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Supervisor Self-Disclosure: Supervisees' Perceptions of Positive Supervision Experiences

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Within clinical supervision in psychology, supervisor self-disclosure plays an important role in normalizing supervisees' clinical experiences and process of identity development. This article explores three examples of supervisees' experiences with supervisor self-disclosure. We discuss the circumstances surrounding supervisor self-disclosure and how it facilitated professional development and clinical competency. Each supervisee reported an existing strong supervisory relationship and experienced the disclosure as beneficial to their identity development. We recommend future research examine the impacts of supervisor self-disclosure on supervisee development. Additionally, we suggest that training on supervisor self-disclosure be more readily available and integrated into existing supervision training opportunities.

Public Significance Statement
Self-disclosure within clinical supervision in psychology has consistently been identified as a core component of the supervision process. The focus, however, has primarily been on supervisee (i.e., psychology trainee) self-disclosure, with limited exploration of supervisor self-disclosure. This article presents case examples that explore the use of supervisor self-disclosure as an effective means of promoting supervisee professional development, self-efficacy, and sense of professional identity.

Keywords: supervision, self-disclosure, professional development, supervisee development, supervisory relationship

Self-disclosure has been broadly defined as "the process of sharing information about the self with another that they would be unlikely to know otherwise" (Spence, Fox, Golding, & Daiches, 2014, p. 179). It follows that supervisor self-disclosure can then be conceptualized as a supervisor sharing personal information, experiences, and reactions that the supervisee would be unlikely to know. There is a wide range of ways for a supervisor to self-disclose; some examples can include sharing personal biographical or demographic information, personal emotional reactions, similar clinical experiences and mistakes, and experiences of the supervision process or relationship (Knox, Burkard, Edwards, Smith, & Schlosser, 2008). Supervisor self-disclosure can be used to provide feedback and promote development in supervisees, strengthen the supervisory relationship and promote supervisee self-disclosure, share lessons from their own professional experiences, and normalize supervisee experiences (Farber, 2006; Knox et al., 2008; Knox, Edwards, Hess, & Hill, 2011). Supervisors commonly report self-disclosing when they observe their supervisee struggling in some way (e.g., experiencing difficult emotional reactions to clients) and attempt to normalize their supervisee's struggle through their self-disclosure (e.g., sharing their own reaction to a client; Knox et al., 2008, 2011).

Having a good existing supervisory relationship has been identified as an important factor in successful supervisor self-disclosure interventions. When used appropriately, supervisor self-disclosure has been shown to further strengthen this supervisory relationship (Knox et al., 2008, 2011). Identifying when and why to self-disclose, then, should be considered carefully before supervisors choose this intervention. Knox et al. (2011) found that supervisees reported supervisor self-disclosure as most appropriate

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and effective when the intentions for the disclosure focused on clinical information. When supervisors disclose personal information without a clear, clinically relevant rationale for doing so, it can leave supervisees with feelings of uncertainty (e.g., "What am I supposed to do with this information?"), particularly when the supervisory relationship is more tenuous (Knox et al., 2011). When supervisor self-disclosure is used effectively, supervisees report experiencing stronger relationships with current and future supervisors and increased comfort with their own use of self-disclosure as an intervention, which in turn is associated with perceived improvements in their clinical work (Knox et al., 2011). Furthermore, supervisors can normalize supervisees' concerns, model accountability, and encourage personal and professional growth by sharing relevant personal experiences (Knox et al., 2008).

The following section of this article presents three case examples of effective use of supervisor self-disclosure. These examples are written in a narrative format from the perspective of the supervisee, each of whom is a counseling psychology doctoral student. The vignettes provided in each example are reflective of true experiences in supervision, though they are not direct quotations. A subsequent discussion of each case example will highlight the purpose of the supervisor's self-disclosure, how it impacted the supervisee's clinical and identity development, and how the intervention was informed from a scientist–practitioner lens.

Case Examples

Example 1: Case Management and Boundary Setting

Throughout my training, I often struggled to prioritize my own self-care when it felt in conflict with my clients' care. Several years into my doctoral program, a client was placed on my caseload with a presenting concern that was similar to an issue I had recently experienced in my own life. The possibility of working with this issue elicited feelings of anxiety and painful memories, so I approached my supervisor to bring it to her attention and explore the issue as soon as possible. I disclosed why the case would be difficult for me, but why I also felt pulled to work with the client and face the challenge. My supervisor expressed her concern for the toll this case might take on my well-being and suggested that we explore all options available to ensure that this client received the care they needed. One of the options we discussed was the possibility of assigning the client to another clinician. However, I still felt conflicted over transferring a case for a personal reason because I worried it meant I would not be meeting expectations or fulfilling my responsibilities as a clinician.

