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SHAME AND RESILIENCE AMONG MENTAL HEALTH TRAINEES:

A SCALE CONSTRUCTION STUDY

by

Claire T. Hauser

A DISSERTATION

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SHAME AND RESILIENCE AMONG MENTAL HEALTH TRAINEES:

A SCALE CONSTRUCTION STUDY

Claire T. Hauser, Ph.D.

University of Nebraska, 2016

Advisor: M. Meghan Davidson

Contemporary research has revitalized interest in the construct of shame, and the pervasive nature with which it impacts psychological functioning. It has been argued that mental health professionals encounter shame regularly in the therapeutic milieu and must be equipped to assist clients in developing shame resilience. The process of learning to provide shame attendant therapy begins during graduate training, as mental health trainees (MHTs) gain first hand experience with feeling shame through the evaluative nature of the training process. Although shame in the MHT role has been discussed in prior literature, it is difficult to study due to lacking instrumentation. Therefore, the purpose of this study was to construct a quantitative instrument for measuring shame and shame resilience among graduate students in mental health training. Using a mixed methods approach, this study included item generation, exploratory factor analysis, and validity estimates with previously published scales. The result is the Shame and Resilience Among Mental Health Trainees Scale (SRMHT), a four-factor, scenario-based instrument, that measures shame proneness as well as shame resilience. The SRMHT demonstrated strong internal consistency reliability and construct validity, and produced a factor structure that closely aligns with the tenets of shame resilience theory. Overall, this study provides support for prior research and theory, while generating a novel tool for use in mental health trainee development.

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CHAPTER ONE: INTRODUCTION

The purpose of the project described herein is to construct a scale for measuring the constructs of shame and shame resilience among mental health trainees. Within this initial chapter, the constructs of *shame* and *resilience* are introduced to the reader and placed within the context of mental health training. Following this, a brief overview of measurement issues regarding shame and other self-conscious emotions is provided. The aim of this introductory chapter is to introduce the reader to core concepts that are described in-depth within later chapters.

Overview of Shame

For most individuals, simply encountering the concept of *shame* elicits an instinctive reaction of discomfort and repulsion. From an objective point of view, the degree of visceral reactivity to this word may seem excessive; however, the feelings and experiences represented by shame resonate powerfully within each of us (Brown, 2009; Dearing & Tangney, 2011; Hultberg, 1988; Lewis, 1971). Shame is the affective experience, or feeling, of believing that one is inherently flawed, defective, or inadequate, and therefore unworthy of love, acceptance, and belonging with others (Brown, 2009; Dearing & Tangney, 2011; Lewis, 1971). Typically, feelings of shame arise when one has made a mistake, committed a transgression, or feels deficient in comparison to social and cultural standards. The central fear underlying shame is the threat of social disconnection (Brown, 2006, 2009; Lewis, 1971). Although shame is uncomfortable, it is a consequence of the innate human drive for love, approval, and belongingness (Brown, 2006; Kemeny, Gruenewald, & Dickerson, 2004).

As with other emotions, shame occurs both as a momentary feeling or state of being, as well as an ongoing affective proneness or trait (Dearing & Tangney, 2011). State shame is

described as a feeling that "washes over" individuals immediately after a *shame episode* occurs (Brown, 2009). State shame is experienced across multiple domains of one's personhood: emotionally as inadequacy or worthlessness; physically as feeling small, shrinking, or wanting to hide; and interpersonally as wanting to quickly escape the scrutiny and disapproval of others (Brown, 2006, 2009; Dearing & Tangney, 2011; Leith & Baumeister, 1998). The discomfort of shame is augmented by inner physical symptoms that are often outwardly visible, such as flushing in the face or body, lowering one's head, trembling, and averting one's eye gaze away from others (Dearing & Tangney, 2011). This combination of emotional, physical, and interpersonal factors makes the experience of shame feel "unbearable" (Brown, 2009).

Shame proneness, or shame as a trait, influences the behaviors and actions of most people throughout their daily lives (Dearing & Tangney, 2011). In an effort to avoid shame and the rejection it signifies, individuals strive to present themselves in a manner that is acceptable to others. The efforts required to engage in this form of impression management extend beyond adherence to social norms; Brown (2009) argued that shame proneness interferes with the ability to demonstrate appropriate vulnerability and authenticity. Paradoxically, attempting to avoid shame through posturing in a socially desirable manner tends to interfere with social connectedness and contributes to feelings of isolation and inadequacy (Brown, 2009).

Shame is characterized as a self-evaluative emotion, residing within the same emotional family as guilt, humiliation, and embarrassment (Brown, 2009; Dearing & Tangney, 2011; Lewis, 1971). These affective experiences are so closely related that their labels are often confused and conflated. Shame is distinguished from guilt, humiliation, and embarrassment due to the unique nature of its associated attributions; when we feel shame, we attribute the associated "badness," defectiveness, or inadequacy to our core or fundamental self (Lewis,

1971). In contrast, negative feelings that arise in the forms of guilt, embarrassment, or humiliation are externally attributed and therefore amenable to change (Brown, 2009). In sum, shame is the most destructive self-evaluative emotion because it contributes to the development of a self-concept that is defective and beyond repair.

Research has demonstrated that the impact of shame is expansive and detrimental. Shame is associated with a variety psychological disorders and symptoms, such as depression (Kim, Thibodeau, & Jorgensen, 2011) and suicidal ideation (Hastings, Northman, & Tangney, 2000). Maladaptive coping behaviors like drug and alcohol use (Dearing, Stuewig, & Tangney, 2005) and eating disorders (Sanfter & Tantillo, 2011) appear to have reciprocal and reinforcing relationships with shame. Furthermore, interpersonal functioning is diminished when feelings of shame manifest as hostility, aggression, lack of empathy, and intense self-focus (Dearing & Tangney, 2011; Ferguson, Eyre, & Ashbaker, 2000).

Despite these negative outcomes, an attempt to completely extinguish feelings of shame would be futile. As humans, as long as we care about connectedness and social belonging, experiencing this universal emotion is unavoidable. Despite the inevitability of shame, there is hope in the concept of shame resilience (Brown, 2006; Brown, 2009).

Shame Resilience

According to shame resilience theory (SRT; Brown, 2006) we can learn to *move through* feelings of shame by engaging in empirically identified practices. These practices entail examination of self, awareness of cultural context, and intentionality in interpersonal relationships. Regarding self-examination, SRT posits that by learning to recognize the physical symptoms of shame (e.g., heart racing, feeling warm, throat tightening), individuals can more easily discern when they are “in shame” and thereby take steps to proactively cope and recover.

Self-examination is also required for identifying personal shame triggers across the salient domains of one's life. Shame triggers take the form of *ideal identities*, or desired ways of being viewed by self and others, and *unwanted identities*, which are feared ways of being perceived. Also, self-examination regarding the necessity of vulnerability is embedded within shame resilience practices. In order to gain resilience, we must first identify areas in which we are vulnerable or "open to attack" (Brown, 2009). Additionally, vulnerability is conceptualized as the "birthplace of creativity" and meaningful human expression within the SRT framework (Brown, 2009).

Practicing critical awareness about the expectations and standards within one's cultures, as well as the larger society, helps us to understand the messages that fuel feelings of shame. In order to gain this perspective, individuals may seek norming information, engage in advocacy, or find a community of others who share their experience. These practices are framed as "zooming out" in SRT, meaning that critical awareness helps us to identify external contributors to feelings of shame. Identification of macro-level factors provides another pathway for contextualizing and challenging shame (Brown, 2009).

Practicing shame resilience also takes the form of "reaching out" to others with empathy and non-judgment. SRT emphasizes the importance of establishing mutually empathic and supportive interpersonal relationships in which individuals can express feelings of shame in order to diffuse the isolation it generates. The ability to demonstrate empathy for others is inherently linked to the practice of self-compassion, meaning that we must act compassionately toward our own struggles in order to effectively empathize with others. Furthermore, creating and sustaining mutually empathic relationships requires the development of emotional and linguistic skills for describing and deconstructing shame (Brown, 2006; 2009).

Shame and Mental Health Training

Given the psychological nature of shame and its correlates, it is clearly a relevant factor for individuals seeking mental health services. Despite its bearing, it seems that shame is not often overtly addressed during therapy (Dearing & Tangney, 2011). One reason for this clinical oversight is that many mental health practitioners have not studied shame and do not adequately understand its implications (Brown, Rondero-Hernandez, & Villarreal, 2011). Aside from a gap in training, researchers who study shame and therapy have asserted that mental health practitioners also avoid shame because it can trigger their own personal vulnerabilities in session (Dearing & Tangney, 2011; Hahn, 2000); therefore, therapists must engage in their own exploration of personal shame in order to effectively facilitate shame work with clients (Brown, 2009; Dearing & Tangney, 2011).

The process of mental health training provides an important opportunity for examining shame in personal and professional forms, while also building associated resilience. Introducing the concepts of shame and shame resilience to mental health trainees would not only meet an important training objective, but would also provide space for examination of professional role shame within the process of clinical supervision. Role specific shame for mental health trainees includes the domains of therapeutic work (Dearing & Tangney, 2011; Kulp, Klinger, & Ladany, 2007; Watkins, 2012), academic performance (Alonso & Rutan, 1988), peer processes (Kemeny & Shestyuk, 2008; Kenneth, Sonne, & Greene, 2006), and experiences in supervision (Dearing & Tangney, 2011; Ladany, Friedlander, & Nelson, 2005; Sanfter & Tantillo, 2011). Facilitating awareness of shame within these role specific domains would better prepare mental health trainees for professional practice, augment gains in self-awareness, and increase their skills for effectively working with client shame (Brown, 2009).

Measuring Shame and Shame Resilience

Given the significance of shame and shame resilience in the mental health community, having a psychometrically-sound quantitative instrument for measuring shame and shame resilience among mental health trainees would be of great use. This type of measure would serve multiple functions, including (a) operationalizing the constructs of shame and shame resilience among trainees in a measurable form; (b) providing a tool for empirically studying this component of the training process; and (c) helping trainees and supervisors appraise the development of shame resilience. Current instruments for measuring shame have been constructed for use across contexts and populations, such as the Test of Self-Conscious Affect-3 (TOSCA-3; Tangney, Dearing, Wagner, & Gramzow, 2000), Other As Shamer Scale (OAS; Goss, Gilbert, & Allan, 1994), and Compass of Shame Scale (CoSS; Elison, Lennon, & Pulos, 2006). Although these instruments are valuable, assessing shame within the specific context of mental health training requires the construction of an instrument that addresses the salient and unique experiences of mental health trainees.

In sum, shame is an affective experience that affects nearly everyone, due to the innate human drive for approval, connection, and belonging. Although shame cannot be avoided, individuals can develop resilience to shame through a set of empirically derived practices. This Introduction asserts that it is essential for mental health providers to be personally and professionally equipped to work through their personal shame in order to be prepared to help clients develop shame resilience. The process of mental health training provides an important window of time and development for engaging trainees in the process of building awareness of shame and working toward personal and professional resilience. In order to facilitate this process, proper measurement of shame and shame resilience among mental health trainees must

exist. Thus, this study is a scale construction project, aiming to create a quantitative instrument for assessing mental health trainee shame and shame resilience.

The following Chapters include an in-depth account of this study, including literature review, research methods, results of analyses, and a discussion of the results. Chapter 2 provides an extensive literature review of the shame and resilience constructs, related mental health outcomes, role of shame in therapy and mental health training, and current trends in assessment of self-conscious emotions. Following the literature review, Chapter 3 describes the methods used for this study, including operationalization of the constructs, sample and participant selection, procedures for data collection, and statistical analyses. Chapter 4 details the results of data cleaning, sample refinement, statistical analyses, and the identified factor structure of the instrument. Finally, Chapter 5 synthesizes the study results, contextualizes the findings within the broader literature, and describes the applicability and limitations of this study.

CHAPTER TWO: LITERATURE REVIEW

In the text titled, *What Therapists Don't Talk About and Why,* Kenneth, Sonne, and Greene (2006) proposed that the cultures of mental health training and practice implicitly support invalid and unrealistic myths about the nature of developing as a therapist. This view is reflected in a passage that states, "We seem to be trying to hold ourselves to a standard requiring us to be immortal, invulnerable, ageless therapists…" (Kenneth et al., 2006, p. 21). For example, although graduate programs in mental health training are inherently competitive in terms of gaining entrance, acquiring resources, and demonstrating ability, aggressive dynamics among students are often not addressed (Kenneth et al., 2006), contributing to feelings of isolation and self-doubt among trainees. The authors argue that exploring and dispelling the myths and unrealistic expectations associated with mental health training and practice is essential for ensuring practitioner well-being and ultimately, the ethical delivery of quality services (Kenneth et al., 2006).

Acknowledging and examining the idealizations and vulnerabilities of the mental health training experience is theoretically linked to the affective experience of shame. Ladany, Klinger, and Kulp (2011) define *therapist shame* as "an intense and enduring reaction to a threat to the therapist's sense of identity that consists of an exposure of the therapist's physical, emotional, or intellectual defects that occurs in the context of psychotherapy" (p. 308). As with shame that is experienced throughout broader contexts, the implicitly held ideal and unwanted identities, unrealistic expectations, and fears of rejection and disconnection (Brown, 2009) underlie feelings of shame for mental health trainees.

Currently, shame is theoretically discussed in regard to mental health training (Dearing & Tangney, 2011; Hahn, 2000), but lacks empirical study. Although quantitative instruments that

measure general shame-proneness and its correlates exist, these instruments have not been utilized in the study of mental health trainee development. To wit, as shame is conceptualized as a highly contextualized emotion, it may be more beneficial to develop an instrument for measuring shame specifically within the context of mental health clinical training, classroom experiences, supervision, and peer culture dynamics from the perspective of the trainee.

The purpose of this literature review is to explore current theoretical conceptualizations and empirical findings regarding shame, mental health training, and quantitative measurement of shame within the mental health-training context. Therefore, four broad domains are incorporated, including (a) a general shame review; (b) a description of Shame Resilience Theory (Brown, 2006); (c) shame in therapeutic, training, and professional contexts; and (d) measurement of shame and shame resilience. In part (a), an overview of the general affective experience of shame will be provided, the behavioral, psychological, and social outcomes that tend to be experienced simultaneously or as a consequence shame will be discussed, and shame will be conceptually distinguished from the affective experience of guilt. Section (b) describes recent conceptual developments regarding resilience to shame, as captured by Brown's (2006) Shame Resilience Theory. Part (c) reviews literature on client shame, therapist shame, and professional role shame for mental health trainees and practitioners. In the final domain (d), the measurement of shame and shame resilience are reviewed. Special considerations for capturing shame, predominant shame instruments, context-specific shame measurement, shame resilience measurement, and therapist shame measurement are reviewed in this section.

Shame: General Introduction and Review

The construct of shame. Current mental health research describes shame as an affective experience that is universal and elicited by perceived threats to the basic human need for group

membership and belonging (Brown, 2006; Kemeny, Gruenewald, & Dickerson, 2004). Shame arises when an individual recognizes that he or she has "committed an offense or violated a standard" (Dearing & Tangney, 2011, p. 4), and therefore perceives a threat of social rejection. The hallmark of a shame experience is the manner in which the event, experience, or mistake is internally attributed as a sign that the *fundamental self* is inherently flawed. This contrasts with other self-evaluative emotions (i.e., guilt, humiliation, embarrassment) in which a perceived offense is instead given external and variable attributions. The prevalence of shame is evident according to its universal nature, as well as the frequency with which it occurs, impacting most individuals on a daily basis (Dearing & Tangney, 2011).

Although shame is an innate human emotion, the manner in which it is experienced is idiosyncratic and develops through each person's formative experiences in key relationships (Dearing & Tangney, 2011). Shame is a self-evaluative, or self-conscious emotion, that utilizes the cognitive ability to make self-appraisals. Therefore, children do not begin to fully experience shame until they are able to differentiate self from others, have gained knowledge of social standards, and make self-attributions, thereby indicating that shame tends to arise around the age of two or three years (Mills, 2003).

Other cognitions and emotions are often used to describe shame, such as being bad, worthless, or contemptible (Dearing & Tangney, 2011). In response to feeling shame, individuals commonly report feeling small, shrinking, or wanting to disappear. Physically, this manifests as a slumped body posture, lowering the head, covering the face, blushing, and averting one's eye gaze. Dearing and Tangney (2011) characterize this shift in physical posture as assuming a "submissive stance," with the subconscious goal of preserving safety and social standing.

Like other emotions, shame occurs as an affective trait, or disposition, as well as a momentary state in which individuals are consumed by its presence (Dearing & Tangney, 2011; Tangney, 1996). The in-the-moment experience of feeling shame "wash over" (Brown, 2009) oneself is considered *state shame*. Conceptually, state shame is the more universal form of this emotion, whereas individual differences in *shame proneness* are represented by shame as an affective trait (Dearing & Tangney, 2011). Shame proneness refers to the differential tendencies that individuals have toward experiencing shame. This state and trait distinction is important for understanding measurement and treatment, as well as developing shame resiliency, because although state shame is inevitable, shame proneness is amenable to change (Brown, 2009).

Correlates of shame. Although the distress associated with shame itself is significant, the empirically associated outcomes of unaddressed shame help justify its significance for study and clinical treatment. Shame is characterized as a core emotion that underlies numerous secondary emotions, behaviors, and physiological responses. For example, the affective experiences of fear, blame, and disconnection are conceptualized as secondary to shame, serving as reactive coping mechanisms (Brown, 2006).

