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# Supervisee Nondisclosure in Clinical Supervision: Cultural and Relational Considerations

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Supervisees often withhold information from their clinical supervisors; however, the factors explaining supervisee nondisclosure (SND) are essentially unknown. We hypothesized that supervisees' perceptions of the supervisory working alliance (SWA) and of their supervisors' multicultural competence would collectively and inversely predict the multidimensional construct of SND (comprised of clinically and supervision related nondisclosures). In addition, we hypothesized that these two variables would uniquely and inversely predict SND. Data from 221 mental health supervisees suggested that supervision-related nondisclosures (information related to clinical supervision) occurred more often than clinically related nondisclosures (information related to the supervisee's clinical work). Moreover, both kinds of SND occurred less often than expected, and the SWA uniquely and inversely predicted SND. Unexpectedly, post hoc analyses suggested that the SWA mediated the relation between supervisor multicultural competence and SND. The mediated relation more strongly predicted supervision-related nondisclosures relative to clinically related nondisclosures. Implications of the findings for clinical training and research are discussed.

***Public Significance Statement***
This study investigated relational and cultural contributions to supervisees withholding information (nondisclosure) in clinical supervision. The findings suggested that supervisees withheld information related to clinical supervision more often than information related to their clinical work, and both occurred much less often than expected. The data suggested that the supervisory working alliance explained how supervisor multicultural competence predicted supervisee nondisclosure.

*Keywords:* clinical supervision, supervisee nondisclosure, supervisory working alliance

Clinical supervisors are responsible for evaluating whether therapists-in-training have the clinical skills needed to be competent mental health professionals (Bernard & Goodyear, 2019). The research suggests that supervisors largely rely on supervisee self-report rather than directly observing clinical work (Amerikaner & Rose, 2012). Thus, supervisors depend on supervisees' willingness to disclose accurately and fully in supervision. Most supervision models implicitly assume that supervisees willingly disclose information about themselves, clients, therapy, and supervision (Ladany, Hill, Corbett, & Nutt, 1996). Nevertheless, it appears that supervisees often withhold information from their supervisors (e.g., Mehr, Ladany, & Caskie, 2010; Yourman & Farber, 1996). Thus, supervisors may not have the information needed to facilitate supervisee development, ensure optimal client care, and minimize legal risk (Bernard & Goodyear, 2019).

Although supervisee nondisclosure (SND), defined as willful withholding of information from one's supervisor, arguably threatens the effectiveness of supervision (Knox, 2015), the extant SND research is largely descriptive, not adequately substantiated, and at times equivocal (e.g., Hess et al., 2008; Mehr et al., 2010; Webb & Wheeler, 1998). Whereas some evidence suggests that SND is a two-dimensional construct consisting of clinically related (e.g., clinical

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mistakes; CRND) and supervision-related nondisclosures (e.g., negative reactions to one's supervisor; SRND; Gibson, Ellis, & Friedlander, 2019; Jakob, Weck, Höfling, Richtberg, & Bohus, 2014; Webb & Wheeler, 1998; Yourman & Farber, 1996), SND is most often conceptualized unidimensionally (e.g., Mehr, Ladany, & Caskie, 2015). It is not surprising then that the salient constructs predictive of multidimensional SND have yet to be identified and tested. If these constructs are not identified, supervisors may unwittingly perpetuate SND, and be ill-equipped to reduce its occurrence.

Although multiple constructs may predict one or both types of SND, two seem particularly salient. One relational construct is the supervisory working alliance (SWA), defined as the supervisor and supervisee's emotional bond, and their agreements on the tasks and goals of supervision (Bordin, 1983). A strong alliance is considered the most important ingredient of training and supervision (Bernard & Goodyear, 2019), and a robust predictor of supervision outcomes, including supervision effectiveness (Ladany, Mori, & Mehr, 2013) and adaptive goal-setting (Lehrman-Waterman & Ladany, 2001). Indeed, data suggest that trainees who perceive the SWA positively report less SND overall (i.e., Gunn & Pistole, 2012; Mehr et al., 2010, 2015; Siembor & Ellis, 2012) and lower clinically and supervision related nondisclosures (Gibson et al., 2019; Webb & Wheeler, 1998). These theoretical connections warrant further investigation.

