like I don't see why it couldn't be added to a competency map of the generic core competencies, those basic clinical skills that go in prior to all the models, specific models, why it couldn't be something on there I don't really know so really I should be speaking to [name redacted] about getting it on a core competency map, which I hadn't really thought about until now but you know it feels to me that integral to the therapeutic relationship that I think it should be a core part of training. *I: Um…which brings me on to how do you therefore approach it or how do you feel it's helpful to approach it with trainees?* P10: So I sort of started to answer this without having thought about it. So every training course is different but where I trained the first month is dedicated to core	Open up, acknowledge Function, Reflection Function of TSD Discussing (in supervision) training and teaching TSD	Taking a declarative approach Beliefs about function of TSD Process of TSD with trainees Desire for something different

clinical skills so there was just um a month of really basic assessment skills conversational skills. I can't remember what we did in it but I'm sure there was some basic Rogerian empathy, you know that sort of stuff, and I don't see any reason why it couldn't form a session at that point even…[[REDACTED to anonymise]…I definitely think there should be a slot on each training course, so a specific teaching slot, ideally mention it a bit early on as well and kind of have it as thread and then I don't see why it can be added as a competency you're also developing in placement that you're also being assessed on, not on how much you do it but how aware you are of it and how much you reflect on it and you've thought about whether to do it or not and the affect it has because I don't judge anybody for doing it or not doing it, it's for not thinking about it or making decisions blindly that I would be more wary of. So yeah I think it should be certainly part of the teaching and then something that gets discussed and monitored as a competency through placements and that forces supervisors to have to think about it and talk about it. I: *And as it stands at the moment, how do you discuss it with trainees that you've supervised?* P10: Yeah so it's interesting because most of my trainee supervision experience - so I haven't had a trainee for a couple of years basically - was actually through the time I kind of was nurturing it really um and yeah	Training and teaching TSD Role of supervision/thinking through TSD	A desire for something different A Desire for something different Process of TSD

so I then I supervised 1 or 2 more afterwards but um it's not like I really felt like I'd become an expert in it and then supervised them, I was supervising them before as well so I was kind of thinking about it while supervising so those earlier trainees I certainly didn't have any systematic way of addressing it, it's not like I put it on my agenda you know and I had to do it and because there's a million competencies you do have to look at. It's definitely come into every relationship I've had with a trainee, both in terms of our relationship but also the clinical work that they've been doing and that's partly because I'm supervising psychosis work, and I think it comes up in psychosis work quite a lot anyway, um, so it's not, it basically so I've waited for it to come up for it to have a reason to come up so when it's first come up in a piece of clinical work I've been supervising then it starts a conversation, and then it usually leads to quite a rich conversation that they go away and act on in the clinical work but also it becomes a thread then maybe throughout our supervision later on.	Feeling unsure unsure/ doubts TSD within supervision TSD within supervision Supervision relationship Role of supervision/thinking through TSD Deeper thinking	Feeling ill-equipped Process of TSD Reactive approach Reflection

Appendix IX: Reflective diary: excerpts

Interview with Participant 3:

I enjoyed this interview and felt at ease, it felt more like a conversation rather than an interview with no an ease of understanding. On reflection, I wonder if I have missed certain important things

This interview felt very different to the previous ones for several reasons:

It was the first female participant, and someone who worked in a context that was aligned with my interests more than the

I felt my confidence grow in the purpose of my research as the rich responses came now in the third interview. An irrational fear or internal voice telling me "this isn't of interest to anyone except you", "will the participants even have anything to say about this" was quietening down. It seemed people were interested and did have a lot to say about TSD and supervising trainees.

This participant seemed particularly engaged in aspects of the research that chimed with my experiences, so I was drawn to speaking. When they spoke about their own use of TSD I found myself drawn to wanting to emulate it. It felt a bit similar to having a supervisor who works in a way that I would like to draw ideas from and embody in my own clinical work.

I felt at ease with this person, and possibly this meant I was more in tune with following the content of the responses she gave. The power dynamic felt more balanced, like we were having a conversation as equals. It makes me question what I become when I work with more senior males, the roles I might inadvertently assume and the social pressures of being a working mother and all the feelings of inadequacies this bring to my professional self.

I felt disappointed that some of the examples were about the supervisor using TSD with clients, rather than about supervising trainees, and I noticed a latent concern that my research interviews might not produce rich examples that I'd

hoped for. Made a note to self to keep an eye on this concern, as could make me force other subsequent interviewees to give examples rather than allow natural flow.

Interview with Participant 5

I was aware that the interview started awkwardly as there was a fundamental misunderstanding that needed correcting, as P5 thought I meant self-disclosure by the trainee within supervision rather than the concept I was interested in exploring.

I found myself feeling embarrassed and inadequate – fearing that my information sheet wasn't clear enough and also that P5 may have thought I was being rude in correcting them. This interacted with the sense that I had less power as a trainee sitting in their place of work and it felt uncomfortable in the same way that it might having to correct a supervisor whilst on placement, in the role of trainee.

Once this initial misunderstanding was resolved, P5 gave very in-depth and thoughtful responses to the questions. During the interview however I continued to feel this tug of the imbalance of power, that as if I held more power having unsettled the interviewee or wrong footing them and I wonder if I held back from probing or left certain themes or avenues unexplored. An example was that I failed to fully explore the client group or setting when it wasn't covered by them. This felt like a missed opportunity as P5 works in an inpatient unit which might have given a different perspective to TSD compared to the other settings I'd encountered so far.

When I asked for examples of this in supervision it felt increasingly intrusive, as P5 struggled to think of any actual examples involving trainees and seemed to be berating themselves for this.

Having spoken to my DOS about a similar issue about examples and trying to get them in my second interview for this research, I felt confident in being "ok" that they didn't have any examples and also being "ok" in asking in different

ways or at different times because it might yet lead to some rich depth or detail that would be important for the research findings. Towards the end of the interview, P5 gave a very rich example that he'd initially discounted because he hadn't realised it 'counted' as TSD. This was about a group involving a trainee and was a very useful description of the process of supervising how to handle TSD in a live situation.

After the interview on the way home I reflected on the at times intense atmosphere and wondered why it might have been so. It had felt the most intimate conversation so far, and Id felt drawn or (invited?) to give my own views and opinions at times which obviously I couldn't, and that process of holding back had felt quite powerful. The awareness that this is not a normal conversation but is a research interview really hit home.