Within the framework of SRT, Karen Horney's (1945) three interpersonal orientations are used to describe how individuals typically react to shame, including *moving toward*, *moving against*, and *moving away* from others. Brown (2009) stated that although individuals differ in their expression of these reactions, most people use all three interpersonal orientations in response to shame at some time. Moving toward others is considered a self-effacing solution, in which one responds to feeling shame by seeking love or approval. Moving toward may take the form of extreme compliance or repression of anger, and is often used when one feels shame in a relationship with someone who has more power (e.g., an employer). In contrast, moving against

is described as “using shame to fight shame” and is often used in one’s closest relationships (Brown, 2009). The reaction of moving against has an underlying motivation of self-protection through garnering power, and may take the form of arrogance or defiance. Finally, moving away is a solution of resignation, in which individuals seek to be free from feeling shame by withdrawal and avoidance. When engaged in moving away, one may become emotionally detached within the shame-inducing relationship or engage in actual physical avoidance of persons, places, or situations. Within SRT, each reactive orientation is not pathologized, but instead framed as a coping mechanism for feeling shame that works best when used with awareness and intention (Brown, 2006).

Hahn (2000) proposed that individuals typically react to feeling shame in one of three ways: through withdrawal, attacks on the self, and avoidance. Withdrawal results from an attempt to avoid anticipated rejection and manifests as detachment, social isolation, and concealing feelings from self and others. In contrast, when the fear of social disconnection is the most salient component of shame, individuals may react with an attack on the self. Hahn (2000) described an attack on the self as a gesture for bolstering interpersonal connection through overtly condemning significant aspects of one’s self, then closely monitoring the reactions of others to ensure acceptance. Persons who characteristically use attacks on the self tend to exhibit a high degree of social hypervigilance, which ultimately interferes with the ability to act in a genuine or authentic manner (Hahn, 2000). Furthermore, an attack on the self may manifest in a more literal manner through self-harming behaviors (e.g., cutting, burning; Hahn, 2000). Avoidance is the final primary reaction to feeling shame, as outlined by Hahn (2000), who argued that avoidance tends to manifest as either narcissistic grandiosity or strategies of diversion. Grandiosity may take the form of angry outbursts against others (i.e., “narcissistic

rage"), or through enacting behaviors that bolster the individual's sense of narcissistic pride, such as sexual exploits or other maneuvers to gain power over others. Hahn (2000) proposed that the purpose of narcissistic strategies is to protect the self from actually feeling shame and inadequacy. In contrast, strategies of diversion are quite indirect and often manifest as compulsions such as alcohol or drug use, sex, food, gambling, and spending money (Hahn, 2000).

As a result of reactive tendencies to engage in withdrawal, attacks on self, or avoidance, Hahn (2000) explained that shame ultimately results in a loss of self-cohesion. As illustrated by the manner in which these strategies are conceptualized, this loss of cohesion typically manifests within one's self-concept and interpersonal style. However, a severe form of loss of cohesion can result in disconnecting one's sense of self from the physical body (Hahn, 2000). The compulsion to engage in self-injury and mutilation are therefore considered attempts to reintegrate the self and body through provoking physical pain (Hahn, 2000).

In terms of behavioral and psychological health, shame has been associated with "problematic action tendencies, interpersonal shortcomings, and psychosocial outcomes" (Dearing & Tangney, 2011, p. 6). Intrapersonally, shame is associated with depression (Kim, Thibodeau, & Jorgensen, 2011), suicidal ideation (Hastings, Northman, & Tangney, 2000), anxiety (Dearing & Tangney, 2011), and low self-esteem (Yelsma, Brown, & Elison, 2002). Naturally, these intrapersonal sources of psychological pain exhibit comorbidity with other severe outcomes. Shame is associated with alcohol and drug use (Dearing, Stuewig, & Tangney, 2005), posttraumatic stress disorder (Herman, 2011; Lawrence & Taft, 2013), eating disorders (Sanfter & Tantillo, 2011), and the development of borderline personality disorder (Rizvi, Brown, Bohus, & Linehan, 2011). Physically, the psychobiological responses of

proinflammatory cytokine activity and cortisol production (Kemeny et al., 2004) offer evidence for the biological underpinnings of shame, as well as its mind-body implications.

Interpersonal functioning is also impaired by the experience of shame in numerous ways (Dearing & Tangney, 2011). Expressions of hostility, anger, aggression, and externalizing blame are typical action tendencies when an individual experiences state shame. Dearing and Tangney (2011) noted that shame induced aggression takes multiple forms, including “physical aggression, verbal and symbolic aggression, displaced aggression, and ruminative unexpressed anger” (p. 6). Ferguson, Eyre, and Ashbaker (2000) demonstrated the relationship between shame and anger when controlling for guilt, a close emotional relative. In their sample of college students, men were especially prone to express anger in reaction to feelings of shame and associated *unwanted identities*. The concept of unwanted identity and its relationship with shame is described further in the Shame Resilience Section of this text.

Individuals who are experiencing shame also have difficulty empathizing with others (Dearing & Tangney, 2011). It seems that the inherent self-focus created by shame interferes with one’s ability to take the perspective of others, feel empathy, or express empathic concern. If a person who is feeling shame provides a response to another’s distress, it is often self-focused in nature, dismissing the experience of the other person in order to more fully focus on the self (Dearing & Tangney, 2011). Naturally, these shame-driven action tendencies interfere with the ability to form and maintain meaningful relationships.

Covert, Tangney, Maddux, and Heleno (2003) studied the relationships between shame proneness, guilt proneness, and the ability to address interpersonal problems. The authors distinguished the participants in their college student sample as either shame prone or guilt prone, using the Test of Self-Conscious Affect (TOSCA; Tangney, Wagner, & Gramzow, 1989).

As hypothesized, the results revealed that shame-proneness was negatively associated with the quality of self-generated solutions for addressing common social problems. Furthermore, students who were shame-prone had lower self-efficacy regarding their ability to implement problem-solving solutions effectively and anticipated that their self-generated solutions would be less effective. In contrast, guilt was positively associated with the quality of solutions, self-efficacy for implementation, and expectations of effectiveness (Covert et al., 2003). In sum, it seems that shame proneness, or the trait-like tendency to experience shame rather than guilt, is associated with barriers to effectively addressing interpersonal conflict and thereby maintaining relationships.

Traditionally, U.S. culture characterizes shame as a moral emotion, based on the presumption that it “limits or averts” socially unacceptable behavior (Dearing & Tangney, 2011). The use of shame as a tool for social control and moral guidance has been promoted and used to justify shame-based parenting approaches, religious traditions, and educational practices (e.g., public exposure of wrongdoing or inadequacy). However, action tendencies that arise from feeling shame have been empirically associated with amoral reasoning and behavior. It seems that individuals tend to respond to shame impulsively and with self-interest in order to provide swift relief from intensely uncomfortable feelings (Dearing & Tangney, 2011). Furthermore, because feelings of shame are attributed to one’s fundamental flaws, individual reactions to shame are based on the assumption that the error at hand cannot be repaired with a simple apology or second attempt (Leith & Baumeister, 1998). For example, feeling shame regarding a criminal offense is related to denying, rather than confessing, one’s transgressions in a correctional setting (Gudjonsson, 2003). As stated by Brown (2009), it is ineffective to use shame as a mechanism for encouraging prosocial behavior because shame “erodes the part of us

that believes we are capable of change." In sum, feeling shame does not appear to result in moral development or prosocial behavior, but rather results in amoral action.

However, the negative quality of shame reaction tendencies may vary contextually. Hooge, Zellenberg, and Breuglemans (2010) studied approach, avoidance, and withdrawal reactions to shame during a series of five empirical studies with undergraduate students. Based on their findings, the authors concluded that following an experience of shame, the primary motivation was to restore a positive view of the self. When experiencing state shame, individuals were likely to engage in approach behavior (e.g., making amends), unless approaching the source of shame was too risky and may result in further injury to one's self view. When the risk of approaching and addressing shame was too great, individuals then engaged in avoidance and withdrawal behaviors. The authors explained that negative manifestations of avoidance and withdrawal reactions (e.g., concealing mistakes) also tend to be elicited by trait shame, because the desire to engage in self-protection is greater than the urge to restore a positive self-view (Hooge et al., 2010).

Distinguishing guilt and shame. Guilt is a related emotion that compares and contrasts with shame in nuanced, but important ways (Lewis, 1971). Guilt and shame are often conflated with one another in everyday discourse, along with the related emotions of humiliation and embarrassment (Brown, 2009). Guilt and shame both fit within the family of self-evaluative emotions, and elicit similar feelings of discomfort, remorse, and regret (Dearing & Tangney, 2011).

Despite these similarities, shame and guilt have significant distinctions. The crucial difference between the two depends on whether attention is focused on a behavior or on the fundamental self (Dearing & Tangney, 2011; Lewis, 1971). Focusing evaluative attention on the

fundamental-self results in shame, provoking attributions that are internal, stable, uncontrollable, and global. While internally attributing their felt inadequacy, persons experiencing shame simultaneously orient their attention outward, seeking cues from the external environment about their social standing. Due to this external orientation, Lewis (1971) characterized shame as a *field dependent* emotion, meaning that the expression of the self adapts to "merge" with the surrounding environment. As a consequence of this external orientation, persons experiencing shame tend to engage in self-other comparisons that heighten feelings of inferiority and scrutiny from others (Lewis, 1971).

In contrast, guilt is characterized by a focus on one's behaviors or traits after violating a moral code or duty (Dearing & Tangney, 2011; Lewis, 1971). Guilt elicits attributions that although internal, are instead unstable, controllable, and specific. This means that despite having erred, the wrongdoing is viewed as exceptional, amenable, and unrepresentative of the fundamental self. Therefore, whereas guilt and shame both involve internal attributions, feelings of guilt are typically attributed to elements of one's personhood that are amenable to change and have limited application. As the attributions that stem from feeling guilt are less global and severe, its associated emotions (e.g., tension or regret) are less distressing (Wright & Gudjonsson, 2007). In fact, the disparity in felt discomfort between shame and guilt manifests physically; unlike shame, guilt is not associated with any outward physical symptoms of distress (e.g., lowering the heard, averting eye gaze; Dearing & Tangney, 2011). Furthermore, guilt is characterized as a *field independent* emotion (Lewis, 1971), meaning that individuals experiencing guilt do not re-organize their self-presentation according to external cues, but are instead able to act as the "highly articulated, ideational, self-imaging I" (Lewis, 1971, p. 420).

The action tendencies associated with guilt are more empowered and motivated than those associated with shame, such as taking action to make amends, apologizing, confessing, or striving for change. Within the corrections population, Gudjonsson (2003) argued that guilt facilitates confession of criminal activity, whereas shame acts as a barrier. In Dearing, Stuewig, and Tangney's (2005) study of shame and guilt in university and corrections samples, shame was positively related to alcohol and drug dependence, whereas guilt had an inverse association with substance abuse and dependence. Additionally, feelings of guilt are more likely to be mentioned in therapy and addressed as targets of change, whereas shame is often concealed (Dearing & Tangney, 2011).

The interpersonal outcomes of guilt are also more adaptive than the interpersonal consequences of shame. When feeling guilt, individuals are able to experience and express empathy, engage in perspective taking, and feel concern for others. Persons feeling guilt are less prone to express anger as aggression than those experiencing shame, and "shame free guilt" is unrelated to psychological symptoms (Dearing & Tangney, 2011).

In sum, the experience of shame is often inherently painful and debilitating in the moment, with additional significant correlates and consequences afterward. As with other emotional states, shame cannot be avoided or repressed in a healthy and adaptive manner (Dearing & Tangney, 2011). However, rather than succumbing to the negative outcomes of experiencing chronic and unmanaged shame, current conceptualizations of *shame resilience* offer a theoretical pathway for developing better emotional and psychological health.

Shame Resilience Theory

Throughout the history of psychology and mental health treatment, multiple theoretical perspectives have addressed the construct of shame, such as Jungian theory (Hultberg, 1988) and

emotion-focused therapy (Greenberg & Shigeru, 2011). In recent years, Brené Brown's study of shame established a new paradigm, called shame resilience theory (SRT; Brown, 2006). SRT was developed using the qualitative methodology of grounded theory research, and holds a unique position in the shame literature due to its contextualized and multidisciplinary nature. SRT builds on prior conceptualizations of shame by exploring and elucidating the components of resilience to shame, thereby emphasizing a desired state rather than pathology. The SRT framework was developed with the purpose of addressing the mental health impacts of shame in a clinical format (Brown, 2006).

Within SRT, shame is defined as "an intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging" (Brown, 2006, p. 45). Brown (2006) asserts that shame occurs because feelings of group membership and belonging are experienced as both important and tenuous, therefore conceptualizing shame as a psycho-social-cultural construct. This means that although the emotions, thoughts, and behaviors associated with shame are experienced intrapersonally, the key elicitors of shame initially stem from interpersonal relationships and cultural norms. The dual intrapersonal and interpersonal nature of shame seems to contribute to its felt complexity (Kemeny et al., 2004). For instance, interview participants who informed the SRT framework associated shame with the experiences of feeling "trapped, powerless, and isolated" (Brown, 2006, p.45).

The social and cultural components of shame refer to rigid expectations about how individuals "should be," and these expectations are communicated throughout the process of socialization (Brown, 2006). Family and educational systems along with cultural forces, such as the media, contribute most profoundly to internalized perceptions of what "parts of us" are unacceptable or unwanted versus ideal and adequate. Brown's research has found that the

experience of shame is organized according to gender, with women experiencing a metaphorical "shame web" and men a "shame box" (Brown, 2009). The shame web metaphor represents the competing, and often conflicting, nature of expectations based on the identities (e.g., cultural, racial, ethnic, socioeconomic, age, sexual orientation) and roles (e.g., familial, professional) that women have (Brown, 2006). For men, the shame box is somewhat more simplified and even more rigid with the single dictate that men must not be perceived as "weak" in any manner (Brown, 2009).

Using a framework that is similar to Dearing and Tangney (2011), Brown et al. (2001) differentiated shame from other "self-evaluative emotions" including (a) guilt; (b) embarrassment; and (c) humiliation. Whereas guilt is the feeling that one has done something wrong, shame is the feeling of being inherently flawed at one's core. For example, a person may experience guilt about mistreating a colleague if she recognizes this behavior as a momentary lapse from her aspirational self-standards (e.g., "Ugh, I really acted in a way that I don't like. I really feel like I did that badly."). This contrasts with making internal and global negative attributions about her worth as a person (e.g., "What kind of a person would treat someone that way? I am such a bad person."), which would result in shame. Embarrassment is characterized as "fleeting and funny," due to the recognition that situations that typically elicit embarrassment (e.g., forgetting someone's name) are experienced universally. Finally, whereas shame is experienced as "deserved," humiliation is associated with feeling indignant because of the belief that we do not deserve the criticism or ridicule it entails (Brown et al., 2011).

Shame resilience theory captures the contextual nature of shame with the concept of "shame triggers" that arise in scenarios, experiences, and expectations that are personally salient (Brown, 2009). Although shame is triggered idiosyncratically, SRT identifies 12 categories that

tend to elicit shame for most people, including (a) appearance and body image; (b) sexuality; (c) family; (d) parenting; (e) professional identity and work; (f) mental and physical health; (g) aging; (h) religion and spirituality; (i) speaking out; (j) surviving trauma; (k) finances; and (l) sexuality (Brown, 2009). These categories function as a tool for creating universality through diminishing the common belief that shame arises within the self and in isolation (Brown, Hernandez, & Villarreal, 2011).

Exploring the "ideal" and "unwanted" identities that individuals have within each of the 12 shame categories can facilitate the exploration of one's individual manifestations of shame (Brown, 2009). Ideal identities are unattainable and perfectionistic ways in which each person wants to be perceived by self and others. In contrast, unwanted identities represent unattractive and flawed aspects of the human experience that individuals strive to avoid. For example, within the domain of aging, an ideal identity may be to exhibit boundless energy and youthful vigor throughout the entire lifespan, whereas an unwanted identity may include being tired and out-of-touch with modern society.

Shame resilience. As with other emotions like sadness or joy, shame is an enduring experience because it is not a solely cognitive process, but also an automatic and typically subconscious wave of emotion (Brown, 2006). Despite its permanency, individuals can learn to become *resilient* to shame, through (a) building awareness of one's triggers and accepting the necessity of personal vulnerability; (b) engaging in critical awareness regarding the social and cultural expectations that drive shame; (c) forming mutually empathic relationships that diffuse isolation; and (d) developing language and emotional competence for speaking and deconstructing shame (Brown, 2009). SRT frames shame resilience as a practice instead of a developmental achievement, using the image of continuums to represent (a) vulnerability; (b)

critical awareness; (c) reaching out; (d) speaking shame; and ultimately (e) the courage, compassion, and connection necessary for demonstrating shame resilience (Brown, 2009).

Despite its negative connotation in many cultures, vulnerability is considered integral to practicing shame resilience (Brown, 2009). SRT reframes vulnerability from a form of weakness, to a mechanism for exhibiting awareness and acknowledgement of one's limitations. Brown (2006) explains that shame is typically experienced in regard to one's areas of vulnerability. For individuals who are cognizant of these areas, the experience of feeling shame can be more readily recognized, understood, and proactively addressed (Brown, 2006). With respect to mental health training, areas of vulnerability as a trainee can be explored through the framework of unwanted and ideal identities. This would entail self or group examination of the implicit ways in which trainees want to be perceived by peers, authority figures, clients, and other context salient figures. Once trainees understand their areas of vulnerability, they would be better able to recognize shame-triggering events as they unfold.