A second construct to consider is supervisees' perceptions of their supervisors' multicultural competence (i.e., the extent to which the supervisor possesses the attitudes, knowledge, and skills needed to work effectively with diverse supervisees and their clients; Inman, 2006). Because all supervision is essentially multicultural supervision (Bernard & Goodyear, 2019; Gardner, 2002), when supervisors dismiss trainee attempts to address cultural issues, or pathologize culturally congruent trainee or client behaviors, supervisees may become more guarded (Burkard et al., 2006; Burkard, Knox, Hess, & Schultz, 2009; Dressel, Consoli, Kim, & Atkinson, 2007). Hence, culturally insensitive supervisors may exacerbate SND in supervision (Duan & Roehlke, 2001). Although qualitative studies (e.g., Burkard et al., 2006, 2009) suggest that supervisor multicultural competence may be an important predictor of the two types of SND, these relations have yet to be tested directly.

In short, the most salient constructs for clinical supervision, beyond the alliance, remain largely unknown (Bernard & Goodyear, 2019). Specifically, supervisors may not know how to promote supervisee disclosure to foster supervisee learning and ensure effective clinical treatment. Thus, as long as supervisors rely on supervisees to disclose in supervision, research that endeavors to identify and test the relative importance of constructs that have been theorized to be influential for SND in supervision seems indispensable. Therefore, the purpose of this study was to advance theorizing regarding SND by investigating the extent to which supervisees' perceptions of the SWA, and their supervisors' multicultural competence, predicted SND.

## Nondisclosure in Supervision

Theoretically, two factors warrant consideration: the evaluative relationship and supervisors' inability to monitor supervisees' work fully. First, clinical supervision in the U.S. is inescapably evaluative and hierarchical (Bernard & Goodyear, 2019). Consequently, supervisees may be motivated to withhold information (Knox, Burkard, Edwards, Smith, & Schlosser, 2008). Indeed, trainees reported withholding information from their supervisors because they (a) believed their supervisors would judge it to be irrelevant (Ladany et al., 1996; Mehr et al., 2010); (b) experienced negative feelings, including shame and disappointment, toward their supervisors (e.g., Hess et al., 2008; Mehr et al., 2010; Pisani, 2005); (c) perceived differences in cultural background or therapy approaches as a source of conflict (Hess et al., 2008; Knox, 2015; Webb & Wheeler, 1998); (d) were concerned about clinical mistakes or vulnerabilities (e.g., Knox, 2015); and (e) wanted to ensure positive evaluations (Hess et al., 2008). Second, even when recordings are used, supervisors cannot review everything. Indeed, 80% of Amerikaner and Rose's (2012) supervisees chose the material to present. Thus, supervisors' capacity to oversee supervisees' clinical work and/or address problems in supervision depends on supervisees disclosing.

Previous research on SND found interesting trends: (a) 40% to 97% of supervisees reported withholding information from supervisors (Ladany et al., 1996; Mehr et al., 2010; Yourman & Farber, 1996); (b) most nondisclosures pertained to negative reactions to supervisors or supervision, and perceived clinical mistakes (e.g., Hess et al., 2008; Ladany et al., 1996; Mehr et al., 2010; Pisani, 2005; Yourman & Farber, 1996); (c) supervision-related nondisclosures were more prevalent than clinically related nondisclosures when type of SND was assessed (Gibson et al., 2019; Jakob et al., 2014; Webb & Wheeler, 1998); (d) the prevalence of SND was consistent across discipline (e.g., social work trainees; Pisani, 2005,master's-level counselors, Webb & Wheeler, 1998; and clinical and counseling psychology doctoral trainees, Mehr et al., 2010; Yourman & Farber, 1996); and (e) SND occurred across levels of training (beginner trainees, Pisani, 2005; predoctoral trainees, Hess et al., 2008). Most participants were worried that disclosing would exacerbate the difficulties in their already tenuous SWAs (e.g., Hess et al., 2008; Mehr et al., 2010; Sweeney & Creaner, 2014). Ironically, a vicious cycle may ensue wherein a poor alliance may impede supervisees' willingness to disclose their concerns, which then persists because unaware supervisors lack the opportunity to resolve the issues, potentially further compromising the quality of the alliance (Bernard & Goodyear, 2019).

## The Supervisory Working Alliance (SWA)

Per Bordin (1983), the SWA entails "a collaboration for change" (p. 73), wherein the supervisor and supervisee develop mutually agreed upon goals and tasks in the context of a supportive relationship (Bernard & Goodyear, 2019). A strong SWA necessitates safety and trust so that supervisees can share their struggles in the service of their learning and client change. Thus, nonjudgmental and empathic supervisors are more likely to promote open communication and, in turn, meet their supervisees' and their clients' needs concurrently (Knox, 2015).