Supervisor: I hear you, but no one would think you were shirking your responsibilities if we reassigned this client. I myself choose to set the boundary of not working with grieving clients because I am still in the process of working through my own grief, and working with a client would trigger some raw stuff for me. But there are others here who specialize in that work and that is ok. You are not alone in this.

Me: Ok, that makes me feel a little better. But I do not want to avoid this forever, and part of me feels like this could be an opportunity to grow.

Supervisor: It might be, but you'll have more opportunities to work with similar clients in the future. Right now, I see how much you're working to contain your activation and I want to know whether you feel like you'd be placing undue stress on yourself for the sake of possible growth.

My supervisor and I continued to explore the decision of whether or not to reassign the client. She listened to me and provided me space to make my own decision, while also challenging me to consider whether I would be in a good place mentally and emotionally to offer the client quality care. We ultimately agreed to assign the client to another clinician and by the end of our impromptu supervision session, I no longer felt guilty or wrong for doing so.

Consistent with previous research (Farber, 2006; Knox et al., 2011; Watkins, 2012), our supervisory relationship was key to this pivotal supervision experience. When the supervision relationship is rooted in trust, openness, and encouragement, supervisees are more likely to feel safe and supported when sharing their insecurities with their supervisors (Watkins, 2012). If executed appropriately, supervisor self-disclosure can teach, normalize, and model a new way to respond to difficult clinical situations for training therapists (Farber, 2006; Knox et al., 2011). In my own case, my supervisor recognized the difficulty I was experiencing in deciding whether it was acceptable to reassign the case. In response to my struggle, my supervisor successfully worked to normalize my experience (Knox et al., 2008) while reaffirming our supervisory relationship. Had she not self-disclosed a similar experience, I may have continued to feel pressure to work through my distress and work with the client. Rather, my supervisor's willingness to appropriately self-disclose helped reduce my anxiety and self-criticism about referring the client to another clinician. Furthermore, it communicated my supervisor's genuine concern for my well-being, which helped me to recognize the stress I was placing on myself and taught me a valuable lesson about self-care, professional identity development, and case management. My supervisor's actions and interventions helped me to realize that my decision to refer would be viewed as growth in my awareness, clinical judgment, and self-care, rather than a failure to fulfill my clinical responsibilities.

Example 2: Understanding Reactions to Clients

Early on in my clinical training, I worked with a client who was diagnosed with a personality disorder and who I found to be particularly challenging interpersonally. This case was especially difficult given that I was still developing my identity as a therapist and my understanding of interpersonal dynamics in the therapy room. During one supervision session, I talked with my supervisor about how I had been feeling frustrated and angry with this client. I had been noticing patterns in the client's behavior in which she often contradicted previous stories and statements, which left me feeling manipulated and unsure of what to believe or how to proceed in treatment. Additionally, I felt guilty that I was having trouble maintaining a positive regard toward the client. My supervisor asked me what it was about the client's presentation that elicited such a strong reaction from me.

Me: Well, I just hate being lied to. To me, it's a sign of disrespect. Feeling respected is really important to me, I guess.

Supervisor: I can understand that, especially thinking about the type of work environment you experienced prior to grad school. Respect was very important there. You know, something else I noticed as I watched the tape was that I felt angry at certain points, too. She reminded me of other clients I've had in the past.

Me: Wow, really? That's really helpful to hear. So what should I do, then? How can I maintain positive regard?

Supervisor: Well, let's think about how she learned how to interact with others. [A discussion of the client's past ensued, focusing on trauma, neglect, and family dynamics, including her role in the family.] When you describe her early experiences, I hear that you feel a lot of empathy for her.

Me: I do. When I think about everything she's been through, I feel for her a lot more.

The remainder of the supervision session was spent discussing the client's treatment plan and strategies I could use to practice this new perspective. By sharing her personal reaction to my client, my supervisor helped me better understand my own reactions and showed me that I could use my reactions to my client as a tool to better understand both our relationship in the therapy room and her relationships with others in her life, and that I could use this information to guide my interventions. Following our conversation, I felt more energized and prepared the next time I saw this client. I was able to implement my new perspective, and the result was a more genuine and productive session with the client.