In addition to gaining awareness of one's areas of vulnerability, it is also essential to reflect upon the physical markers of the shame experience (Brown, 2009). As with other emotions, the feeling of shame has prominent physical attributes that are typically experienced before cognitive recognition of shame can be achieved. Generally, the physical symptoms of shame resemble fight or flight reactions that people have when their safety is threatened, such as a racing heartbeat, tunnel vision, or shortness of breath, among others (Brown, 2009). Recognizing physical shame symptoms and acknowledging vulnerability contrasts with experiencing unacknowledged shame, during which individuals are likely to feel overwhelmed and react based on feelings of "confusion, fear, and judgment" (Brown, 2006, p. 48).

Developing critical awareness entails examining the social and cultural expectations that

motivate unwanted and ideal identities (Brown, 2009). This is a primarily cognitive process that involves “reality checking” the implicit expectations that underlie areas of vulnerability. Typically, these expectations are unrealistic and rigid, and can be effectively dismissed through the processes of deconstruction and contextualization (Brown, 2006). For example, a trainee who feels shame because a client did not return to counseling after a previous session may practice critical awareness through researching the modal number of therapy sessions along with common client reasons for abrupt termination. If obtaining this information helps the trainee to “zoom out” and diminish her feelings of shame, she will also be better able to engage in examination of therapeutic factors that may have also contributed to the client’s withdrawal from counseling. With the knowledge that nearly all therapists experience abrupt client termination, the trainee can now engage in self-examination from a place of greater security and worthiness.

The next continuum for developing shame resilience involves “reaching out” to others in order to develop mutually empathic relationships (Brown, 2006). In the SRT curriculum, the significance of this process is described through the phrase “Shame happens between people and heals between people” (Brown, 2009). The skill of reaching out to seek and provide empathy demonstrates resilience in multiple ways, through building tolerance for multiple worldviews, diminishing feelings of isolation, and engendering more authentic interpersonal connections. SRT encourages individuals to carefully discern when and to whom it is best to reach out, as it is common for others to have difficulty practicing empathy and authenticity (Brown, 2009). Mental health trainees who are able to reach out may have established safe relationships among cohort peers, or with an advisor or supervisor.

“Speaking shame” is the final continuum for practicing shame resilience within SRT (Brown, 2006). This refers to acquiring language about one’s experience of shame that allows for

the ascription of meaning and development of shame resilience strategies. Based on the research used to develop SRT, Brown (2006) asserts that persons who are resilient to shame are able to articulate associated experiences and emotions, and are then naturally more comfortable with reaching out. Without language for describing shame, individuals are apt to engage in "silencing and secret-keeping" about their areas of vulnerability (Brown, 2009), thereby enhancing the isolation, powerlessness, and diminished self-worth associated with this painful and destructive experience.

Despite the pervasive nature of shame, shame resilience theory provides a framework for understanding how individuals can successfully cope with this painful component of the human experience. SRT was created for the purpose of broad applicability (Brown et al., 2011) meaning it can be adapted for use with most populations and in many contexts. Given this, SRT will be used to conceptualize shame resilience for trainees throughout their roles as therapists and students.

Shame in Therapeutic, Training, & Professional Contexts

Addressing client shame. Research regarding shame and its correlates supports the assertion that the experiences of trait and state shame are either related to or underlying many concerns that clients bring to therapy (Dearing & Tangney, 2011). Despite its relevance, shame tends to be ignored or merely addressed in an indirect manner during psychotherapy. Dearing and Tangney (2011) hypothesized three reasons for this oversight, namely that (a) the word "shame" is not used in everyday language; (b) individuals experience an inherent desire to "hide and conceal" shame; and (c) therapists inadvertently avoid the discomfort associated with client shame. Given that it is natural for clients to avoid discussing shame, mental health practitioners must learn to recognize the subtle linguistic and nonverbal indicators of its presence.

Dearing and Tangney (2011) asserted that it is especially important for therapists to be attuned to client shame, because the act of help-seeking is inherently shaming. For many clients, seeking therapy equates to acknowledging one's inability to cope with life independently. In addition, client reporting in therapy is diminished by anticipatory shame, defined as the unconscious expectation of feeling shame when discussing a shame-laden topic. As a result of this natural aversion, clients may underreport or completely avoid relevant therapeutic content (Dearing & Tangney, 2011).

Therapist shame. Researchers who study shame and psychotherapy assert that therapists should engage in their own exploration of personal vulnerability to shame as a means for developing shame resilience and building the necessary skills to effectively process client shame as professionals (Brown, 2009; Dearing & Tangney, 2011). Unfortunately, the relative absence of shame as a concept in mental health training creates a barrier to clinical education and therapist self-work in this area. Brown, Rondero Hernandez, and Villarreal (2011) asserted that the "vast majority of clinicians have not studied shame" (p. 355), and argued that in order to ethically conduct shame work with clients, therapists must first explore their own areas of shame and vulnerability.

Therapist shame is defined as "an intense and enduring reaction to a threat to the therapist's sense of identity that consists of an exposure of the therapist's physical, emotional, or intellectual defects that occurs in the context of psychotherapy" (Dearing & Tangney, 2011, p. 308). This definition can be broadened to include experiencing shame across multiple contexts, such as in class, supervision, or broader professional settings. The severity of therapist shame can be discerned by the degree to which a shame experience continues to bother or disturb a therapist long after the event occurred (Dearing & Tangney, 2011).

Shame in session. Kulp, Klinger, and Ladany (2007) studied therapist shame in the context of facilitating therapy and identified events that tend to be primary elicitors, including (a) falling asleep; (b) chronic time mismanagement; (c) misnaming a client with another client's name; (d) forgetting significant client history or information; (e) "bodily function difficulties;" (f) internal recognition of intervention failure; and (g) client sexual behaviors. Additionally, the "contagious" nature of shame makes it likely that clients' feelings of shame will resonate with therapists (especially regarding therapeutic content to which therapists are personally vulnerable), and possibly elicit state shame (Brown et al., 2011; Morrison, 2008).

Group counseling has been identified as a milieu in which therapists are especially vulnerable to feeling shame. Dearing and Tangney (2011) argue that the greater number of clients in a group "emboldens" negative feedback directed at the therapist. With the presence of peer allies, clients may be more willing to overtly challenge an intervention or the facilitator directly. In response, it is natural for the therapist to generalize this negative feedback and feel disparaged or devalued by the entire group. Additionally, treating a greater number of clients within a single therapy session increases the odds that the therapist will be triggered by group content or process (Dearing & Tangney, 2011).

Shame in graduate training. Outside of the therapeutic relationship, the conditions for shame-inducing *social evaluative threat* are often met during the graduate mental health training process. Kemeny and Shestyuk (2008) state that social evaluative threat occurs in conditions in which one may be negatively judged, in performance contexts in which one's group membership is at risk, and when uncontrollable aspects of one's identity are salient to others. These conditions are met in mental health graduate training, as evaluation and feedback from supervisors, instructors, and peers are conventional components of supervision and classroom

interactions. Second, trainees have not secured group membership in the mental health field until completion of a graduate degree program and state licensure. Feelings of fraudulence (i.e., "imposter syndrome") are commonly reported for beginning trainees, as they tend to feel they are posing in the therapist role (Watkins, 2012). Finally, as therapist training involves the development of the self as a therapeutic instrument, self-examination and interpersonal feedback are integral to the training process. Students early in their graduate training program typically experience heightened self-consciousness and discomfort due to the scrutiny of personality traits and characteristics that are initially outside of immediate consciousness (Bernard & Goodyear, 2009).

Alonso and Rutan (1988) described ways in which mental health trainees are especially vulnerable to experiences of shame and humiliation. They argued that trainees experience a *learning regression*, in which the demands of developing a new professional ego generates intellectual and emotional demands that contribute to a generally uneasy state for trainees. Students must recognize their lack of skills, process this deficiency in public environments (i.e., classrooms and supervision), while also trying to maintain an internal professional self-concept. Alonso and Rutan (1988) refer to this as a *learning dilemma,* in which the trainee must engage in painful self-awareness regarding professional deficiencies, while also maintaining the necessary ego strength to continue in the training process. The discomfort associated with experiencing the learning regression and learning dilemma of mental health training is especially difficult for most graduate students, as they are accustomed to demonstrating strong academic ability. Although intellectual proficiency and academic work ethic are necessary for success in graduate coursework, the authors noted that this form of achievement is not sufficient for success in the provision of mental health services, and may actually serve as a barrier to trainee development

(Alonso & Rutan, 1988). Although the aforementioned dynamics of mental health training are necessary for long-term development, they often act as sources of shame within the mental health-training context.

Finally, the concept of mental health trainee demoralization was used by Watkins (2012) to describe the vulnerability that trainees experience as they transition from classroom learning to in-session clinical training. Didactic instruction cannot adequately prepare trainees for the ambiguity of therapeutic work, and trainees tend to experience a harsh confrontation with the realities of their undertaking, and experience concern regarding their potential in the mental health field. Furthermore, trainees are apt to internalize perceived failures in therapy as evidence of personal inadequacy, thereby eliciting shame. Watkins (2012) argued that in order for development to progress, it is imperative for trainees to process these difficulties in supervision and eventually develop an identity as a "healer."

Shame in professional context. Beyond one's years in graduate training, mental health providers are still prone to experiencing role specific shame. The cross-disciplinary "pecking order" of mental health professions (Shapiro & Powers, 2011) can elicit feelings of shame by emphasizing deficits in the training and service delivery of some fields, while prizing the contributions of others. For example, Dearing and Tangney (2011) describe prescriptive privileges as one common source of interdisciplinary rivalry. Another shame eliciting element of the mental health professions is "one-upmanship" within the institutional hierarchy (Morrison, 2011), in which the public status obtained through holding expertise, authority, or a positive reputation among one's colleagues and clients contributes to a culture of comparison and diminished professional efficacy (Dearing & Tangney, 2011).

Dearing and Tangney (2011) wrote that the aging process is another significant source of shame for mental health professionals. As aging and declining health often co-occur, therapists may find they are unable to sustain the energy levels and caseloads they once had. This is a sharp turn from the prior period in their professional lives in which a mental health practitioner is well established and esteemed in the field (Dearing & Tangney, 2011). It may be that witnessing the deterioration of one's professional identity is the final major role-salient source of shame for mental health professionals.

Therapist responses to shame. Kemeny and Shestyuk (2008) use the concept of *social evaluative threat* to describe conditions in which shame is likely to occur and then initiate a sequence of submission and withdrawal. Kulp, Klinger, and Ladany (2007) named three primary therapist reactions to experiencing shame. First, body changes may be visible in session, specifically through tensing individual muscle groups or the overall posture. Second, reactions to shame may manifest in the subsequent session, in which therapists are apt to apologize, use humor, process the shaming event, or avoid it completely. Third, therapists may engage in persistent rumination about the shame eliciting event, thereby continuing to re-experience shame. In addition, Dearing and Tangney (2011) suggested that a therapist who is exhibiting anger or irritation toward the client is likely experiencing some form of shame.

A therapist's awareness of experiencing shame and the ability to process role-specific shame effectively has important consequences for the therapeutic process. Lewis (2006) stated, "unanalyzed shame in the patient-therapist relationship is a special contributor to a negative therapeutic reaction" (p. 419). In general, therapist shame may result in feelings of reluctance to address negative client behaviors (e.g., lateness, bill paying) and exhibiting professional and ethical boundary violations (e.g., seeing a client past a time limit, answering client calls late at

night; Koerner, Tsai, & Simpson, 2011). Brown (2009) asserted that when a therapist experiences state shame during a session, she is unable to effectively engage in the helping role until she is able to move through the experience of shame and "get back on her emotional feet."

Using a psychoanalytic framework, Hahn (2000) described common countertransference reactions in response to client expressions of shame. Hahn argued that countertransference is a relevant concept for therapeutically addressing shame for two primary purposes. First, as described by other shame and psychotherapy researchers (Brown, 2009; Dearing & Tangney, 2011), therapists will experience activation of their personal feelings of inadequacy when they identify or resonate with the content of client shame. Furthermore, clients subconsciously externalize shame in the therapeutic relationship as a coping mechanism. This often elicits parallel feelings of shame and inadequacy for the therapist, thereby impacting one's clinical judgment. Hahn's description of the symbiotic relationship between client reactions to shame and therapist countertransference reinforces the rationale for identifying and managing therapist shame. In the description of shame-elicited countertransference, Brown's (2009) terminology from shame resilience theory (SRT) will be integrated with Hahn's analytic language in order to create continuity for the reader.

Hahn (2000) argued that shame results in an internal splitting of the self into *devaluing introjects* and *devalued introjects.* The traits, characteristics, or actions of the self that provoke feelings of shame are contained within the devalued introject. A somewhat analogous concept from Brown's (2009) SRT is the *unwanted identity*, representing the inadequate, inferior, or defective components of the self that one strives to conceal from the perceptions of self and others. In opposition, the devaluing introject represents a "condemning audience" that reinforces contempt for the devalued introject and is ultimately internalized as an inner critic. Within SRT,

the concepts of a devaluing introject or *self-critic* results from outside judgment and rejection that are internalized over time (primarily in childhood) for the purposes of self-protection (Brown, 2009).

In reaction to client feelings of shame, Hahn (2000) explained that therapists tend to experience either concordant or complementary countertransference identification. As with countertransference generally, both types of identification are elicited when the therapist personally identifies with some aspect of the client's therapeutic content or presentation. The difference between concordant and complementary countertransference depends on how the therapist reacts to experiencing personal identification with client shame (Hahn, 2000).

Concordant countertransference occurs when the therapist identifies with a devalued introject or unwanted identity of the client (Hahn, 2000). For example, in reaction to a client's description of feeling body shame while exercising at a gym, a therapist would be experiencing concordant countertransference if the client's report resonated with his own feelings of shame regarding his body shape or size, leading him to align with the client's devalued self while also projecting his own feelings and experiences onto the client. In response to this, the therapist may feel especially sympathetic or protective toward the client (e.g., "You shouldn't return to that gym if it makes you feel that way. Exercising privately would be more safe."). When concordant countertransference occurs, therapists will likely feel helpless, incompetent, and unworthy in their work with the client. These feelings tend to manifest in behavior that is either distancing or colluding in the therapeutic relationship. Brabender (1987) noted that therapists who are experiencing concordant countertransference facilitate therapy that is emotionally detached and technique oriented in order to avoid emotional attunement and their own feelings of shame. Collusion occurs when the therapist joins the client in avoiding deeper exploration and instead

focuses on behavioral objectives aimed at resolving the client's numbing behaviors (e.g., alcohol and drug use, food addiction, gambling, etc.). Hahn (2000) asserted that therapists who collude in avoidance of shame due to concordant countertransference might ultimately push the client away, by canceling appointments or forgetting significant client information.

In contrast, complementary countertransference involves aligning with the devaluing introject (Hahn, 2000). In this form, the therapist instead identifies with the client's inner critic, and although not overtly hostile or rejecting, tends to view the client as either unprepared for therapeutic change or entirely "beyond repair." Using the prior example, the therapist who experiences complementary countertransference in reaction to his client's expression of body shame would internally align with the client's devaluing or critical self in regard to feelings of inadequacy. In order to create distance from his own feelings of shame, the therapist experiencing complementary countertransference may have a blaming internal dialogue (e.g., "Just deal with it. You're at the gym to lose weight."). Hahn (2000) argued that this form of shame-elicited countertransference is more potentially harmful because therapists tend to respond with overly confrontational or critical methods of intervention that subtly reinforce the client's feared rejection. For instance, the therapist from the above example may suggest that the client needs to ignore her irrational feelings and instead focus her energy on her physical transformation, in a similar manner as other gym patrons. This response may further elicit the client's feelings of shame and rejection, as the therapist has refused to engage in emotional attunement and validation of the client's experience and contrasted her "irrational" feelings with the feelings of other (i.e., "normal") persons who attend her gym. Unfortunately, therapists who are experiencing complementary countertransference are less likely to have awareness of it than those experiencing the concordant type, because they have projected the inadequacy solely onto

the client. Therefore, the therapist is able to avoid feeling the inner discomfort of shame and is prone to relate to the client with a critical, disapproving, or superior approach (Hahn, 2000).

The manner through which client shame and therapist countertransference interact is further complicated when the client's devalued introject is externalized (Hahn, 2000). When this occurs, the client does not present as shame ridden, but instead acts aggressively toward others. Using the prior scenario, a client who experiences body shame at the gym and externalizes her devalued introject would avoid feelings of shame by criticizing or ridiculing the body type of other gym patrons. Through the process of projection, the client is able to ease the discomfort of shame, and instead views others as inadequate and deserving of harm (Hahn, 2000). From the framework of SRT, an equivalent (though subdued) concept is *judgment* (Brown, 2009). When describing the connection between feeling shame and judging others, Brown (2009) asserted that individuals center on their own issues of vulnerability and shame when judging others. In sum, the unworthy and unacceptable parts of the self are viewed as most contemptuous in others.

Hahn (2000) explained that in reaction to a client who is projecting a devalued introject, a therapist experiencing concordant countertransference is likely to join the client in attacking the "other." This manifests as helping to place blame on outside parties such as parents, romantic partners, or other targets of the client's projection. In contrast, a therapist experiencing complementary countertransference will feel like the target of the client's hostility. Small mistakes or moments of misattunement in session will result in overcompensation on the part of the therapist. This is problematic because it will likely damage the therapist's professional efficacy and may perpetuate the client's process of projection and externalization (Hahn, 2000).

Given the degree to which therapists are vulnerable to clients' expression of shame, it seems imperative that mental health practitioners are educated about shame and equipped to cope

with its therapeutic impacts. Understanding shame may be even more critical for mental health trainees, as they are naturally more vulnerable to feelings of inadequacy and shame within the helping role (Dearing & Tangney, 2011). Fortunately, the process of supervision provides a milieu in which mental health trainees can explore and better understand shame.