In a poor alliance, supervisees perceive their supervisors and supervision negatively (e.g., feelings of frustration, disappointment, shame; Hess et al., 2008; Ladany et al., 1996; Mehr et al., 2010; Webb & Wheeler, 1998), and experience their supervisors as overwhelmingly dismissive and unsupportive of their needs and concerns (Sweeney & Creaner, 2014). In fact, half of Ladany et al.'s (1996) participants cited a poor SWA as the reason for not disclosing in supervision. Webb and Wheeler (1998) later found

that the SWA and SND were inversely related; as the quality of the alliance decreased, both types of SND increased. This finding, however, lacks replication.

## Multicultural Competence in Supervision

Sue, Arredondo, and McDavis's (1992) renowned tripartite model of multicultural competence is comprised of beliefs and attitudes, knowledge, and skills. Beliefs and attitudes entail striving for self-awareness and regularly examining one's cultural background, biases, and assumptions. Knowledge comprises an understanding of clients' experiences within their cultural contexts. Finally, skills refer to the use of culturally sensitive interventions. Given their importance for trainee development and client welfare, multicultural issues in supervision have received increased empirical attention (Inman, 2006). Overall, the findings (e.g., Dressel et al., 2007; Soheilian, Inman, Klinger, Isenberg, & Kulp, 2014) highlight the need for supervisors to initiate and be responsive to cultural discussions, and underscore the consequences of supervisors' lack of cultural awareness. When supervisors are unaware of how their areas of privilege (e.g., being White, heterosexual) confer additional social power beyond that inherent in their supervisory roles, not only will they be unprepared to model culturally sensitive practice, they may also engage in acts of discrimination toward supervisees and/or their clients (Ladany, 2014).

Evidence suggests that a supervisor's lack of multicultural competence deleteriously effects the SWA and the sense of safety and trust supervisees need to disclose (Inman, 2006). This makes sense given that graduate trainees are increasingly diverse and multicultural training has become a focus in mental health education (Soheilian et al., 2014). For example, supervisor insensitivity to gender (Walker, Ladany, & Pate-Carolan, 2007), sexual orientation (Burkard et al., 2009), and racial and ethnic differences (Burkard et al., 2006) led to withholding information in supervision. Moreover, supervisor cultural insensitivity has been cited as a reason for SND (Hess et al., 2008; Ladany et al., 1996; Webb & Wheeler, 1998). Because negative reactions to supervision appear to be the most common type of SND (e.g., Jakob et al., 2014), and supervisors' lack of cultural competence compromises supervisees' positive perceptions of supervision (e.g., Burkard et al., 2006), supervisees who perceive their supervisors as multiculturally incompetent may withhold information in supervision (SND).

## Hypotheses

We hypothesized that (a) the SWA and supervisor multicultural competence would collectively and inversely predict the multivariate composite of both SND types: clinically related nondisclosures (CRND) and supervision related nondisclosures (SRND; Hypothesis 1: H1); (b) controlling for supervisor multicultural competence, the SWA would uniquely and inversely predict SND (Hypothesis 2: H2); and (c) controlling for the SWA, supervisees' perceptions of their supervisors' multicultural competence would uniquely and inversely predict SND (Hypothesis 3: H3). As there was insufficient theorizing for hypotheses of any differential effects on SRND and CRND, we only performed follow-up tests for significant SND findings.

# Method

## Participants

**Participant characteristics.** An a priori power analysis with a per comparison $\alpha = .025$ and a conservative effect size of 0.05 indicated that 186 participants were needed for power of .80 (Cohen, Cohen, West, & Aiken, 2003). Eligible participants were trainees enrolled in mental health graduate programs currently engaged in clinical work, and receiving formal individual clinical supervision for at least one month. The majority of the 221 participants were female (80.0%), with a mean age of 29.39 years ($SD = 6.82$). Participants identified as Caucasian (68.2%), Asian American/Pacific Islander (9.5%), Bi/Multiracial (7.7%), Latino/a/Hispanic (6.4%), African American (5.5%), Native American (1.8%), and other (0.9%). In terms of sexual orientation, most participants identified as heterosexual (86.9%); participants also identified as bisexual (4.5%), gay (3.2%), lesbian (2.7%), queer (1.4%), and other (1.4%). Participants identified as agnostic (17.2%), spiritual/not religious (16.7%), Roman Catholic (15.8%), Protestant (15.4%), atheist (10.4%), Jewish (6.3%), Buddhist (3.2%), Hindu (2.3%), Evangelical Christian[1] (2.3%), Muslim (.5%), and other (10.0%, e.g., Wiccan, Pagan, etc.). The largest proportion of participants (41.2%) identified as middle class; participants also identified as upper middle class (24.9%), lower middle class (15.8%), working class (11.3%), lower class (3.6%), lower upper class (1.8%), and upper class (1.4%). Most participants (93.7%) were able-bodied.