Several of my supervisor's actions in this supervision session were important in facilitating her use of self-disclosure. First, she empathized and normalized what I was experiencing, rather than dismissing my concerns or shaming my reaction, which opened the door for further discussion. This effect is supported in the supervision literature; specifically, the use of mutual empathy in the supervisor–supervisee relationship has been associated with increased trainee willingness to admit and discuss clinical mistakes (Walsh, Gillespie, Greer, & Eanes, 2002), and normalizing trainee reactions through self-disclosure has been linked to positive effects on the supervisory relationship (Knox et al., 2008).

Second, she helped me explore my thoughts and emotions to identify the core value at the heart of my reaction. Her knowledge of my previous experiences, which informed my worldview and perspective of my client, facilitated her ability to use positive reframing (Masters, 1992). This would not have been possible had she not previously taken the time to get to know me and build a strong supervisory relationship. My supervisor saw that I was struggling with a form of "imposter syndrome," wherein I feared that what I was thinking and feeling could not possibly be congruent with a good therapist. Without needing to provide detail about why she could relate to my reaction, she was able to show me (rather than simply tell me) that my reaction was human, acceptable, and workable. Consistent with previous research, this experience normalized my concerns and increased my sense of safety in supervision, thereby opening the door for deeper exploration of the clinical issue and successive improvement in my work with the client (Knox et al., 2011).

Following her use of self-disclosure, my supervisor strategically helped me consider all of my reactions toward my client to reframe how I saw my client in an intentional way. I learned that my reactions are natural and powerful and can be channeled toward understanding a way forward when I feel stuck. This technique has been described as one of the most effective means of teaching supervisees about use of self (Gayle, 2011). By sharing her own reaction, my supervisor modeled how to use my own interpersonal reactions in therapy, which subsequently helped me gain a deeper understanding of my identity as a therapist.

Example 3: Clinical Mistakes and Self-Doubt

While working with a client who had a past history of abuse, I needed to assess whether any children were currently at risk of harm by the client's perpetrator. The client was aware of my role as a mandated reporter and was hesitant to share any details. I consulted with one of the available psychologists during session to ensure that I had sufficiently assessed and gathered enough information despite the client's hesitancy. During supervision later that week, I expressed continued uncertainty that I had done enough in assessing potential for harm and we talked through the information I had gathered. I was also open with my supervisor about feeling very nervous to acknowledge a potential misstep, given the evaluative nature of our relationship.

Me: I feel a little anxious bringing this up, but I'm having a hard time putting this case behind me, so I think it would be helpful to talk about. I know there's only so much I can do if the client is not willing to share information with me and I know I made the right choice to consult before the session ended, yet I still have this feeling that maybe there was something more I could have done.

Supervisor: I really appreciate your willingness to bring this up. I can definitely understand that anxious feeling, but I also want to normalize this experience for you.

Me: You've expressed trust and confidence in my abilities, and that has really helped me to feel confident and own the room . . . but that confidence is feeling a little shaken right now.

Supervisor: None of us are perfect, and there are going to be times we make mistakes, whether it's as a student or as a licensed professional. Just the other week I failed to complete a piece of paperwork that was required for a client in crisis and had to discuss this with our director to correct it. Mistakes are going to happen. But let's talk through the case some more and see what we come up with.

We then proceeded to review the case more in depth by watching video and discussing ways that I could have approached the

situation differently, though my supervisor validated that the situation was appropriately handled. We also took time to process why this case had been more difficult for me despite clinical experience in this area.

Prior to bringing this up with my supervisor, I was experiencing feelings of shame and I was worried about how my supervisor would view me as a therapist if I shared a concern about my performance with her. Watkins (2012) described similar supervisee experiences as demoralization, in which the supervisee feels discouraged and may experience a loss of morale, potentially due to feeling they have not lived up to expectations. He further stated that it is the role of the supervisor to help "remoralize" through interventions dependent upon the needs of the supervisee. Through her use of normalizing, validating, and self-disclosing, my supervisor helped communicate that my experience was a normal part of professional development. By normalizing that these situations can arise throughout our professional careers and by providing a personal example, it helped to remoralize me, alleviate feelings of shame, and to feel more comfortable in bringing similar situations to supervision.

Supervisees report that positive supervisor self-disclosures come from strong supervisory relationships and that self-disclosure is commonly used when supervisors have similar clinical examples as the supervisee (Knox et al., 2011). These were certainly true of my own experience in that it was the strong relationship with my supervisor that helped me to feel safe in acknowledging self-doubt. In addition, the recency of the example she shared and its relevance to high-risk cases (e.g., crisis, abuse) strengthened the message that my experience was normal and wholly acceptable.