Supervision and mental health trainee development. In addition to personal therapy, supervision can serve as an important vehicle for exploring trainee shame within the mental health-training context. Exploration of trainee shame can be therapeutically necessary when supervisees are feeling "confused, stymied, or ineffective" in the therapist role (Dearing & Tangney, 2011; p. 397). However, Dearing and Tangney (2011) commented that in a manner that parallels therapy, supervisors do not appear to address shame in the supervision process. Although this observation was based upon personal perceptions and not empirical evidence, it seems likely that inattention to shame in therapy and supervision would parallel one another. Dearing and Tangney argue that it is the supervisor's responsibility to introduce and address shame, as it is unlikely that a less experienced and less professionally socialized supervisee would either know to acknowledge feelings of shame, or be willing to address shame without guidance from the supervisor (2011).

Although supervision serves an important function in providing a time and place to address trainee shame, the parameters of this training relationship may also contribute to feelings of shame for supervisees. Sanfter and Tantillo (2011) wrote that the inherent differentials in power and experience that exist between the supervisor and supervisee augment the supervisee's vulnerability to shame. Therapist trainees may experience role salient shame in multiple ways, especially regarding fears about inadequacy and competence (Dearing & Tangney, 2011).

Naturally, these fears serve as a barrier to trainee disclosure in supervision regarding perceived mistakes or areas of incompetence.

Additionally, shame can be experienced due to (a) identification with a client's feelings of shame or triggering content; (b) feeling that he or she is not producing successful clinical outcomes; or (c) comparing skill level with fellow trainees. As trainees will inevitably have assumptions about the psychological attributes of "good" therapists, experiencing shame in the helper role can create a sense of "meta-shame," or shame about feeling ashamed (Dearing & Tangney, 2011). For instance, a trainee may internally aspire to be a therapist who is selfless and poised at all times, making the experience of feeling shame in this role even more uncomfortable.

Thankfully, the supervisory relationship also allows supervisors to facilitate shame resilience work for supervisees within the training context. In order to do this, supervisors can convey a tone of non-judgment in reaction to supervisee disclosures (Sanfter & Tantillo, 2011). They may also reframe supervisee feelings of vulnerability as facilitative for growth and development, and thereby essential for the process of therapeutic training. Supervisors can encourage trainees to approach areas of shame and vulnerability with an attitude of non-judgment toward themselves, as well as curiosity and self-compassion. Also, the wisdom gained from holding more experience uniquely positions supervisors as able to help trainees re-examine and challenge self-expectations that are based in ideal and perfectionistic standards (Sanfter & Tantillo, 2011). The supervisor is poised to "demystify" (Brown, 2009) mental health training, through normalizing feelings of insecurity and inadequacy, disclosing one's own professional errors or struggles, and contextualizing the supervisee's experience within the process of graduate training.

Ladany, Friedlander, and Nelson (2005) proposed a critical events model of supervision for working through shame events. The critical events model encompasses (a) the supervisory working alliance; (b) the marker, or signal, that a critical event is about to occur; (c) creating a task environment for exploring shame; and (d) achieving a resolution (Ladany et al., 2005). As the components of creating a task environment and achieving a resolution are most salient to processing supervisee shame, they are described in greater detail below.

Within the critical events model, creating a proper task environment for exploring shame is essential. The task environment is comprised of five interaction sequences, of which the first is to attend to the supervisory working alliance and ensure that trust and safety are established. In the second interaction sequence, the supervisor guides exploration of supervisee feelings of shame, aiming to deepen the supervisee's cognitive and emotional understanding of the shame experience. Third, the supervisor helps connect the supervisee's feelings of shame to countertransference (using a framework such as Hahn, 2000). Then, the supervisor focuses on rebuilding and reinforcing supervisee self-efficacy. In the fifth interaction sequence, the supervisor normalizes clinical errors and validates the supervisee's experience (Ladany et al., 2005).

As a result of addressing shame in supervision, Ladany et al. (2005) proposed that supervisees would achieve resolution across four dimensions. First, supervisees will gain self-awareness and be better able to conceptualize the manner in which their experiences and personhood function in therapy. Second, supervisees will also have a restored or even improved sense of efficacy within their professional roles. Next, addressing shame increases supervisee knowledge of the nature and process of therapy. The final component of achieving resolution is

that the supervisory working alliance is altered and (ideally) strengthened by the process of working through shame (Ladany et al., 2005).

In sum, scholars who study shame (Brown, 2009; Dearing & Tangney, 2011), therapy (Hahn, 2000; Kulp et al., 2007), training (Kemeny & Shestyuk, 2008), and supervision (Ladany et al., 2005; Sanfter & Tantillo, 2011) have recognized the importance of addressing shame in the mental health training process. In order to equip mental health trainees with the skills necessary to effectively work with client shame, they must undergo self-exploration regarding their personal domains of vulnerability and professional experiences of shame (Brown, 2009). Therefore, developing an appropriate psychological instrument that facilitates trainee self-awareness, and appraises the development of shame resilience is an essential undertaking.

Measurement of Shame and Shame Resilience

A search of literature across mental health fields including counseling psychology, school psychology, marriage and family therapy, social work, and clinical psychology reveals the lack of a specific instrument intended to measure shame or shame resilience in the mental health provider or trainee context. Prior studies of therapist shame have either relied on qualitative methodology or the construction of qualitative questionnaires that were designed to capture categorical data (Klinger et al., 2012). A quantitative instrument designed to assess mental health trainee shame resilience would serve multiple purposes within the individual trainee context, training program development, and empirical study.

With the aid of a quantitative instrument, supervisors would be equipped to assess baseline shame resilience, track progress and development within this domain, and use instrument items to anchor the exploration of shame and insight development. In addition, an instrument of this nature could be used to identify trends in shame and resilience within cohorts

of students or entire programs. This type of information could serve as a tool for monitoring the training climate, possibly indicating areas or periods in which program level intervention or structural changes are necessary. For instance, a training director who finds that a second year cohort is experiencing high shame proneness and low resilience may organize periodic seminars about understanding shame for students. Finally, a quantitative measure of trainee shame resilience would assist researchers in better identifying and understanding correlates and outcomes relating to trainee shame, thereby better informing didactic and experiential efforts at developing resilience.

Measuring Shame Resilience. Although a quantitative measure has not yet been developed, the ability to demonstrate shame resilience as a mental health provider has been theoretically discussed. Both Brown (2009) and Dearing and Tangney (2011) asserted that in order to develop resilience to shame within the helping role, therapists must (a) build awareness regarding one's areas of vulnerability; (b) learn to recognize shame when it arises in session; (c) build skills for managing shame in session; and (d) deal with personal areas of vulnerability and shame in one's own therapy. This conceptual framework, in combination with SRT and prior literature regarding the measurement of shame and shame resilience, provided conceptual grounding for instrument development in the present study.

In broader contexts, shame resilience is measured through the concept of self-compassion; entailing self-kindness, common humanity, and mindfulness (Neff, 2003a). Self-kindness reflects the ability to respond to experiences of pain or failure with kindness and understanding toward oneself rather than self-criticism. The defining feature of common humanity is the ability to recognize that one's mistakes are part of the larger human experience,

and not unique to the self. In the context of self-compassion, mindfulness entails acknowledging one's thoughts and feelings about pain without over-identifying with them (Neff, 2003b).

The concept of self-compassion is intricately linked to the practice of shame resilience (Brown, 2009) and often measured using the Self-Compassion Scale (SCS; Neff, 2003b). The SCS includes 26 items divided into three subscales that reflect the self-kindness, common humanity, and mindfulness components of the construct. Using a five-point Likert rating scale, respondents indicate the frequency with which they respond in a self-compassionate manner. Responses from each subscale are then aggregated to produce a mean score of self-compassionate behavior. The three subscales demonstrate high inter-correlations and internal consistency reliability, yielding a Cronbach's alpha coefficient of 0.97 (Neff, 2003a).

At this time, the SCS (Neff, 2003b) is the sole quantitative instrument for assessing shame resilience. This gap in the field of mental health measurement seems natural, given that the concept was recently developed (Brown, 2006). However, filling this void is essential, given that resilience is not conceptualized as the absence of shame, but rather the practice of internal and interpersonal strategies for managing shame and developing personal worthiness (Brown, 2009).

General Considerations for Measuring Shame. Tangney (1996) provided recommendations for developing measures of shame and guilt, based on theoretical conceptualizations and empirical evidence. First, Tangney cautioned against using morally relevant standards or beliefs as prompts for assessing shame, because respondents will differ according to the frequency with which they commit a moral transgression (e.g., stealing, infidelity, cheating on an exam) as well as in their willingness to acknowledge violations (1996). In addition, the societal designation of moral transgressions are apt to change over time and some

evidence has suggested that individuals are less likely to feel shame in response to a moral transgression than in response to some type of socially inappropriate behavior (e.g., wearing unsuitable apparel, telling a tasteless joke; Tangney, 1996). Finally, it seems that orienting respondents' attention toward moral standards helps to shift their attention outward, creating distance from the self-evaluative nature of shame.

Assumptions about shame and guilt from earlier periods of psychological study have contributed to difficulties in measuring shame (Tangney, 1996). Shame was once viewed as situationally driven, relying on the assumption that certain experiences or situations were inherently shaming, while other situations would produce guilt. Contributing to the situational conceptualization was the belief that shame was a public emotion and was therefore experienced interpersonally, whereas guilt was an analogous emotion experienced privately. Tangney (1996) cited empirical findings (Niedenthal et al., 1994; Tangney, 1992; Tangney et al., 1994 Taylor, 1985;) indicating that this distinction is false, and demonstrating that individuals do experience shame intrapersonally, both in public and private ways.

Tangney (1996) also advised that the close relationship between shame and guilt creates difficulty in discerning the sole experience of shame for measurement purposes. Despite the significance of their distinctions, shame and guilt often co-occur as "shame-fused guilt," in which they are linked to a common shaming experience and difficult to differentiate (Dearing & Tangney, 2011). This common ground makes it crucial to differentiate a focus on self versus a focus on behavior when measuring shame. Studies that fail to make this distinction typically associate guilt with psychological symptoms, and contribute to further conflation of the constructs (Dearing & Tangney, 2011).

In Tangney's (1996) review of the status of shame and guilt measurement, instruments were classified according to the assessment techniques, structure, and format with which they assessed shame. For instruments measuring shame and guilt proneness, the common categories included (a) use of shame vs. guilt-inducing situations, in which the content of each situation-based item is constructed to elicit either shame or guilt; (b) global adjective checklists that list self-descriptive adjectives with which respondents identify and endorse; and (c) scenario-based measures, in which common, uncomfortable situations are described along with potential responses that reflect feelings of either shame or guilt. Tangney (1996) critiqued each category of shame measurement in a number of ways. First, the use of situations for inducing shame or guilt is problematic, as these situations rely on the premise that certain circumstances will inherently produce either emotion. Although the distinction between shame and guilt was characterized as content driven during earlier periods of study (see Beall, 1972; Johnson et al., 1987; Perlman, 1958), current theories emphasize internal processes of directing negative attributions toward the self versus behavior as the key source of contrast between the two emotions. Additionally, Brown (2009) noted that although there are 12 common categories in which individuals are likely to experience shame, the manner in which shame manifests within each domain is idiosyncratic and based on one's life experiences. Therefore, shame and guilt cannot be elicited through content-based situations because this method does not address internal attribution processes.

Although global adjective checklists have high face validity and simple administration procedures, their reliance on a well-developed respondent vocabulary presents an important limitation. Tangney (1996) also noted that adjective checklists tend to use the phrases "guilt" and "shame" within items, thereby requiring the respondent to have a well-developed conceptual

understanding of the difference between the two emotions. As well, requiring respondents to directly characterize themselves by selecting self-relevant adjectives is likely to be a shame-inducing task. Tangney (1996) noted that this aspect of adjective checklists is a greater concern for measuring guilt rather than shame, because the checklist task requires the respondent to make global self-assessments, rather than rating behaviors or transgressions that would be characteristic of feeling guilt.

When using scenario-based measures, respondents are presented with a series of common and specific everyday situations, followed by a list of possible responses. Each response is designed to represent a phenomenological description of shame or guilt within the context of the given scenario (Tangney, 1996). One advantage of using scenario-based measures is that they do not require the respondent to have an abstract knowledge of the differences between shame and guilt. Also, scenarios are less likely to elicit a "defensive response bias" in comparison with adjective checklists. Despite these advantages, however, scenario-based measures tend to yield lower internal consistency estimates of reliability than other forms of shame and guilt measurement. Although Tangney (1996) cited examples in which scenario-based instruments have achieved adequate internal consistency (Harder & Zalma, 1990; Hoblitzelle, 1987; Tangney et al., 1996b), the situational element of each item introduces an additional source of unique variance into the measurement process. However, the psychometric strength of scenario-based measures is bolstered by higher test-retest reliability coefficients (Tangney, 1996).

Another limitation for scenario-based measurement of shame is that a finite number of scenarios can be contained within a given instrument. Naturally, it is only possible to represent a limited range of shame-inducing situations and behaviors, thereby constraining the range of responses that may resonate with different individuals (Tangney, 1996). In acknowledgement of

this, Tangney (1996) noted that it is essential to represent an array of settings and behaviors within the items of the instrument. Despite efforts to diversify items, it seems that biases toward certain groups of respondents is difficult to avoid when using scenario-based instruments. For this reason, contextually targeting scenario-based instruments may be especially useful.

Prevalent Shame Instruments

The task of assessing and quantifying shame is complex and can be approached through multiple pathways. In this portion of the review, shame instruments that are currently predominant in the psychological literature are organized according to type of conceptualization, measuring shame as either (a) a global proneness; (b) a state-like or experiential reaction; (c) stemming from external judgment; (d) domain-specific; and (e) a physical manifestation. Instruments representing each of these categories will be described in order to inform the current status of shame measurement.

Shame proneness. The measurement of shame proneness as a global construct appears to be quite ubiquitous in the psychological literature. The predominant instrument in this domain is the Test of Self-Conscious Affect (TOSCA; Tangney, Dearing, Wagner, & Gramzow, 2000), garnering over 450 citations in the published literature (Google Scholar, March, 2014). The TOSCA measures *guilt proneness* in addition to *shame proneness*, thereby assisting literature development regarding the mutuality and distinction between the two concepts. Respondents are presented with 16 scenarios that are potentially shame and guilt eliciting, and are given four potential responses to each scenario. For each potential response, the respondent rates the likelihood of reacting accordingly using a five-point Likert rating scale. The TOSCA has demonstrated adequate internal consistency reliability with Cronbach’s alpha of 0.77 for the shame-proneness subscale and 0.70 for guilt-proneness (Tangney, 1996).

The Compass of Shame Scale (CoSS; Elison, Lennon, & Pulos, 2006) uses a scenario-based method similar to the TOSCA to elicit shame-proneness. The CoSS presents respondents with 12 scenarios in which shame may occur, with four possible responses to each scenario. As with the TOSCA, respondents indicate how likely they are to act according to each response using a five-point Likert rating scale. Each of the four response options represents the four primary reaction tendencies to shame using an analytic framework (Hahn, 2000) including *withdrawal, attack on self, attack on others*, and *avoidance*. Data regarding the internal consistency reliability and test-retest reliability over a three week time period of each subscale were provided by Elison et al. (2006) and demonstrated adequate overall psychometric strength. The withdrawal subscale has obtained a Cronbach's alpha coefficient of 0.89 and test-retest reliability of $r = 0.75$. Items representing attacks on self had an alpha coefficient of 0.91 and test-retest reliability of $r = 0.81$. The attacks on others subscale obtained an alpha coefficient of 0.85 and test-retest reliability of $r = 0.85$. Finally, items representing avoidance had an alpha coefficient of 0.74 and test-retest reliability of $r = 0.75$.

Two other instruments measuring shame as a global proneness include the Adapted Shame and Guilt Scale (ASGS; Harder & Zalma, 1990; Hoblitzelle, 1982;) and the Internalized Shame Scale (ISS; Cook, 1996). The ASGS provides respondents with 30 adjectives, each of which are theoretically representative of either shame or guilt. Respondents rate the degree to which each adjective is self-descriptive using a five-point Likert scale rating. The ASGS has demonstrated adequate internal consistency reliability, obtaining Cronbach's alpha coefficients of 0.88 for guilt, 0.90 for shame, and 0.94 for combined guilt and shame (Harder & Zalma, 1990).

The Internalized Shame Scale (ISS; Cook, 1996) contains 30 items, divided between measuring shame (24 items) and self-esteem (six items). As with other global shame proneness measures, respondents rate each item using a five-point Likert scale rating. Del Rosario and White (2006) indicated that the ISS has strong psychometric properties with a Cronbach's alpha coefficient of 0.88 and test-retest reliability of $r = 0.81$. However, Tangney (1996) criticized the manner in which shame is operationalized in the ISS because it is conceptually close to low self-esteem and has failed to demonstrate discriminant validity with this concept.

State shame. As shame is an emotion that occurs in trait and state forms (Dearing & Tangney, 2011), instruments for assessing momentary shame are also important for adequately measuring the construct. The Experiential Shame Scale (ESS; Turner, 1998) is designed to assess in-the-moment shame in a nonintrusive manner. It utilizes 30 items to measure shame across physical, emotional, and social domains. The ESS demonstrated adequate internal consistency reliability, obtaining a Cronbach's alpha coefficient of 0.86 (Turner & Schallert, 2001).

Another instrument for measuring state shame, as well as state guilt, is the State Shame and Guilt Scale (SSGS; Marschall, Sanftner, & Tangney, 1994). This instrument includes 15 items that inquire about current feelings of shame, guilt, and pride using a self-report format. Respondents rate each item using a Likert scale, ranging from 1 (*not feeling this way at all*) to 5 (*feeling this way very strongly*). Marschall et al. (1994) found that the SSGS produced higher shame scores for respondents who had participated in a shame induction condition, as compared with respondents who had been in a control condition.