Regarding education, 57.9% of participants held master's and 32.1% had bachelor's degrees. The majority were in counseling psychology programs (54.8%) or from clinical psychology (19.9%) and mental health counseling (15.8%) programs. Participants had an average of 3.34 years of clinical experience ($SD = 2.48$) and an average of 5.36 supervisors ($SD = 3.40$), including their current supervisors. Most participants were at college counseling centers (41.6%), community mental health centers (17.6%), and university-based training centers or clinics (12.2%). Most participants either were completing a practicum (47.3%) or were on internship (35.0%). The majority (55.7%) had received training in clinical supervision. Participants had taken, on average, 3.03 ($SD = 2.94$, $Mdn = 2.00$) graduate courses focused on multicultural counseling, 5.73 courses ($SD = 3.21$, $Mdn = 5.00$) where multicultural topics were an integral part, and had attended an average of 6.09 multicultural workshops ($SD = 3.80$, $Mdn = 5.00$). Participants rated it to be very important to address cultural issues in clinical training and practice ($M = 9.16$, $SD = 1.37$, $Mdn = 10$, where 1 = *not important at all* to 10 = *very important*).

Participants worked with their current primary supervisors for an average of 7.99 months ($SD = 25.03$, $Mdn = 6.00$) and 23.68 sessions ($SD = 35.67$, $Mdn = 15.00$). The supervisors were mainly female (66.8%) and White (76.0%), as well as Asian American/Pacific Islander (7.2%), Latino/a/Hispanic (5.0%), African American (4.5%), Bi/Multiracial (3.6%), and other (1.4%). Most supervisors were trained in counseling (38.0%) or clinical (30.3%) psychology programs. Most participants' supervisors

[1] Participants chose "other" and self-identified as Evangelical Christians.

were reportedly licensed in their field (83.1%); however, 12.8% were not, and 4.1% of participants did not know their supervisors' licensure status.

## Measures

To improve the scientific rigor of the one-group *ex post facto* research design, we tested proxy comparison groups (e.g., Shadish, Cook, & Campbell, 2002); the scores on the major variables were compared to their respective norms. These data served (a) to provide a context for interpreting the subjects' scores descriptively, (b) to better understand and circumscribe the study's sample and inferences thereof, and (c) to aid in interpreting the major findings.

**Supervisee Non-Disclosure Scales (SNDS).** The self-report SNDS (Ellis & Colvin, 2016; Siembor & Ellis, 2012) measures the extent to which supervisees intentionally withhold information from their supervisors. Siembor and Ellis's (2012) 30 items were rated on a 7-point Likert-type scale (1 = *fully disclosed*, 7 = *decided to not disclose*), with a *not applicable* (NA) option. An 11-item SNDS (Ellis & Colvin, 2016) was derived and tested via graded response item response theory (IRTPRO; Cai, Thissen, & du Toit, 2011). A rating scale utility analysis (Linacre, 1999) yielded a 3-point scale (1 = NA, and 1, *fully disclosed*; 2 = 2–6, *somewhat disclosed*; 3 = 7, *decided to not disclose*). Items with better fit indices, as measured by an item-level fit statistic, $S-\chi^2$ (Kang & Chen, 2011), and the standardized local dependence $\chi^2$ fit statistic (Liu & Thissen, 2014), were retained, yielding two SNDS scales: Clinically Related Non-Disclosures (CRND; 7 items) and Supervision Related Non-Disclosures (SRND; 4 items). The goodness of fit indices suggested acceptable psychometric properties, CRND: $M_2(77) = 442.36$, $p < .001$, RMSEA = .07; "marginal reliability," similar to Cronbach's alpha, was .83; SRND: $M_2(20) = 446.34$, $p < .001$, RMSEA = .20, marginal reliability = .77. IRT scores range from 1 to 10; higher scores indicate greater nondisclosure. Participants' CRND and SRND scores (see Table 1) did not differ ($\alpha_{pc} = .01$) from the original scores ($M = 4.22$; $M = 4.11$, respectively), $t(218)$s $< 3.39$, $p$s $> 0.02$, $\hat{\rho}^2$s $< 0.045$, CI [.01, .11].