Discussion

According to the American Psychological Association (2014), clinical supervision in psychology strives to enhance trainees' professional competence using a collaborative relationship between supervisor and supervisee that is both facilitative and evaluative in nature. Research has consistently demonstrated that positive supervision experiences are associated with trainees' perceptions of their clinical skills and self-efficacy (e.g., Borders, 1991; Cashwell & Dooley, 2001). Further, supportive supervision experiences are associated with reductions in trainee anxiety, increased confidence in their clinical practice, and increased job commitment (e.g., Bambling, King, Raue, Schweitzer, & Lambert, 2006; Kennard, Stewart, & Gluck, 1987).

Supervisor self-disclosure may be beneficial to the supervisee's professional development, and it is generally viewed as positive by both supervisors and supervisees (Knox et al., 2008, 2011). Through modeling the use of their own self-disclosure, supervisors can assist their supervisees in learning how to engage in healthy disclosure and self-reflection (Farber, 2006). In fact, supervisee self-disclosure has been shown to be a critical component of supervision (Yourman, 2003) and is associated with the quality of the supervisory relationship (Spence et al., 2014). These disclosures can include content directly related to therapy sessions, personal issues that may influence clinical practice, or dynamics in professional relationships (Spence et al., 2014). Although supervisees consistently identify self-reflection as a valuable part of clinical practice, many also report having withheld information from supervisors or experiencing difficulty self-disclosing due to fear of negative consequences (Spence et al., 2014; Yourman, 2003). In the clinical examples detailed here, each supervisee indicated feeling some apprehension about disclosing their thoughts, emotions, and reactions to their supervisor. The subsequent supervisor self-disclosure facilitated further supervisee self-disclosure that contributed to both supervisee growth and healthy resolution of the clinical issue.

Consistent with previous research on the use of supervisor self-disclosure (Knox et al., 2011), each of the supervisees identified having an existing strong supervisory relationship. The supervisory relationship has been identified as one of the most impactful aspects of effective supervision (DePue, Lambie, Liu, & Gonzalez, 2016; Watkins, 2014). Research suggests that the supervisory relationship is associated with supervisees' perceptions of the supervision process, confidence in their clinical practice, and satisfaction with supervision (DePue et al., 2016; O'Donovan, Halford, & Walters, 2011). When the supervisory relationship is strong and supervisees view their supervisors as empathetic, supportive, respectful, and knowledgeable, they also report experiencing effective and positive supervision (Beinart & Clohessy, 2017; Lizzio, Wilson, & Que, 2009). Poor supervisory relationships, on the other hand, have been associated with reduced supervisee well-being and job satisfaction, as well as increased anxiety, stress, burnout, and role conflict (Beinart & Clohessy, 2017). Each of the supervisees in the examples noted that the existing supervisory relationship and the presence of a recent clinical or professional concern that prompted the self-disclosure were factors that contributed to their positive perceptions of the self-disclosure.

These cases also demonstrate how supervisor self-disclosure can take many forms, whether it be through sharing a reaction to a client, providing an example of a personal clinical mistake, or discussing their own boundaries with clients and caseloads. These examples suggest that supervisor self-disclosure is effective when it closely matches the supervisee's clinical or professional concern; when disclosures are unrelated or unprompted, the supervisee may be less likely to perceive it as helpful or warranted. Overall, supervisors should consider a number of factors when determining whether to self-disclose, including supervisee developmental readiness, appropriate supervisory boundaries, and the strength of the supervisory relationship (Knox et al., 2008).

Research has demonstrated that supervisees tend to report little to no training on the use and purpose of supervisor self-disclosure (Knox et al., 2011); thus, there may be a gap in the education of future supervisors beyond observing their own supervisors' self-disclosure. It may be valuable for courses or trainings on supervision to include topics related to supervisor self-disclosure to educate future supervisors. Specifically, supervisors-in-training might benefit from learning to recognize when, how, and with whom self-disclosure is most appropriate and facilitative. Given how supervisor self-disclosures positively impacted supervisee development, self-efficacy, and sense of identity in our case examples, research should examine the strength and consistency of these relationships on a larger scale. Additionally, future research is needed to explore situations in which supervisor self-disclosure is harmful to supervisee development and the supervisory relationship to delineate appropriate usage of this intervention.

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