External shame. A prominent component of shame is the fear of being judged, viewed by others as unworthy, and socially rejected (Brown, 2009; Dearing & Tangney, 2011). In order to capture this component of feeling shame, the Other As Shamer (OAS; Goss, Gilbert, & Allan,

1994) scale was developed. The OAS includes 18 items that measure external shame, defined as global beliefs about how one is viewed by others. Using a five-point Likert rating scale, respondents indicate the degree to which each item (representing external shame) aligns with their feelings and experiences. Goss et al. (1994) determined that the OAS had adequate internal consistency reliability with a Cronbach's alpha coefficient of 0.92.

Domain-specific shame. The Experience of Shame Scale (ESS; Andrews, Qian, & Valentine, 2002) takes a multiple-domain approach to measuring shame. The ESS utilizes self-report regarding feelings of shame within one's character, behavior, and body. Shame in reaction to one's character is conceptualized as arising from self-evaluation of habits, interpersonal style, and abilities. Within the behavioral domain, shame is elicited through doing or saying something wrong or failing in a competitive venture. Finally, body shame refers to feelings about specific body parts or the body as a whole. Respondents are instructed to answer in reference to the past year, and indicate the frequency (using a four-point Likert-type rating scale) with which they experienced, thought about, or avoided shame within each domain. Andrews et al. (2002) indicated that the ESS has adequate internal consistency reliability with a Cronbach's alpha coefficient of 0.92 and 11-week test-retest reliability of $r = 0.83$.

Physical manifestation of shame. Shame as a physical manifestation is assessed using the Shame Posture Measure (SPM; Feiring & Taska, 2005). The SPM presents respondents with seven drawings of human figures, two of which have assumed neutral stances, and five that depict postures of shame. Respondents rate the degree to which each drawing represents their current feelings using a five-point Likert rating scale. Ratings from the five shame posture drawings can be summed to create a total shame score. Feiring and Taska (2005) also suggested that ratings from the two neutral postures could be subtracted from the five shame postures in

order to increase the sensitivity of the instrument. Fearing and Taska (2005) reported that the SPM has adequate internal consistency reliability with a Cronbach's alpha coefficient of 0.92.

Review of the preceding instruments demonstrates that the measurement of shame has been attempted using diverse approaches and conceptualizations. However, the primary shame measures used in current psychological research share a common feature in that they are intended to measure shame across populations and contexts. In the following section, the development of a context-specific instrument will be reviewed in order to describe shame measurement in reference to specific identities or experiences.

Measuring Shame in Context

Feelings of shame and guilt are considered highly relevant for confessing versus denying criminal activity (Gudjonsson, 2003). In response to this premise within forensic psychology, Wright and Gudjonsson (2007) developed a measure of criminal offense-related shame and guilt in a sample of male inmates with psychiatric disorders. The purpose of the study was to engage in confirmatory factor analysis for the Offense Related Shame and Guilt Scale (ORSGS; Wright & Gudjonsson, 2007). The authors constructed the scale items to reflect the conceptualization of shame and guilt proposed by Lewis (1971) and Gilbert (1992), and developed item content reflective of criminal actions (e.g., "I can't help thinking about the hurt I have caused the people involved;" Wright & Gudjonsson, 2007, p. 311). The use of contextual item construction differs from the scenario-based approach, in which an event or experience is described for the purpose of triggering feelings of guilt or shame (Tangney, 1996).

To determine convergent and discriminant validity, participants also completed the Test of Self-Conscious Affect-3 (TOSCA-3; Tangney, Dearing, Wagner, & Gramzow, 2000), the State Shame and Guilt Scale (SSGS; Marschall, Sanfter, & Tangney, 1994), and the guilt

subscale of the Gudjonsson Blame Attribution Inventory (GBAI-R; Gudjonsson & Singh, 1989). The ORSGS demonstrated appropriate convergent and discriminant validity with the shame and guilt subscales from the TOSCA-3 and GBAI-R. However, SSGS guilt was positively associated with ORSGS shame and not with ORSGS guilt. In order to account for this, the authors proposed that because the SSGS does not provide a "trigger event" for eliciting guilt, it may be capturing *free floating* guilt instead of conceptually distinctive guilt. Free-floating guilt is similar to Lewis's (1971) concept of maladaptive guilt, defined as guilt that is fused with shame and therefore takes a ruminative and unproductive form. Given these results, it seems that providing respondents with a scenario or trigger event for feeling shame or guilt provides a necessary degree of context and helps to distinguish the two emotions.

Wright and Gudjonsson (2007) commented on the difficulty of capturing the inverse concepts of shame and guilt after two reverse-scored items did not load as expected based on the exploratory factor analysis. For example, one item was written as "Despite what I did I feel equal to other people" (Wright & Gudjonsson, 2007, p. 312). The authors noted that reverse-scored items used different wording than other items, which may have elicited a response that was overly contextualized (i.e., interpreting the item in the context of their specific crime rather than being judged as unworthy in general). Of note, the authors did not describe the use of a theory for operationalizing emotions that are opposite of shame. Within shame resilience theory, resilience is not considered the absence or inverse of shame, but rather engagement in the processes of recognizing shame, gaining critical awareness, reaching out, and speaking shame. Therefore, measuring resilience rather than the absence of shame may better capture the conceptual inverse of shame.

In sum, Wright and Gudjonsson's (2007) scale development study provides important information about effectively assessing and quantifying shame. Overall, the study augmented prior evidence that shame and guilt do share common ground, but continue to represent distinctive emotional experiences. In order to precisely elicit feelings of either emotion, use of a prompting scenario or trigger event may be necessary. Use of a triggering event also helps to contextualize the instrument, which is not overtly discussed by Wright and Gudjonsson (2007) but appears to be a helpful scale characteristic for effectively measuring shame for a specific population. Finally, assessing the inverse or absence of shame appears to be difficult and may be more effectively accomplished by measuring shame resilience.

CHAPTER THREE: METHODS

The impact of shame is pervasive throughout the domain of mental health services; shame underlies many client concerns (Brown, 2006; Dearing & Tangney, 2011), elicits therapist countertransference (Hahn, 2000; Kulp, Klinger, & Ladany, 2007), and influences the process of supervision (Dearing & Tangney, 2011; Ladany, Friedlander, & Nelson, 2005; Sanfter & Tantillo, 2011). For the purpose of the present study, the manifestation of shame within the mental health trainee context is considered most significant. Trainees are vulnerable to experiencing shame in multiple ways that intersect and exacerbate one another, including conditions of social evaluative threat (Kemeny & Shestyuk, 2008), a rigorous learning regression, learning dilemmas embedded in the training process (Alonso & Rutan, 1988), and doubts regarding one's personal and professional adequacy for pursuing a helper role (Watkins, 2012). Clearly, the experience of shame is highly pertinent to the process of mental health trainee development.

The ability to quantitatively measure role-specific shame within the mental health trainee population will serve multiple purposes. Foremost, researchers who study mental health training and therapist development will be better equipped through the use of this instrument to measure the correlates and outcomes of trainee shame and resilience with ease and precision. Second, a quantitative instrument could facilitate trainee self-assessment regarding feeling shame and practicing shame resilience. Finally, supervisors and clinical instructors would be able to utilize this type of instrument for didactic instruction as well as appraisal of trainee development. In sum, the purpose of this study was to develop a quantitative instrument for assessing mental health trainee shame and shame resilience.

In order to create fit between the study objectives and the temporal parameters of the dissertation project, this study encompasses the initial phases of instrument development with respect to qualitative inquiry, item development, and exploratory factor analysis; it does not include the process of confirmatory factor analysis. The tasks encompassed in this study include: (a) conceptualizing and operationalizing shame and shame resilience as constructs; (b) conducting a literature review of shame, shame resilience, and mental health training; (c) generating items, indicators, and response formats; (d) engaging in item content analysis, pilot testing, and item revision; (e) collecting data from a broad sample of mental health trainees; and (f) conducting exploratory factor analysis to determine the underlying dimensions of the instrument. Furthermore, analyses for estimating internal consistency reliability as well as convergent and discriminant validity were conducted.

Several recommended steps were taken in order to develop an appropriate foundation for this scale construction study. These include identifying the constructs and population of interest, searching for existing instruments that measure shame, and seeking consultation from faculty and peers about this project (Lee & Lim, 2008). Shame and shame resilience were identified as constructs of interest based on the author's clinical experiences facilitating shame resilience therapeutic groups, while also conducting research regarding the efficacy of this intervention. Studying shame and shame resilience within the mental health trainee population arose as a function of several factors, including (a) recognizing the centrality of shame to many client concerns and the importance of therapeutic training for effectively conducting work in this area; (b) learning about the impact of shame within the therapeutic process in both theoretical and experiential forms; (c) engaging in self-awareness and exploration in order to effectively conduct shame resilience work in clinical settings; and (d) reflecting upon the intrinsic vulnerability of

engaging in mental health training. In sum, the primary catalysts for the proposed study include the theoretical premises of shame resilience theory, as well as the author's applied experiences in clinical practice.

An essential step in forming this study was to determine if an instrument for measuring shame, shame resilience, and/or related constructs (i.e., inadequacy, humiliation, guilt, esteem, worthiness, pride) among mental health practitioners and trainees is already in existence. Although the population of interest for this study is mental health trainees, and not licensed practitioners, it was reasoned that an instrument intended to measure these constructs within a practitioner population would have relevance and potential adaptability for a trainee population. Searches for published instruments were conducted using online databases including PsychInfo, Google Scholar, Social Services Abstracts, as well as the Buros Center for Testing. After an exhaustive search, no published instruments were identified that measure shame, shame resilience, or related constructs among mental health practitioner or trainee populations. Based on this, the author concluded that a quantitative instrument of this nature does not currently exist in the extant literature. Therefore, a clear gap exists in the area of psychological measurement of mental health trainee shame and shame resilience.

Consultation with the author's faculty adviser and peer colleagues who are fellow mental health trainees was sought in order to further develop the foundation for the proposed study. Based on personal report from peer mental health trainees, it was confirmed that the experience of shame during mental health training is well founded and presently unaddressed. As a result of faculty consultation, the proposed study was refined to exclusively entail the processes of item development, exploratory factor analysis, and estimates of internal consistency reliability, convergent validity, and discriminant validity. Although confirmatory factor analysis is not

included as a component of this study, subsequent data collection and CFA will be conducted to finalize the instrument.

Study One: Focus Groups

Within the scale construction process, it is critical that items, indicators, and response formats are developed with thorough consideration of construct validity. One standard way of striving for construct validity is to use focus groups to gather qualitative data that directs the item generation process (Heppner, Wampold, & Kivlighan, 2008). The use of focus groups was particularly relevant for this scale construction, because the elicitors of shame and resilience processes are primarily context specific (Brown, 2006, 2009). The research that undergirds shame resilience theory (SRT) has demonstrated that within each individual, there are multiple sets of idealized and unwanted selves that correspond to each identity role (e.g., parent, graduate student, woman). Therefore, it was important to gather descriptions about the *unique* experiences, interactions, and dynamics that elicit shame for MHTs, as well as the strategies used to develop shame resilience.

The aims of the focus group study were the following: to (a) determine if MHTs would acknowledge or identify with the term "shame;" (b) gather descriptions of specific events, scenarios, or processes that elicit shame; (c) determine if the experience of MHT shame shifts or changes through the training process; (d) gather information about how MHT shame is noticed or perceived; (e) gather information about effective coping strategies for developing shame resilience; and (f) gain feedback regarding the study title, amount of time required, and potential compensation for participation.

Participants. Prior to beginning the recruitment process, IRB approval was obtained for the focus group portion of the study. The researcher contacted mental health training programs from the Lincoln and Omaha communities for participation in the focus groups. Permission to recruit MHTs was granted by each local program's Training Director and students were contacted with a recruitment message through email listservs. Two focus group meetings were held, with a total sample of six graduate trainees. Four trainees participated in the first focus group and two in the second. Five of the trainees were affiliated with Counseling Psychology and one with Clinical Psychology. In order to protect confidentiality, demographic information was not collected during this part of the study. Focus group members were informed that contributing to this part of the scale construction process would preclude them from participating in the online survey study. Of the six focus group participants, two were randomly drawn for an IRB approved prize of a $20 gift certificate to a local coffee house.

Careful consideration was given to the ethics of participant protection during this study. Focus group members were informed that their participation was entirely voluntary and that they could withdraw at any time. They were reminded verbally and in the informed consent document to only answer questions and offer information that they were comfortable sharing in a public format. They were encouraged to share their perspectives as "community observers," and cautioned about self-disclosing direct personal experiences. Participants were reminded not to name or identify other individuals when discussing their observations, including faculty members, peers, clinical supervisors, and others. In sum, the researcher and co-facilitator provided structure to focus group members regarding how to discuss trainee shame and shame resilience, in order to protect their personal and professional well-being.

Focus Groups. The focus group interviews were audio-recorded for the purpose of transcription and analysis. The primary researcher and a peer colleague facilitated the interviews. The peer colleague was asked to assist in the focus group study because he had trained in qualitative research methods, provided gender balance among the facilitators, and was not affiliated with or trained in shame resilience theory. The absence of his affiliation with shame resilience theory was considered important, in order to provide balance to the manner through which qualitative data was gathered and analyzed, and correct for any biases within the primary researcher's perspective. The focus group co-facilitator was approved and listed as a co-investigator with the IRB.

The interviews were conducted in a semi-structured manner in order to have consistent questions asked across groups, while maintaining a necessary degree of flexibility to naturally direct the dialogue (Merriam, 2009). The questions used to guide the focus group interviews were generated by the primary researcher and reviewed with the co-facilitator to identify any areas that would need rewording or clarification. The questions were primarily of "experience and behavior" and "sensory" types, meaning that they were geared toward gathering specific data about feelings, behaviors, actions, and activities, as well as what can be seen or heard (Merriam, 2009).

To begin, participants were given an informed consent document to read and sign (Appendix C). They were next provided with the following working definition of shame within the mental health-training context:

Mental health trainee shame elicits feelings of inadequacy, defectiveness, or lack of worth in response to perceived exposure of flaws and vulnerabilities within the provision of therapeutic services, the learning environment, peer process, or

supervisory relationship. Trainee shame elicits feelings of inadequacy in both personal and professional domains and may result in temporary or ongoing demoralization within the training process.

After reviewing this definition, the following questions were used to direct the data collection: (a) What does the word shame mean to you? Do you think shame is relevant to the process of mental health training? (b) How do you think shame is experienced during mental health training? What types of training situations elicit shame (e.g., in class, while facilitating therapy, during supervision, etc.)? What kind of evaluative events are most common? What types of training processes provoke strong feelings of vulnerability? (c) Do you think that feelings of shame or inadequacy vary as one moves through the training process? If so, how? (d) How can trainee shame be noticed or perceived? How would a trainee notice shame within oneself (e.g., thoughts, emotions)? What attitudes or behaviors would be visible to a peer, instructor, or supervisor? (e) How do trainees cope with or respond to feelings of shame or inadequacy? What coping behaviors or responses seem effective?

In addition to discussion questions, participants were also asked to provide written answers to questions regarding the structure of the survey study. They were first asked to give feedback regarding the study title, and were instructed to, "Please numerically rank (1-3) the following survey study titles according to which you would be most likely to respond to:" (a) Shame and Shame Resilience in Mental Health Training; (b) Emotional Experiences & Coping in Mental Health Training; (c) Shame, Vulnerability, and Resilience in Mental Health Training; (d) Other suggestions [Please enter]. Next, they were asked to provide feedback regarding compensation and were instructed to, "Please make a mark on the continuum below to indicate the minimal amount of potential monetary compensation at which you are likely to respond to

survey questionnaires,"($5 - $60). Finally, participants were asked to, "Please make a mark on the continuum below to indicate the maximum amount of required participation time that you are willing to invest when completing a survey questionnaire" (25-90 minutes).

Data Analysis. The focus group interviews were each transcribed verbatim and de-identified to protect participant confidentiality. The primary researcher, focus group co-facilitator, and an additional peer colleague, then analyzed the transcripts. This third colleague was asked to assist in order to have an "external eye" in the analysis of the transcripts, as she had not participated in the focus groups and was not trained in shame resilience theory. The members of the data analysis team first analyzed the transcripts individually, using the method of content analysis. This form of qualitative analysis is inductive in nature, and involves the generation of themes or categories while coding raw data (Merriam, 2009). Content analysis was deemed an appropriate technique for analysis because it broadly captures situations, settings, and nuanced meanings (Merriam, 2009), which aligned well with the goal of understanding how MHT shame and shame resilience manifest in an everyday sense.

Following individual analysis, the team gathered to compare and contrast findings, highlighting the major themes gathered across both interviews. From this, the data were organized into the following categories: (a) words defining shame; (b) shame triggers; (c) descriptions of the internal experience of shame; (d) how shame looks externally; and (e) markers of resilience. Additionally, direct quotes that included poignant language from participants were highlighted and discussed. Although participant quotes would not be used verbatim in the instrument, the researchers attended to the specific words and phrases that would help translate the authentic MHT experience into construct validity (Dawis, 1987). The

researchers reached agreement regarding the data contained in each category. The focus group data is summarized in Appendix K.

Study Two: Item Generation, Review of Items, Pilot Testing

The purpose of this study was to (a) generate items for the instrument, (b) obtain expert review of the items, and (c) engage in pilot testing with a sample of mental health trainees.