**Supervision Working Alliance Inventory—Trainee Version (SWAI-T).** Based on Bordin (1983), the SWAI-T (Bahrick, 1989) is a self-report measure of supervisees' perceptions of the supervisory working alliance. Composed of 36 items with three 12-item subscales (agreement on goals, agreement on tasks, and the emotional bond), items are rated on a 7-point Likert-type scale from 1 (*never*) to 7 (*always*) with 14 reverse-scored items. Total scores range from 36 to 252; higher ratings indicate a stronger working alliance. Due to highly intercorrelated subscales, total scores are preferred (e.g., Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999). Cronbach's alphas were .97 in prior research (e.g., Ladany et al., 1996) and the current study. Participants' SWAI-T scores (see Table 1) did not differ ($\alpha_{pc} = .01$) from the original scores (Bahrick, 1989; $M = 204.50$), $t(218) = 2.23$, $p = .03$, $\hat{\rho}^2 = 0.02$, CI [.001, .065].

Table 1
*Means, Standard Deviations, Inter-Correlations, and Cronbach Alpha Coefficients Among the Major Variables*

| Variable | *M* | *SD* | SRND | CRND | SWA | SMC |
|---|---|---|---|---|---|---|
| SRND | 4.80 | 2.76 | .77 | | | |
| CRND | 3.70 | 1.80 | .37* | .83 | | |
| SWA | 198.47 | 40.01 | −.60* | −.43* | .97 | |
| SMC | 127.26 | 39.79 | −.41* | −.26 | .70* | .98 |

*Note.* SRND = Supervision-Related Supervisee Nondisclosure; CRND = Clinically-Related Supervisee Nondisclosure; SWA = Supervisory Working Alliance; SMC = Supervisor Multicultural Competence. Cronbach's alpha coefficients are presented in the diagonal, except for SRND and CRND, which are marginal reliabilities for IRT scores.
* $p \leq .005$.

**Supervisor Multicultural Competence Inventory (SMCI).** The SMCI (Inman, 2006) is a 34-item self-report measure assessing trainee perceptions of supervisor multicultural competence. Rated on a 6-point Likert-type scale (1 = *never* to 6 = *always*), summed item total scores range from 34 to 204 such that higher scores suggest greater SMC. The measure, which was developed and validated using a sample of 147 marital and family therapy (MFT) trainees, evidenced a Cronbach's coefficient alpha of 0.97 and convergent validity. Observed Cronbach's alpha was 0.98. Participants' SMCI scores (see Table 1) were significantly lower than the initial sample ($M = 144.84$; Inman, 2006), $t(218) = -6.54$, $p < .0001$, $\hat{\rho}^2 = 0.16$, CI [.09, .24].

## Procedure

Participants were solicited via e-mails to training directors of APA-accredited programs and internships through professional listserv and social media postings, as well as e-mails to colleagues. Trainees were invited to participate in a study on "participants' experiences in multicultural clinical supervision." Using a password-protected website, measures were administered in counterbalanced order to avoid sequence effects, followed by the demographic questionnaire, which was presented last. For every 20 participants, one $30 Amazon.com gift card was randomly awarded. Response rate was not obtainable due to the impossibility of calculating how many individuals were reached via emails and postings.

# Results

## Missing Data and Preliminary Analysis

Of 261 initial respondents, 37 discontinued the study, and 3 were dropped due to missing more than five percent of item responses on a given measure. For others with missing data (randomly), responses were deduced via logical imputation procedures. Testing the statistical assumptions revealed no leverage, influential cases, multivariate outliers, or violations of linearity, normality, homoscedasticity, independence of data, multicollinearity, or measure administration sequence effects. Thus, the data appeared appropriate for the major analyses.