Item Generation

Format. Through an integration of focus group data, theoretical concepts, and literature review, items were generated to represent two distinct factors of MHT shame and shame resilience. Based on a review of shame and guilt assessment (Tangney, 1996), the researcher considered four potential scale formats, including (a) shame-inducing situations, (b) global adjective checklists, (c) scenario-based questions, and (d) statement-based questions. The relative strengths and weaknesses of each format were evaluated, and the researcher developed brief versions of scenario- and statement-based measures for review. Six items were generated and translated across each format. A group of research team colleagues and the researcher's doctoral advisor examined each exemplar and concluded that the scenario-based format was preferable because it helped to contextualize the experience of shame and elicited the lowest degree of defensiveness. Based on this feedback, the researcher developed the instrument as a scenario-based measure.

Structure. Having determined that the instrument would be scenario-based, the structure of response options was next decided. The conceptual framework of SRT (Brown, 2006, 2009) and prior shame research (Dearing & Tangney, 2011) were particularly useful in guiding these structural decisions, as they have demonstrated that individuals have multiple behavioral response tendencies when experiencing shame, and may use a combination of strategies within a

single instance. Thus, it seemed best to write multiple response options for each scenario, rather than forcing respondents to choose or rate a single behavioral reaction. Accordingly, each item contains a scenario, followed by five "sub-items" that represent various emotional, cognitive, and behavioral responses to this situation. The respondent's task is to consider the scenario and rate their likelihood of responding according to the description of each sub-item, independent of the others. The structure of scenarios and sub-items can be viewed in Appendix A.

The response format was designed as a four-point Likert-type scale. A four-point scale was chosen, rather than five-point scale, in order to eliminate the middle "neutral" point at which little information can be inferred (Dawis, 1987). This structure helps to "force a choice" among respondents in that they must choose whether they are likely or unlikely to enact a particular response, and then are able to specify a degree of likelihood.

Content. Item content was generated using a combination of SRT, prior research, and qualitative findings from the focus group study. Additionally, the primary researcher considered several principles for writing clear items that yield intentional responses. These include (a) isolating one idea within each item; (b) using precise language; (c) brevity; (d) avoiding confusing or awkward phrasing; (e) including only relevant information; (f) using positive language; (g) avoiding double negatives; (h) avoiding extreme terms, e.g., "all" or "none;" and (i) avoiding indeterminate terms like "frequently" or "sometimes" (Kline, 2005).

Conceptually, SRT informed the generation of each sub-item or response behavior category. According to the theory, individuals tend to respond to shame in a manner that parallels Karen Horney's (1945) interpersonal tendencies of moving toward, moving away, and moving against. In Brown's later work (2012), additional shame responses are named, including

comparison, which was deemed highly relevant for capturing part of the MHT peer process, based on literature review and focus group findings.

In regard to shame resilience content, SRT draws from Neff's (2003a) self-compassion framework, which includes self-kindness, common humanity, and mindfulness. These components of self-compassion were used to generate specific and varied descriptions of responses that demonstrate the construct. Additionally, SRT describes shame resilience through the response tendencies of reaching out to discuss shame with trusted individuals and being able to "speak" one's experience of shame (Brown, 2006, 2009; Brown et al., 2011). These two behavioral descriptions of resilience were also used to generate shame resilience sub-items.

Initially, the primary researcher intended for each item to include four sub-items for describing responses to the associated scenario. Two sub-items would represent shame responses and the remaining two as resilience responses. Therefore, the four sub-items (a-d) were written to include consistent conceptual representations of shame and resilience as: (a) Moving toward/Away/Against (shame); (b) Self-compassion (resilience); (c) Comparison (shame); and (d) Reaching out/speaking shame (resilience).

Prior research regarding trainee shame within supervision (Bernard & Goodyear, 2009; Ladany et al., 2005; Sanfter & Tantillo, 2011), clinical work (Brown, 2009; Dearing & Tangney, 2011; Hahn, 2000; Kulp et al., 2007; Lewis, 2006; Morrison, 2008), the training context (Alonso & Rutan, 1988; Kemeny & Shestyuk, 2008;), role induction (Dearing & Tangney, 2011; Watkins, 2012) and peer processes (Shapiro & Powers, 2011) were also used to inform the content of scenarios and sub-items. This research was used in conjunction with the focus group data to determine what types of scenarios would be most common and relatable among trainees. Prior literature was also helpful for generating examples that fit within the sub-item responses.

The researcher generated 40 items, according to the procedures described above. It was anticipated that generating this number of items would provide an adequate pool for eliminating the weaker scenarios during factor analysis.

Review of Items

At the conclusion of item generation, three content experts within the domains of shame, shame resilience theory, and mental health trainee shame were asked to review the instrument's structure, content, construct validity, and clarity. The reviewers included two academic psychologists who have studied shame and shame resilience theory, and one psychologist in practice who has published an empirically based paper regarding shame among mental health providers. In accord with the guidelines used by Neville et al. (2000), reviewers were asked to examine: (a) the relevancy of item content to the MHT experience; (b) the clarity of item wording and phrasing; (c) the overall format and structure of the instrument; (d) the content appropriateness of each item; and (e) to suggest any missing or alternative concepts to include. Those familiar with shame resilience theory were also asked to evaluate the degree to which scenario and sub-item content aligned with the constructs of shame and shame resilience. Reviewers were invited to share any additional concerns and questions as well.

Following reviewer feedback, 44 modifications were made to the content of scenarios and sub-items across the instrument. The majority of these changes were regarding word use and scenario descriptions that were problematic in relevancy, and may have impacted the construct validity of the instrument. Based on suggestions from two reviewers, the instructions were slightly reworded to be more precise. Additionally, the four-point Likert response format changed in order to reflect likelihood of a response (i.e., *Definitely would not –Definitely would*), rather than frequency of a response (i.e., *Never - Always*).

The most significant alteration based on reviewer feedback was to add a fifth sub-item to each scenario. The fifth sub-item was designed to assess the respondents' direct report of feeling shame, and was therefore framed as a basic question about whether one would experience an internal sense of shame or synonymous emotion. The reviewer who suggested this modification had significant expertise researching shame, constructing a shame instrument, and assisting with the development of shame resilience theory. She explained that although the responses to shame (sub-items a-d) were important to capture, it would be helpful to elicit a more direct assessment of whether the respondents acknowledge the internal experience of shame in response to each scenario. The primary researcher added this fifth sub-item after consultation with her dissertation chair. An additional sub-item was generated for all 40 scenarios, and the expert who suggested this change then re-reviewed the modified instrument and approved the revisions.

Pilot Testing

After receiving expert feedback, further evaluation of the generated scale items was sought through pilot testing. The primary purpose of this phase of development was to have individuals respond to items and identify any ambiguous or unclear elements of specific items or response formats (DeVellis, 2003). Eight current trainees from the primary researcher's doctoral seminar were asked to pilot test the instrument, with the understanding that this precluded them from participating in the survey study.

The method for soliciting pilot feedback was delineated by Lee and Lim (2008). Participants were asked to circle words, phrases, or items that were unclear and make note of suggested alterations. Verbal feedback was also elicited following completion of the instrument. Suggested revisions were primarily related to word choice, phrasing, and clarity. Based on this

feedback, the researcher made 21 revisions to item content, after which the scale was considered ready for dissemination. The final pool of items can be viewed in Appendix B.

Study Three: Exploratory Factor Analysis

The purpose of this study was to analyze the constructed Shame and Resilience Among Mental Health Trainees (SRMHT) items using exploratory factor analysis. This method was used to determine an appropriate factor structure for the scale and discern which items were most useful.

Participants

Participants were recruited via email and social media for the survey portion of the scale construction study. After obtaining IRB approval, the researcher contacted individual professors in mental health training programs across the U.S., as well as their associated institutional review boards. A multiple contact strategy was used, in which the professors were first contacted regarding the upcoming request for participation, and then contacted with a follow-up email two-three days later that included the request for participation (Dillman, 2007). Professors were asked to disseminate a recruitment email to students in their programs, which included a link for participating in the study through the Qualtrics online portal. Recruitment messages were also posted to social media sites (Facebook, LinkedIn) by the researcher and her peer colleagues. Upon accessing the survey in Qualtrics, Participants were presented with an informed consent document (Appendix C), and were allowed to begin the study after providing electronic consent. At the conclusion of all survey items, participants were invited to enter a prize drawing for one of four $50 Amazon.com gift cards. The informed consent stated that odds of winning were about 1 in 75. Identifying information was collected for the purpose of sending prize winnings and was stored separately from the study data, on a secured and private computer.

The sample included mental health trainees from Counseling Psychology, Clinical Psychology, Marriage and Family Therapy, Clinical Social Work, and School Psychology. A total of 247 individuals began the online survey. After accounting for data missing completely at random (n = 76) and invalid data (n = 1), the remaining dataset included 170 cases. There were a small number of cases that had missing data within the SRMHT (n = 6). In line with common practices for exploratory factor analysis (Tabachnick & Fidell, 2007), data imputation was used to estimate the missing data points. The rationale and procedure for imputation is described in greater detail in Chapter 4.

The demographic characteristics of the sample generally aligned with that of the larger MHT population. The majority of participants were between 19-29 years of age (60.6%, n = 103), followed by 30-49 years of age (27.1%, n = 46), with 1.8% of the remaining sample being 50-65 and older (n = 3). The sample was 71.8% female (n = 122), 12.9% male (n = 22), 2.4% Androgynous (n = 4), with the remaining 2.4% comprised of individuals who identify as Transgender (n = 1), Male to Female (n = 1), and “Other” (n = 2). In terms of racial and ethnic identities, the sample was predominantly White (66.5%, n = 113). The racial and ethnic identities of the remaining sample included Asian American (7.1%, n = 12), Multiracial (5.3%, n = 9), African American/Black (4.1%, n = 7), Hispanic/Latino/a (3.5%, n = 6), “Other” (1.8%, n = 3), American Indian/Native (0.6%, n = 1), and Hawaiian/Pacific Islander (0.6%, n = 1). The largest religious/spiritual affiliation in the sample was non-religious (40.6%, n = 69), followed by Protestant Christian (19.4%, n = 33), Catholic (10.0%, n = 17), “Other” (9.4%, n = 16), Buddhist (2.9%, n = 5), and Mormon (2.4%, n = 4). Finally, there was small and equivalent representation of individuals identifying as Muslim, Jewish, and Hindu (1.2%, n = 2, for each religious group).

Each targeted training program was represented in this sample, although not in equivalent numbers. Over half of the sample was comprised of MHTs from Counseling Psychology (52.9%, n = 90), with the next largest group being Clinical Psychology (11.8%, n = 20). The remaining program types were represented as follows: School Psychology (10.6%, n = 18), Marriage and Family Therapy (7.1%, n = 12), and Clinical Social Work (4.7%, n = 8). Four participants (2.4%) indicated that they were affiliated with “Other” types of training programs, two of which reported combined training in Clinical/Counseling. Two others reported training in Counselor Education. Due to the core similarities of these fields, these participants were deemed appropriate and retained in the sample.

The models of training included in the sample were predominantly Scientist-Practitioner (58.8%, n = 100) and Practitioner-Scholar (18.8%, n = 32). The next largest group of participants indicated that they did not know what type of model their program has (9.4%, n = 16). The remaining individuals (2.9%) endorsed “Other” and reported training within Scientist-Practitioner-Advocate (n = 3) and Scientist-Practitioner-Scholar (n = 1) programs.

Participants were also asked to answer questions regarding the number of years completed in graduate training. In response, 23.5% indicated that they have completed one year (n = 40), 17.6% three years (n = 30), 15.3% four years (n = 26), 14.1% two years (n = 24), 10% five years (n = 17), 5.3% six years (n = 9), and 3.5% have completed seven or more years (n = 6). There was also a range of experience in regard to years of applied clinical training, which for obvious reasons paralleled the data regarding number of years in graduate training. Finally, the majority of participants reported working with 31 clients or more (42.9%, n = 73), followed by 2-10 clients (21.8%, n = 37), 21-30 clients (12.4%, n = 21), and 11-20 clients (11.8%, n = 20).

Given the nature of this study, participants were asked about whether they had experienced some typical challenges as MHTs. In response, 37.6% of participants (n = 64) reported that they had received a negative evaluation of their clinical work, 55.3% reported that they had received a negative evaluation of their academic work (n = 94), and 37.1% received a negative evaluation regarding their work in research (n = 63). A minority of participants (9.4%, n = 16) had been given a remediation plan and 15.3% (n = 26) had been given individualized behavioral objectives to meet. Also, 14.1% (n = 24) reported that they have received less than a "B" in a graduate course.

Finally, participants were asked to report on their familiarity with the study constructs. About one third of the sample (34.1%, n = 58) had studied shame during graduate training, with 19.4% (n = 33) indicating that they had studied shame resilience theory, specifically. Similarly, 34.7% (n = 59) reported that they are familiar with Brené Brown's work. In sum, a significant number of participants were somewhat familiar with the study constructs, although they still represented a minority within the sample.

Instruments

Participants first responded to the newly developed Shame and Resilience Among Mental Health Trainees (SRMHT) items, followed by instruments for establishing convergent and discriminant validity, and demographic items. The validity instruments included the Compass of Shame Scale (CoSS; Elison, Lennon, & Pulos, 2006), the Other As Shamer Scale (OAS; Goss, Gilbert, & Allan, 1994), the Test of Self-Conscious Affect-3 (TOSCA-3; Tangney, Dearing, Wagner, & Gramzow, 2000), and the Self-Compassion Scale (SCS; Neff, 2003b), which will be further described in Study 4: Validity Estimates.

Shame and Resilience Among Mental Health Trainees (SRMHT; Appendix B). The SRMHT is the central instrument within this scale construction study. It is a self-report survey of shame and shame resilience within the graduate mental health trainee context. At the time of dissemination the SRMHT included 40 items, each containing a potentially shame eliciting scenario, followed by five sub-items that represent acknowledgement of shame, a shame response, and a resilience response. The items were written in a positive direction to ensure clarity and promote accurate responding (Kline, 2005). Following each scenario, participants are provided the following prompt: "How likely am I to do the following?" They then respond to each sub-item along a four-point Likert-type scale (*Definitely Will Not-Definitely Will*), intended to capture the likelihood of using the described response. Items are scored and summed within their associated factors, meaning that higher scores represent independently higher degrees of shame and resilience response tendencies. One validity check item was embedded in the SRMHT in order to ensure attentive responding.

Demographic questionnaire. The demographic questionnaire (Appendix D) included 17 questions that inquired about participant age, gender identity, racial and ethnic identities, religious or spiritual identities, type of training program (e.g., Counseling Psychology), model of training (e.g., scientist-practitioner), year in graduate training, years providing clinical work, and approximate number of clients seen. Additionally, questions were asked regarding challenging training experiences, including (a) receiving a negative evaluation regarding clinical work, academic work, or research; (b) being assigned a remediation plan or individualized behavioral objectives within any domain of training; and (c) obtaining less than a B in a graduate course. Following this, participants were asked if they were familiar with shame resilience theory and Brené Brown's work. The demographic questionnaire was intentionally positioned last in the

study protocol, in order to avoid biasing or priming participants for the scale development portion of the study.

Study Four: Validity Estimates

The purpose of this study was to conduct convergent and discriminant validity analyses to determine the degree to which the SRMHT aligns with established instruments. It was expected that the factor(s) associated with a shame response would demonstrate convergent validity with other shame instruments and discriminant validity with a scale for self-compassion. It was expected that the shame resilience response factor(s) would demonstrate the opposite pattern.

Participants

This study utilized the same sample as Study Three: Exploratory Factor Analysis. Of note, because there was a greater degree of missing data for the validity instruments, the data used for these analyses was augmented using data imputation. The rationale and procedures for data imputation are described in greater detail in Chapter 4.

Instruments

The validity instruments were presented to participants after they had completed the SRMHT, in the order displayed below. These included the Compass of Shame Scale (CoSS; Elison et al., 2006), the Other As Shamer Scale (OAS; Goss, et al., 1994), the Test of Self-Conscious Affect-3 (TOSCA-3; Tangney et al., 2000), and the Self-Compassion Scale (SCS; Neff, 2003b).

Compass of Shame Scale (CoSS; Elison, Lennon, & Pulos, 2006; Appendix E). The CoSS was created to assess four types of shame coping styles, including (a) Attack on Self; (b) Withdrawal; (c) Attack on Other; and (d) Avoidance. These distinct styles represent the manner

in which shame is associated with different motivations, affects, thoughts, and behaviors. The CoSS is a scenario-based, self-report instrument in which participants respond to 12 items, each describing a potentially shame inducing situation. For example, the first scenario is, *"When an activity makes me feel like my strength or skill is inferior:"* and is followed by four sub-items that correspond to the shame coping styles, resulting in 48 total questions. For the example above, the sub-items include: (a) *I act as if it isn't so* [Avoidance]; (b) *I get mad at myself for not being good enough* [Attack on Self]; (c) *I withdraw from the activity* [Withdrawal]; and (d) *I get irritated with other people* [Attack on Other]. Participants rate their frequency of response for each sub-item along a five-point Likert scale (*Never-Almost Always*). As each sub-item is written in a positive direction, the instrument is scored by summing the subscale items according to their corresponding coping style (i.e., Avoidance, Withdrawal, Attack on Self, Attack on Other). Higher scores within the individual subscales indicate more frequent use of that coping style in response to feeling shame. The CoSS has demonstrated adequate internal consistency reliability within each subscale; Withdrawal $\alpha = 0.89$, Attack on Other $\alpha = 0.85$, Attack on Self $\alpha = 0.91$, Avoidance $\alpha = 0.75$ (Elison et al., 2006). Within the current sample, internal consistency reliability values were very similar, Withdrawal $\alpha = .89$, Attack on Other $\alpha = .86$; Attack on Self $\alpha = .92$; and Avoidance $\alpha = .80$.

Other As Shamer Scale (OAS; Goss, Gilbert, & Allan, 1994; Appendix F). The OAS was developed to measure the external components of shame, namely global beliefs about how one is viewed by others. The OAS was modified from the Internalized Shame Scale (ISS; Cook, 1996) in order to better capture beliefs about external perception. It is a self-report survey that includes 18 items. Respondents rate the frequency with which they feelings and beliefs align with each item, using a five-point Likert rating scale (*Never-Almost Always*). As an example, item 4 reads,

"I feel insecure about others opinions of me." All items are written in a positive direction. Scores are calculated by summing each individual item, with higher scores indicating higher levels of external shame. It has a three-factor structure, but items are summed into one total score. The OAS has demonstrated strong internal consistency reliability across two studies, $\alpha = 0.92$ (Goss et al., 1992) and $\alpha = 0.91$ (Pinto-Gouveia & Matos, 2010). For this sample, internal consistency reliability was similar to prior studies, with $\alpha = 0.91$.

Test of Self-Conscious Affect-3 (TOSCA-3; Tangney et al., 2000; Appendix G). The TOSCA-3 measures proneness to using shame, guilt, and blame in response to challenging scenarios. This self-report instrument includes 16 items, each describing an everyday scenario in which feelings of guilt, shame, or blame are likely to be experienced. For example, *"At work, you wait until the last minute to plan a project, and it turns out badly."* Three potential responses are offered for each item that represents different ways of feeling or thinking in response to experiencing this scenario. Using the prior example, potential responses include, (a) *You would feel incompetent* [shame]; (b) *You would think: "There are never enough hours in the day"* [blame]; and (c) *You would feel: "I deserve to be reprimanded for mismanaging the project"* [guilt]. For each potential response, participants rate the likelihood of thinking or feeling in that manner, using a five-point Likert scale (*Not likely-Very likely).* Subscale scores are summed and interpreted within normative standards, based on binary gender identity (i.e., men or women). Tangney (1996) found that an earlier version of the TOSCA had adequate internal consistency reliability across two subscales, obtaining a Cronbach's alpha of 0.77 for shame-proneness and 0.70 for guilt-proneness. For the current sample, the TOSCA-3 *Shame Self-Talk* yielded comparable internal consistency reliability, with $\alpha = 0.75$. Furthermore, the mean Shame Self-Talk score suggested that the average participant responded an "average" to "often" amount,

depending on gender identity (m = 34.74, SD = 6.93). The *Guilt Self-Talk* subscale demonstrated an $\alpha = 0.71$, with m = 46.72, and SD = 4.95. This suggests that on average, participants in this sample use an average amount of guilt self-talk, regardless of gender. Last, the Blaming Others subscale had an $\alpha = 0.66$, m = 22.52, SD = 5.44. This subscale demonstrated low reliability, and suggested that on average, participants in the sample seldom used Blaming Others, regardless of gender.

The Self-Compassion Scale (SCS; Neff, 2003b; Appendix H). The SCS was designed to assess the frequency of practicing self-compassion during times of difficulty. The concept of self-compassion encompasses three components, including self-kindness, common humanity, and mindfulness, each of which is represented by a subscale within the instrument. Neff (2003b) defines each component using the following language: (a) self-kindness means "extending kindness and understanding toward oneself rather than harsh judgment and self-criticism;" (b) common humanity entails "seeing one's experiences as part of the larger human experience, rather than viewing them as separating and isolating;" and (c) mindfulness is "holding one's painful thoughts and feelings in balanced awareness rather than over-identifying with them." The SCS assesses self-compassion using 26 items that reflect either the presence or absence of self-compassion. For example, the item stating, *"I'm disapproving and judgmental about my own flaws and inadequacies,"* reflects a lack of self-compassion, whereas, *"When something painful happens I try to take a balanced view of the situation,"* represents the presence of this construct. Respondents indicate the frequency with which they respond according to each item description, using a five-point Likert rating scale (*Almost Never-Almost Always).* The SCS is scored by reverse-scoring the negative subscale items, and then computing mean subscale scores (for individual subscale interpretations). Responses from each subscale are then combined to produce

a mean score of self-compassionate behavior. Neff (2003a) found that the three subscales demonstrate high inter-correlations and internal consistency reliability, yielding a Cronbach's alpha coefficient of 0.97. For this sample, internal consistency reliability was high, $\alpha = 0.94$. On average, participants tended to respond to themselves in a self-compassionate manner about half of the time ($m = 2.92$, $SD = 0.66$; Neff, 2016).

CHAPTER 4: RESULTS

The aim of the present study is to construct a quantitative self-report instrument for measuring shame and resilience to shame among mental health trainees. The purpose of this Chapter is to describe the statistical analyses and associated outcomes of this scale construction study. The following text will begin with a description of rationales and procedures for data screening and imputation. Next, preliminary analyses are described, including methods used to identify outliers, initial item reduction, and analyses of factorability. A detailed summary of the exploratory factor analyses is then provided, including the Shame Resilience Among Mental Health Trainees (SRMHT) factor structure, names and descriptions of factors, and internal consistency estimates. Finally, the Chapter closes with convergent and discriminant validity estimates between the SRMHT and published measures of shame and resilience.

Study Three: Exploratory Factor Analysis

Data Screening. At the onset of data analysis, 247 individuals had begun participation in the study. However, 76 did not provide any data after consenting to participate, and were therefore removed from the sample. As they did not provide any information that would suggest a pattern of withdrawal, these individuals were deemed missing completely at random (MCAR). Following their removal, 171 individuals remained in the sample.

Next, the embedded validity items were examined for the remaining 171 participants. One validity item was included among each scale in the study, resulting in five validity checks in total. Validity items were written as simple instructions to select a specific response choice, such as *"Please select choice 2."* Participants with more than one incorrect validity item were suspected of random responding and removed from the sample. Four individuals responded incorrectly to one validity check, but given their correct responses to the remaining four validity

questions, this was deemed a random error and their data was included for analysis. One participant responded incorrectly to three validity checks and was thereby suspected of random responding. This individual was removed from the sample, resulting in 170 remaining participants.

Of the remaining 170 participants, 20 did not complete the entire study, but completed a sufficient number of SRMHT items to be included. The missing data for these 20 participants ranged from 8.0 - 92.3%, with only three individuals missing more than 40% (61.8%, 66.2%, 92.3%). Before proceeding, the researcher consulted with literature and a quantitative methods consultant to determine how to proceed with these cases. Despite this high degree of missingness (>40%), the three cases were retained for the purpose of using their SRMHT data, given the small sample size and availability of data imputation (Tabachnick & Fidell, 2007). There was not a discernable pattern among the 20 cases that were incomplete, so attrition was attributed to fatigue. In sum, there were a total of 150 completed cases and 170 functional cases within the study sample.

Missing Values Analysis. Descriptive statistics for each variable within the SRMHT were examined, as variables with 40% or more data points missing should be eliminated from a scale construction study (Tabachnick & Fidell, 2007). No items met or approached this degree of missingness, with the largest degree of missingness at 3.5% for a single item. Therefore, all 200 SRMHT items were retained for further analyses.

The next step was to perform a missing value analysis, to check for problematic patterns of missing data and evaluate methods for eliminating incomplete cases or replacing missing data. Missing Values Analysis (MVA) was conducted using SPSS, which yielded a description of

missingness, including where missing values are located, whether pairs of variables have missing values in individual cases, and whether any extreme data values were present (IBM, 2013).

The MVA revealed that although the vast majority of values (96.84%) in the sample were complete, 33.53% of participants had some missing data. Given that a significant percentage of the total sample had some missing data, further analysis was required. Of the instruments included in the study, the Self-Compassion Scale (SCS; Neff, 2003b) had the greatest degree of missing values (11.8%). As this was the last scale given in the study, this degree of missingness was deemed due to fatigue.

Next, the researcher visually examined a MVA graph of missing value patterns. The purpose of this step was to discern if there was a potential relationship between the SRMHT items and missing values throughout the dataset. If there were, it could mean that certain scenarios or items written for the SRMHT were eliciting participant withdrawal, which would clearly be problematic for the utility of the instrument. Fortunately, there were not any patterns of missingness, aside from that of attrition. Due to the standardized order of instruments in the study (SRMHT → CoSS → OAS → TOSCA → SCS), participants who withdrew during an earlier scale would have missing data on all subsequent scales. In sum, the MVA analyses provided evidence that missing values within the dataset were not attributable to any systematic problems with the SRMHT or other scales used in this study.

Data Imputation. Given the relatively small sample size, pattern of missing data due to attrition, and small amount of missing data from the SRMHT, data imputation was deemed appropriate (Tabachnick & Fidell, 2007). Imputation was performed using an automatic process within SPSS, which generated five iterations of imputed data using fully conditional specification. All scale score variables were included in the imputation process, with

demographic variables omitted from this process. The method of imputation was, in part, chosen by the researcher and also determined through SPSS analysis. Multiple imputation was chosen by the researcher due to its appropriateness for scale construction, relative to alternate means of estimation. Specifically, multiple imputation was deemed most favorable because it does not result in reduction of variance (i.e., mean substitution), create factors (i.e., regression), or rely upon the assumption of missing totally at random (i.e., expectation maximization; Tabachnick & Fidell, 2007). In fact, because multiple imputation generates multiples iterations of a completed dataset, it is particularly useful for examining whether imputation has altered the original data in a major, and problematic manner.

For this sample, SPSS was set to automatically select the appropriate multiple imputation method, based on the monotonicity, or presence of random or patterned missingness in the data. Fully conditional specification (FCS) was used, which is an iterative Markov chain Monte Carlo method that can be applied to an arbitrary pattern of monotonicity. FCS fills in missing data by imputing the missing value for a single dependent variable, using all other available variables in the dataset as predictors. FCS continues this fitting process until the maximum number of iterations is reached, and then saves the maximum iteration values into an imputed dataset (IBM, 2013). Five iterations were generated through FCS for the current dataset.

The five iterations were pooled and compared in order to determine whether the imputed data created problematic deviations from the original data. Internal consistency analyses for the SRMHT revealed that the imputed data yielded subscale alphas that were functionally identical (differing by .001 or less) and mildly more conservative than those of the original dataset. Therefore, the imputed data were deemed appropriate for further analyses.

Preliminary Analyses. Preliminary analyses were conducted for the purpose of eliminating problematic items and facilitating item reduction prior to EFA. First, the normality of each SRMHT item was examined, with the intent of removing any item that demonstrated skewness or kurtosis greater than 2.0 (Tabachnick & Fidell, 2007). No SRMHT items met these criteria and therefore, all 200 items remained for further analysis.

Next, SRMHT items yielding a low shame response were identified and removed from analysis. The rationale for this preliminary analysis was two fold; first, in response to a reviewer suggestion, it was deemed important to consider the quality of scenarios for capturing context specific MHT shame. Second, given the volume of items generated ($n = 200$), it was necessary to reduce the items to a factorable item-to-participant ratio prior to EFA. Therefore, the *Shame Response* subscale was examined within each scenario to facilitate scale refinement.

The purpose of the *Shame Response* subscale was to assess the overall degree to which the associated scenario elicited shame for respondents. As forty scenarios were generated for this scale, the researcher anticipated that scenarios that on average elicited *probable* or *definite* feelings of shame would be useful for measuring shame and resilience responses. Therefore, the frequency statistics for *Shame Response* subscale items 1-40 were examined for mean and modal outcomes. Scenarios were retained on two conditions: those with mode ≥ 3 and those with $M \geq 2.25$ on the shame response variable were judged as adequate. In essence, the items that elicited *Probable* or *Definite* shame responses were kept. This reduced the total item number by half, retaining 20 scenarios and 100 items for further analysis (Appendix I, Table 1).

Next, the remaining 100 items were examined for the presence of outliers among variables. This process ensures that all items adequately relate within the shame and resilience construct domains, and excess error or unreliability is not introduced by outliers (Hinkin, 1998).

SRMHT items without significant ($p < .05$) inter-item correlations were deemed outliers. All items demonstrated at least one significant inter-item correlation, with most yielding multiple correlations. Therefore, no items were eliminated as outlier variables. Furthermore, Tabachnick and Fidell (2007) suggest that a factor analysis correlation matrix should have multiple correlation coefficients of 0.3 or higher. The current SRMHT items yielded multiple correlation coefficients of 0.3 and greater, providing further evidence of factorability.

In order to determine if the scale was factorable, the Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy was conducted. The KMO was .73, which is greater than the cut-off criteria of .60, suggesting sampling adequacy. Additionally, Barlett's test of sphericity yielded a significant chi-square, ($x^2 = 9777.45$, $p < 0.00$), indicating that there are meaningful relationships among the SRMHT items. Together, the KMO and Barlett's test indicate that the variables are adequately related for factor analysis.

Exploratory Factor Analysis. Next, exploratory factor analysis was conducted for the purpose of determining a suitable factor structure for the SRMHT. Principal axis factoring was deemed the most appropriate method, as it is the recommended process for theoretically driven analyses (Tabachnick & Fidell, 2007). Factor analysis was conducted using SPSS, with factor extraction determined by (a) eigenvalues = 1.0; (b) visual scanning of a scree test (Cattell, 1966), and (c) factors loadings over .30.

First, principal axis factoring was conducted with no factor restrictions, using a direct oblimin rotation. A direct oblimin rotation was selected because it can yield an oblique or orthogonal rotation, depending on the degree of correlation in the variables. In this initial analysis, 27 factors yielded eigenvalues greater than 1.0, accounting for 63.42% of the variance. As eigenvalues commonly produce an excessive number of factors (Tabachnick & Fidell, 2007),

further factor reduction was sought through examining Catell's scree plot. This visual analysis suggested discontinuity in eigenvalues following three to four factors. Therefore, the subsequent factor analyses were conducted with factors fixed at four- and three-factor solutions.

Each solution was examined and compared in regard to variance accounted for, with the four-factor solution accounting for 31.92% and the three-factor accounting for 29.53% of total variance. Factor loadings for each solution were examined, with a cut-off of .30 used for identifying significant primary and cross-loading values (Tabachnick & Fidell, 2007). Items that failed to load significantly on any value, had high cross-loadings, or loaded in a theoretically incorrect manner were flagged for examination and possible removal. In all, the researcher conducted ten iterations of factor analysis in order to identify the most suitable solution.

As factor loadings were examined across both three- and four-factor solutions, it became clear that items from the *Moving Toward, Moving Away, and Moving Against* (MTAA) subscale were particularly problematic. The MTAA subscale was designed to capture a range on intra- and inter-personal responses to feeling shame, in accord with the theories of Horney (1945) and Brown (2009). Although MTAA items were reliably aligned with other subscales for capturing shame, several of its items failed to load on any factor and many others yielded numerous cross-loadings. After seeing this trend consistently across multiple iterations of the factor analysis, the researcher determined that the MTAA subscale was diminishing the integrity of the SRMHT factor structure. The MTAA subscale items were therefore removed, resulting in a 20-item reduction.

Furthermore, six scenarios and their associated items were removed through the process of EFA (*items 3, 4, 6, 19, 21,* and *39*). These scenarios contained multiple items that consistently failed to load significantly on a factor and/or had multiple cross-loadings. As the SRMHT is a

scenario-based instrument, the elimination of one sub-item would clearly be problematic for the scenario as a whole. Therefore, *patterns* of loadings and cross-loadings were carefully analyzed in order to ensure conservative item reduction. Eliminating these six scenarios and their associated sub-items resulted in a 24-item reduction.

The final two factor analyses included 14 scenarios and 56 items. These analyses provided the final examination of whether a three- or four-factor solution would best fit the data. The four-factor solution yielded the best fit, accounting for a great amount of variance (39.25%), and resulting in fewer cross-loadings (n = 4) and low-loadings (n = 3) than its 3-factor counterpart. The first factor (19 items) accounted for 22.84% of total variance (eigenvalue = 13.35). The second factor (10 items) accounted for 9.97% of total variance (eigenvalue = 6.16). The third factor (11 items) accounted for 3.43% of total variance (eigenvalue = 2.50). Finally, the fourth factor (13 items) accounted for 3.00% of total variance (eigenvalue = 2.26).

Theoretically, the SRMHT items loaded onto these four factors in a clear and parsimonious manner (Appendix I, Table 2). There were four items that yielded cross-loadings ($\geq$.30), which were only included and scored on the factor of their primary loading. Therefore, no items are used twice for factor scoring. Factor one primarily consisted of positive loadings from the *Shame Response* and *Comparison* subscales, as well as two negative loadings from the *Self-Compassion* subscale. Factor one yielded strong internal consistency reliability, with α = .92. Factor two solely consisted of *Reach Out, Speak Shame* subscale items and also demonstrated strong internal consistency reliability, with α = .86. Factor three was more heterogeneous, with negatively loaded items from *Shame Response* and *Comparison,* as well as one item loading each from *Self-Compassion* and *Reach Out, Speak Shame.* These loadings suggest that factor three does not primarily represent the presence of resilience, but rather the absence of a shame

reaction. The internal consistency reliability estimate for factor three was $\alpha = .84$. Finally, factor four mainly consists of items from the *Self-Compassion* subscale. It also includes one positive loading from *Reach Out, Speak Shame* and one negative loading from *Comparison*. This factor demonstrated strong internal consistency reliability, with $\alpha = .86$. Overall internal consistency for the entire SRMHT was $\alpha = .72$.

Normative information. The mean and standard deviation for the SRMHT total scale (Appendix I, Table 3) was $M = 139.15$, $SD = 10.62$. Within each factor, the means and standard deviations were as follows: Factor 1: $M = 45.16$, $SD = 10.39$; Factor 2: $M = 31.35$, $SD = 4.91$; Factor 3: $M = 25.50$, $SD = 5.77$; and Factor 4: $M = 37.05$, $SD = 5.77$. Skewness and kurtosis indices were also examined for the SRMHT total scale and factors. For the total scale, skewness was -.29 and kurtosis was .65. Among the four factors, skewness and kurtosis were -.03 and -.03, -.44 and .46, .28 and .08, -.14 and -.11. These values fall within the acceptable range of -2.0 – 2.0, suggesting that the SRMHT and it's factors meet the assumption of normal linearity (Tabachnick & Fidell, 2007).