## Major Analyses

We conducted a simultaneous multivariate multiple regression analysis ($\alpha_{pc} = .025$) to test the unique and collective contributions of the SWA and supervisor multicultural competence in predicting the multivariate composite of SND (Cohen et al., 2003). We used the

univariate $F$ tests plus the standardized discriminant function coefficients (*sdfc*; Haase & Ellis, 1987) to follow up significant multivariate effects. The test of H1 (the SWA and supervisor multicultural competence collectively, and inversely predict the multivariate composite of SND) was significant, $\hat{\rho}^2_{MV} = .19$, Pillai's $V = 0.42$, $F(4, 436) = 28.59$, $p < .0001$, CI [0.12, 0.28], where $\hat{\rho}^2_{MV}$ is the estimated population multivariate effect size or adjusted multivariate $R^2$ (Haase & Ellis, 1987). Supervisor multicultural competence, in combination with the SWA, were significantly related to SRND, $F(2, 218) = 62.19$, $p < .0001$, $\hat{\rho}^2 = .36$, CI [0.27, 0.44], *sdfc* = 0.83, and CRND, $F(2, 218) = 24.89$, $p < .0001$, $\hat{\rho}^2 = .18$, CI [0.11, 0.26], *sdfc* = 0.45. Thus, H1 was supported. The test of H2 (the SWA uniquely and inversely predicts the multivariate composite of SND controlling for supervisor multicultural competence) was significant, $\hat{\rho}^2_{MV} = .28$, Pillai's $V = 0.29$, $F(2, 217) = 43.47$, $p < .0001$, CI [0.20, 0.37], thus, supporting H2. Regarding the relative contributions of the SWA to each SND component controlling for supervisor multicultural competence, the SWA significantly predicted SRND, $F(1, 217) = 67.70$, $p < .0001$, $\hat{\rho}^2 = .23$, CI [0.15, 0.32], *sdfc* = 0.81, and CRND, $F(1, 217) = 31.23$, $p < .0001$, $\hat{\rho}^2 = .12$, CI [0.06, 0.20], *sdfc* = 0.48. The test for H3, supervisor multicultural competence uniquely predicts the multivariate composite of SND controlling for the SWA, was not significant, $\hat{\rho}^2_{MV} = 0.0$, Pillai's $V = 0.004$, $F(2, 217) = .42$, $p = .66$, CI [0.00, 0.01]; thus, H3 was not supported.

### Post Hoc Analyses

The pattern of findings suggested that the SWA may mediate the relation between supervisor multicultural competence and SND (Hayes, 2017). Given the research identifying the working alliance as a mediator of cultural variables and therapy outcomes (e.g., Hook, Davis, Owen, Worthington, & Utsey, 2013), it seemed reasonable to infer that the SWA might explain how and why supervisor multicultural competence inversely predicts SND (i.e., SWA may be the mechanism through which supervisor multicultural competence predicts SND). We hypothesized, post hoc, that the SWA would mediate the inverse relation between supervisor multicultural competence and SND. Per Hayes (2017), to assess if the path coefficients (here effect size) between supervisor multicultural competence and the multivariate composite of SND differed when SWA was and was not included required an additional analysis, testing if supervisor multicultural competence inversely predicted SND. The multivariate regression ($\alpha_{pc} = .017$) was significant, $\hat{\rho}^2_{MV} = .17$, Pillai's $V = 0.18$, $F(2, 218) = 24.03$, $p < .0001$, CI [0.11, 0.26]. Supervisor multicultural competence was significantly related to SRND, $F(1, 219) = 43.44$, $p < .0001$, $\hat{\rho}^2 = .16$, CI [0.10, 0.25], *sdfc* = 0.85; and CRND, $F(1, 219) = 16.27$, $p < .0001$, $\hat{\rho}^2 = .07$, CI [0.02, 0.13], *sdfc* = 0.33. Thus, the path coefficient dropped significantly from $\hat{\rho}^2_{MV} = .17$ to $\hat{\rho}^2_{MV} = 0.0$ when SWA was included as a mediator (H2), supporting the hypothesis that SWA mediates the inverse relation between supervisor multicultural competence and SND.

## Discussion

### Major Findings

The major findings of this study were (a) two sets of descriptive findings (the comparative data for the major variables, and the overall level of SND and specific levels of CRND and SRND), (b) the unique contribution of the SWA to predicting SND, and (c) the SWA may mediate the relation between supervisor multicultural competence and SND. Descriptively, compared to Inman's (2006) MFT trainees, participants in this study rated their supervisors' multicultural competence lower. Perhaps this was due to our participants completing several multicultural courses and workshops and highly valuing cultural issues. Previous research (e.g., Burkard et al., 2006; Dressel et al., 2007) suggests that supervisees' multicultural training and the value they ascribe to diversity seem to influence how they perceive their supervisors' multicultural competence. Perhaps our participants evaluated their supervisors more critically (e.g., Duan & Roehlke, 2001), or perhaps their supervisors were less multiculturally competent.

Descriptively, the content and incidence of nondisclosures differed from the bulk of the previous research in two fundamental ways. First, participants in the current study and three recent studies (i.e., Gibson et al., 2019; Jakob et al., 2014; Siembor & Ellis, 2012) reported low levels of SND overall, whereas other researchers (e.g., Ladany et al., 1996; Hess et al., 2008; Mehr et al., 2010, 2015) found that supervisees frequently withhold information from their supervisors. Second, the most commonly reported SNDs in the literature pertained to supervisees' negative reactions to supervision and their perceived clinical mistakes (e.g., Hess et al., 2008; Webb & Wheeler, 1998; Yourman & Farber, 1996). Indeed, Mehr et al. (2010) and Ladany et al. (1996) found that 38% and 90% of supervisees, respectively, did not disclose their negative reactions to their supervisors, and 44% withheld clinical mistakes (Ladany et al., 1996). Like others (Gibson et al., 2019; Jakob et al., 2014; Siembor & Ellis, 2012), (a) supervision-related nondisclosures were the most frequent type of SND here, but only 23% of participants withheld this information from their supervisors, and 29% indicated that it was not applicable, and (b) nearly half of our participants reported disclosing fully their clinical mistakes in supervision—only 1.4% decided not to disclose this information. The divergences are intriguing.

Clinical experience seemed to differentiate recent (e.g., Jakob et al., 2014; Siembor & Ellis, 2012) from previous studies (e.g., Ladany et al., 1996; Mehr et al., 2010). Earlier studies averaged 1–1.3 years of experience, whereas our participants and recent studies (Gibson et al., 2019; Jakob et al., 2014; Siembor & Ellis, 2012) averaged 2–3 or more years of experience. Paralleling Gibson et al. (2019), supervised clinical experience, however, was not significantly related to SND or either type of SND in our sample (nor were any of the other demographic variables), thus disconfirming this proposition. Nevertheless, it appears we can tentatively conclude that recent evidence suggests that CRND occur less frequently than SRND, and both occur much less often than found in previous studies. Further research is warranted.

Regarding the SWA and supervisor multicultural competence predicting SND, and in particular CRND and SRND, the working alliance was uniquely and inversely related to SND, and post hoc testing suggested that the SWA seems to be the mechanism through which the inverse relation between supervisor multicultural competence and SND can be explained (i.e., mediation). Consistent with previous studies (e.g., Ladany et al., 1996, 2013; Mehr et al., 2010, 2015; Webb & Wheeler, 1998), the quality of the SWA also appears to be a strong predictor of both types of SND. In fact, when assessing the relative contributions of the

SWA to each type of SND, the alliance accounted for almost twice as much variance in SRND relative to CRND (23% vs. 12%, respectively). Hence, in the context of an evaluative relationship, talking with one's supervisor about supervision and the supervisor's actions (or inactions) appears risky and thus at least partially dependent on the quality of the SWA.

Given that a strong SWA is considered essential for effective supervision (e.g., Bernard & Goodyear, 2019; Ladany et al., 2013), it is not startling that the SWA emerged as the dominant predictor of SND. Nevertheless, that it appears to explain the influence of perceived supervisor multicultural competence on SND was unexpected. Consistent with the finding that when supervisors are not sensitive to culture in supervision, supervisees withhold information to protect themselves and their clients (Burkard et al., 2006, 2009; Walker et al., 2007), supervisor multicultural competence appears to contribute, albeit indirectly, to our understanding of SND. Our and other (Inman, 2006) findings suggest that the SWA and supervisor multicultural competence are strongly related, such that a stronger SWA is associated with higher perceived supervisor multicultural competence, which, in turn, appears to be associated with lower levels of both types of SND, but especially those related to supervision. Thus, these results offer a more nuanced understanding of how SWA may operate vis-à-vis SND. That is, we can tentatively infer that the SWA is not just a major predictor of SND, but may also be a mediator. Indeed, psychotherapy process studies found that the therapeutic alliance mediated the relation between cultural variables and therapy outcomes (e.g., cultural humility; Hook et al., 2013). As such, the SWA may serve as the explanatory mechanism for other supervision variables.

### Limitations

Several limitations were apparent. First, we used a cross-sectional, one-group (supervisees), ex post facto research design that presents inherent limitations. For example, the lack of longitudinal data precludes an assessment of how these variables and their relations may shift over time. Second, although the SMCI scores demonstrated strong reliability (i.e., Cronbach's alpha $\geq$ .90) in both the original (Inman, 2006) and present studies, the psychometric properties require further testing. Third, participants were disproportionately psychology students who tended to be White, heterosexual, able-bodied, middle-class females who were United States citizens, trained in supervision, and highly knowledgeable about and invested in multicultural issues, thus potentially circumscribing the results to this subset of trainees. Fourth, a response rate was unobtainable given our recruitment process (e-mails and listserv postings). Moreover, it is possible that participants who were interested in multicultural supervision and/or who had particularly positive or negative supervision experiences were more likely to participate, thus limiting the generalizability of our findings and introducing the possibility that these biases influenced the results. Finally, our participants had been working with their current supervisors for a median of half a year. It is unknown whether this pattern of results would hold for supervisees working with their supervisors for less time.

### Strengths

We aimed to advance theorizing by identifying and testing constructs that may predict SND using psychometrically viable measures. Other conceptual–methodological strengths included reporting detailed sample demographic data, specifying falsifiable hypotheses, testing the statistical assumptions, controlling measure administration order effects, controlling studywise Type I and Type II error rates, statistically controlling confounds among the variables, and testing proxy comparative samples to contextualize the sample and results.

## Implications for Training and Practice

The findings suggest that to facilitate supervisees' disclosure, promote their development, and protect client welfare, supervisors need to have the knowledge, skills, and attitudes to work competently with diverse supervisees and their clients, and build strong SWAs with their supervisees (Ladany et al., 1996, 2013; Mehr et al., 2010, 2015). A supportive supervisory alliance involves supervisors creating a climate where supervisees can openly discuss (a) the relationship, (b) the power differential in supervision, (c) their reactions to the supervisor and supervision, and (d) the supervisor's, supervisee's, and client's multiple intersecting identities (Inman, 2006; Soheilian et al., 2014). When supervisors initiate these discussions, an atmosphere of transparency can be promoted, thereby enhancing diverse supervisees' willingness to disclose in supervision (Knox, 2015; Knox et al., 2008) and in turn furthering their ability to intervene effectively with diverse clients (e.g., Gardner, 2002). We encourage supervisors to address nondisclosure early on and explicitly both to normalize it and to facilitate supervisee disclosure.

## Directions for Future Research

First, a more nuanced understanding of the SWA and how it operates is needed as this is the first study to investigate the relation between supervisor multicultural competence and SND. Chiefly, the post hoc finding that the SWA mediates the relation between supervisor multicultural competence and SND needs to be tested a priori with a new sample. Second, our and others' results (e.g., Gibson et al., 2019; Gunn & Pistole, 2012) suggest that continued study of the SWA in relation to the two types of SND is warranted. Replicating this study with a more diverse sample (e.g., cultural characteristics, training backgrounds, and clinical experience) may enhance the generalizability of our results and help explain our sample's low levels of SND. Others might also extend this work by including other cultural variables, such as supervisor multicultural orientation, and cultural humility (e.g., Hook et al., 2013), to determine their relations to SND and whether the SWA also serves as a mediator between these variables and both types of SND. Similarly, it might be important to investigate the influence of other dimensions of supervisor competence (e.g., competence in providing feedback) in relation to the SWA and SND. Third, given the cross-sectional design, it seems worthwhile to explore how SND changes over time and across supervisors and settings. Such research could assess longitudinally whether particular types of SND and supervisees' overall SND fluctuate as trainees progress and how perceived changes in the alliance (e.g., ruptures) may influence supervisees' willingness to disclose. Fourth, although we tested the supervisor demographic variables and found no evidence of multiple supervisees per supervisor (i.e., nested data), we encourage researchers to approach this issue proactively (e.g., mul-

tilevel research designs). Finally, as SND risks limiting supervisors' access to the information needed to protect client welfare (Ladany et al., 1996), including client outcomes in the future would be beneficial.

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