Naming of factors. The four factors within the SRMHT scale each correspond to distinct constructs that are theoretically and empirically representative of shame and resilience to shame. The first factor was titled "Shame Reactions" (SR) as it primarily consists of items representing an internal recognition of shame, as well as the reaction of comparing oneself with others. This factor is the strongest within the scale, consisting of 19 items and accounting for 22.84% of the total variance within the SRMHT. To score the SR factor, the 17 items corresponding to *Shame Response* and *Comparison* are summed with two reverse-scored items derived from the *Self-Compassion* subscale. Higher scores indicate a greater likelihood of responding to shaming inducing scenarios with a shame reaction. For example, the scenario *"You are feeling apathetic*

and struggling to get your work done: How likely [are you] to do the following?" corresponds to two subscale items that fall within the SR factor; (a) *Feel like you do not belong in your program* [Shame Response]; and (b) *Believe that your peers would never be as lazy in their studies* [Comparison]. The SR factor yielded very strong internal consistency reliability, with α = .92

The second factor consists entirely of items aligned with Brown's (2009) component of shame resilience titled *Reach Out, Speak Shame*. The premise of this component is that individuals are more resilient to shame when they are willing to discuss shame-inducing experiences with someone they trust. Factor two is therefore named "Seeking Support" (SS), because each of its ten items represent this behavioral strategy for generating shame resilience. Drawing upon the aforementioned scenario: *"You are feeling apathetic and struggling to get your work done: How likely [are you] to do the following?"* SS corresponds to the subscale item stating, *"Talk about your feelings of apathy with a supportive friend."* The SS factor accounts for 9.97% of total scale variance. It is scored by summing each item, with higher scores indicating a greater likelihood of building shame resilience by reaching out to a trusted individual and describing one's shame inducing experience. The SS factor also demonstrated strong internal consistency reliability, with α = .86.

Factor three was named "No Shame," (NS) based on its strong negative loadings for *Shame Response* and *Comparison* as well as positive loadings for *Self-Compassion* and *Reach Out, Speak Shame*. Though unexpected, this factor makes sense theoretically, as the absence of shame does not automatically signify resilience behaviors. In essence, NS captures a MHT's ability to move through a difficult experience without having a shame reaction. For the scenario: *"After you disclose a personal struggle, your supervisor seems uncomfortable and avoids the topic,"* counter-acquiescent responses to (a) *"Worry that your supervisor will now think less of*

you in comparison with other trainees" and (b) *"Feel that you have exposed an unacceptable part of yourself"* would load on the NS factors. This factor accounts for 3.43% of total scale variance. It is scored by reverse scoring nine of its 11 items, and then summing to achieve a total score. Higher total scores suggest a lower likelihood of feeling shame, and can be conceptualized as contributing to resilience. The NS factor demonstrated strong internal consistency, with α = .84.

Finally, factor four consists almost entirely of items representing self-compassion, with one item derived from *Reach Out, Speak Shame*, and another from *Comparison*. As the *Comparison* item loads negatively, this factor represents resilience behaviors and is named "Self-Compassion" (SC). The SC factor includes 13 items and accounts for 3.00% of the total variance. As an example, the scenario: *"While in session, a client expresses dissatisfaction with your approach as a counselor,"* is followed by the sub-item, *"Tell yourself that every counselor has experienced this,"* which would contribute to the SC factor. The factor is scored by summing 11 *Self-Compassion* items with one *Reach Out/Speak Shame* item and one reverse-scored *Comparison* item. Higher scores indicate greater likelihood of using self-compassion as a mechanism for resilience to shame. The SC factor demonstrated strong internal consistency reliability, with α = .86.

In sum, each of the four factors with the SRMHT has clear theoretical interpretations and strong internal consistency estimates. Overall, the total SRMHT scale accounted for 39.25% of total variance and yielded an internal consistency estimate of α = .72.

Study Four: Validity Estimates

The purpose of this study was to determine the concurrent and discriminant validity of the SRMHT scale, using four previously published measures of shame and shame resilience. The

participant sample used for this study was identical to that of Study Three. Each participant was administered all four validity measures during the course of the online survey. Instruments measuring shame included the Compass of Shame Scale (CoSS; Elison, Lennon, & Pulos, 2006), the Other As Shamer Scale (OAS; Goss, Gilbert, & Allan, 1994), and the Test of Self-Conscious Affect-3 (TOSCA-3; Tangney, Dearing, Wagner, & Gramzow, 2000). As the construct of shame resilience was more recently developed, The Self-Compassion Scale (SCS; Neff, 2003b) was the sole instrument representing resilience. The outcomes of the validity estimates can be viewed in Appendix I, Table 4.

Concurrent validity. To establish convergent validity, the total score for the first factor "Shame Reactions" (SR) was correlated with subscale or summary scores for the CoSS, OAS, and TOSCA-3. As the remaining factors, "Seeking Support" (SS), "No Shame" (NS) and "Self-Compassion" (SC) were theoretically representative of resilience, they were correlated with total scores from the Self-Compassion Scale.

The Shame Reactions (SR) factor yielded significant and positive relationships with each subscale of the Compass of Shame Scale (CoSS), including *Avoidance*, ($r = .16$, $p < .05$), *Withdrawal* ($r = .50$, $p < .001$), *Attack on Self* ($r = .71$, $p < .001$), and *Attack on Other* ($r = .17$, $p < .05$). Additionally, the SR factor yielded a significant and positive correlation with the Other As Shamer (OAS) total score ($r = .55$, $p < .001$). Finally, the SR factor was significantly correlated with two subscales of the Test of Self-Conscious Affect-3 (TOSCA-3), including *Shame* ($r = .58$, $p < .001$), and *Guilt* ($r = .22$, p = .01). The SR factor and TOSCA-3 *Blame* subscale did not yield a significant correlation, ($r = .03$, $p = .75$). Overall, the Shame Reactions factor of the SRMHT demonstrated strong convergent validity with all three published shame instruments.

Next, the second, third, and fourth factors were analyzed individually with the Self-Compassion Scale (SCS) total score to determine convergent validity. The second factor, Seeking Support (SS), was significantly correlated with the SCS, (r = .21, p = .01). The third factor, No Shame (NS), was highly correlated with the SCS, (r = .64, p < .001). Last, the Self-Compassion (SC) factor was also highly correlated with the SCS, (r = .64, p < .001). Following exploratory factor analysis, factors two, three, and four were conceptualized as representing distinct dimensions of shame resilience, with factor one representing shame. Convergent validity analyses seem to support this interpretation of the SRMHT factors, as all four converged with their respective instruments of shame and resilience.

Discriminant validity. The following analyses were conducted in order to examine discriminant validity. First, the Shame Reaction (SR) factor was analyzed with the Self-Compassion Scale (SCS). In line with the researcher's hypothesis, the SR factor demonstrated discriminant validity with the SCS, yielding a strong and negative correlation, (r = - .70, p < .001).

The Seeking Support (SS), No Shame (NS), and Self-Compassion (SC) factors were analyzed with summary scores for the Compass Of Shame Scale (CoSS), Other As Shamer (OAS), and Test of Self-Conscious Affect-3 (TOSCA-3), with the expectation of yielding negative correlations. The SS factor was significantly and negatively correlated with the CoSS *Withdrawal* subscale, (r = -.20, p = .01), but was not significantly correlated with any other CoSS subscales (*Avoidance* r = -.11, p = .18; *Attack Self* r = -.10, p = .21; *Attack Other* r = -.05, p = .56). The SS factor was also not significantly correlated with the OAS total score (r = -.07, p = .40), the TOSCA-3 *Shame* subscale (r = .02, p = .80), or the TOSCA-3 *Blame* subscale (r = -.001, p = .99). In sum, the SS factor demonstrated discriminant validity only with the CoSS

Withdrawal subscale. This finding makes sense, as the act of seeking support in reaction to feeling shame is the direct opposite of withdrawing from social support.

Interestingly, the Seeking Support factor was positively and significantly correlated with the TOSCA *Guilt* subscale ($r = .23$, $p = .004$). This finding aligns with prior research and theory (Brown, 2009; Tangney & Dearing, 2011), which suggests that guilt is a more functional self-conscious emotion than shame, because it motivates action. Therefore, the feeling of guilt and the behavioral response of reaching out to discuss it, appear to co-vary in a significant manner.

The No Shame (NS) factor was then analyzed with the three shame instruments. The NS factor demonstrated significant and negative correlations with all Compass of Shame subscales, including *Avoidance*, ($r = -.29$, $p < .001$), *Withdrawal* ($r = -.59$, $p < .001$), *Attack on Self* ($r = -.66$, $p < .001$), and *Attack on Other* ($r = -.22$, $p = .005$). The NS also had a significant and negative correlation with the Other As Shamer (OAS) total scale score ($r = -.52$, $p < .001$). Finally the NS yielded significant and negative correlations with the Test of Self-Conscious Affect-3 (TOSCA-3) *Shame* ($r = -.57$, $p < .001$) and *Guilt* subscales ($r = -.18$, $p = .03$). It did not yield a significant correlation with the TOSCA-3 *Blame* subscale, ($r = -.08$, $p = .31$). In sum, the No Shame factor demonstrated strong discriminant validity with published measures of shame.

Last, the Self-Compassion (SC) factor was analyzed for discriminant validity with the three shame instruments. The SC had strong and negative correlations with CoSS *Withdrawal* ($r = -.45$, $p < .001$), *Attack on Self* ($r = -.41$, $p < .001$), and *Attack on Others* ($r = -.18$, $p = .03$). It did not yield a significant correlation with CoSS *Avoidance* ($r = -.13$, $p = .10$). Next, the SC factor demonstrated a significant and negative correlation with the Other as Shamer (OAS) total scale ($r = -.31$, $p < .001$). Finally the SC factor was analyzed with each individual subscale of the Test of Self-Conscious Affect-3 (TOSCA-3) and yielded a significant negative correlation with

Shame ($r = -.24$, $p = .003$). The SC and TOSCA-3 *Blame* did not yield a significant correlation ($r = -.02$, $p = .80$). Finally, the SC factor and TOSCA-3 *Guilt* subscale actually yielded a significant positive correlation ($r = .18$, $p = .03$), providing further evidence for the covariance of guilt and adaptive behavioral responses.

CHAPTER FIVE: DISCUSSION

The purpose of this study was to construct a scale for measuring shame and shame resilience among graduate mental health trainees (MHTs). This Chapter will first provide an overview of the results of this study, within the context of the original research hypotheses. Then, the results of the scale construction will be compared with prior research and theory, as well as existing shame and resilience scales. Finally the implications of this study for future research and practice will be described, as well as the limitations of this investigation.

Shame and Resilience among Mental Health Trainees: Overview of Results

Exploratory Factor Analysis. Overall, the four-factor structure of the SRMHT accounted for 39.25% of the total variance in the data, representing a sufficient, though limited, degree of explanatory power. The internal consistency estimates for individual subscales and the overall instrument were high, yielding Cronbach's alpha coefficients above .70. The final version includes 14 scenarios and 56 items (see Appendix J). In sum, the instrument appears to have sound psychometric qualities, thereby providing a strong basis for theoretical extrapolation.

From its inception, the purpose of this study was to construct an instrument for measuring shame and resilience among MHTs, drawing from the theoretical framework of Brown's (2006, 2009) shame resilience theory (SRT). The underlying hypotheses for this scale construction were that (a) MHT experiences of shame and shame resilience would occur in a manner that conceptually maps onto SRT; (b) shame and resilience would exist as independent factors; and (c) SRMHT factors would be significantly correlated with one another, and with the overall instrument.

In regard to hypothesis (a), the results of this study partially support the assumption that the MHT experiences of shame and resilience align with shame resilience theory. The SRT

conceptualizations of shame, comparison, reaching-out/speaking shame, and self-compassion were manifested within the SRMHT factors in a theoretically congruent manner. Shame and comparison share the same factor (*Shame Reactions*), and diverge from the resilience counterparts of reaching out/speaking shame (*Seeking Support*) and self-compassion (*Self-Compassion*). However, the hypothesis was not fully supported due to the elimination of the *Moving Toward*, *Away*, and *Against* subscale, which failed to fit consistently on a given factor in the EFA. This deviation is further explored later in this Chapter.

Hypothesis (b) was fully supported by the outcomes of this study, in that shame and resilience were represented by distinct factors. One might assume that *resilience to* shame is synonymous with the *absence of* shame, suggesting that these constructs are conceptually binary. If this were true, the shame and resilience items might have loaded on a single factor in opposite directions. This assumption is not supported by SRT, which asserts that shame resilience requires the development of healthy responses to shame, rather than elimination of the experience altogether. As argued by many (Brown, 2006; Kemeny, et. al, 2004; Lewis, 1971), complete eradication of shame as an emotional experience is not possible, as shame is the result of our inherent human needs for approval, acceptance, and belonging. Shame and resilience co-occur and therefore, the generation of distinct factors associated with shame (*Shame Reactions*) and resilience (*Seeking Support* & *Self-Compassion*) fits well with this hypothesis and prior conceptualizations of shame and resilience.

In regard to hypothesis (c), three of the four factors were correlated with each other and all factors were significantly correlated with the overall instrument (Appendix I, Table 5). The *Shame Reactions* (SR) factor demonstrated significant negative correlations with the *No Shame* (NS) and *Self-Compassion* (SC) factors. The *Shame Reactions* factor and *Seeking Support* (SS)

had a non-significant negative correlation. The *Seeking Support* factor yielded a positive and significant correlation with *Self-Compassion*, but was not significantly correlated with the remaining two factors. Finally, *No Shame* and *Self-Compassion* factors demonstrated significant and positive relationships with one another. Each of these relationships fits with the constructs and theory that underlie this instrument; the factor accounting for shame (SR) was negatively correlated with those representing resilience (SS & SC) and the absence of shame (NS). Also, factors representing resilience (SS & SC) were positively related to one another. Interestingly, the factor for reaching out to speak shame (SS) was not significantly correlated with the factor representing shame (SR) or the absence of shame (NS). This lack of relationship seems to support the notion that resilience practices (i.e., reach out, speaking shame) can yield resilience, independently of an individual's degree of shame proneness (Brown, 2006, 2009).

Validity Estimates. The construct validity of the SRMHT was strongly supported by the manner in which its factors converged and diverged with existing measures of shame and shame resilience (Appendix I, Table 4). First, the *Shame Reactions* (SR) factor included items for capturing a shame response (i.e., *"Feel really terrible about yourself*") as well as comparison (i.e., *"Think that this would never happen to a trainee who works hard enough"*) to a given scenario. Among the four factors of the SRMHT, the SR factor is conceptualized as the sole component for measuring shame proneness, which was supported by the convergent validity analyses. The SR factor demonstrated strong convergence with each of the three previously published instruments for measuring shame. This factor aligned with the *Shame* and *Guilt* subscales of the Test of Self-Conscious Affect-3 (TOSCA-3; Tangney et al., 2000), as well as the total score for the Other As Shamer (OAS; Goss et al., 1994). The SR factor also converged with all four subscales of the Compass of Shame Scale (CoSS; Elison et al., 2006), including *Attack*

on Self, *Attack on Other*, *Withdrawal*, and *Avoidance*. Additionally, the SR factor demonstrated discriminant validity with the Self-Compassion Scale (SCS; Neff, 2003b), which has been the standard instrument for capturing resilience within shame resilience research (Brown, 2006, 2009). In sum, the SR factor fits well with other empirically validated shame scales and diverges from the Self-Compassion Scale, suggesting that this factor is capturing shame proneness among mental health trainees in a valid manner.

The *Seeking Support* (SS) factor contains items that represent an individual's attempt to reach out and discuss her/his emotions after having a challenging experience (i.e., *"Share any difficult feelings about this with someone you trust"*). This factor was written to represent a domain within shame resilience, and the convergent and discriminant validity analyses suggest that it does capture resilient behavior. The SS factor converges with the Self-Compassion Scale, and discriminates from the CoSS *Withdrawal* scale. As stated in Chapter 4, it makes sense that the SS factor discriminates from the CoSS *Withdrawal* scale, as it is capturing the act of seeking social support, rather than social withdrawal. The SS factor does not diverge from the other CoSS subscales, the TOSCA-3, or the OAS. Though nuanced, this finding is significant, as it illustrates the manner through which resilience behaviors occur in response to shame, rather than in place of it (hence, hypothesis b). In sum, the SS validity analyses support the role of seeking support in contributing to shame resilience.

The *No Shame* factor is the most surprising and conceptually interesting result of this study. This factor is primarily comprised of negative loadings, or dissenting answers to shame response and comparison items such as, *"Feel that you have exposed an unacceptable part of yourself,"* or *"Worry that your supervisor will think less of you than other trainees."* This factor demonstrated convergent validity with the Self-Compassion Scale, as well as discriminant

validity with all Compass of Shame subscales, the Other As Shamer, and the *Shame* and *Guilt* subscales of the TOSCA-3. Therefore, the NS factor seems to represent an absence of a shame response, distinct from the resilience behaviors represented by the *Seeking Support* and *Self-Compassion* factors. The presence of this factor is interesting, as it suggests that certain items within the instrument are hanging together due to a pattern of dissenting responses. Conceptually, while this factor relates to shame resilient factors (SS & SC), it seems distinct in that the absence of feeling shame does not necessarily indicate resilience practices.

Finally, the Self-Compassion factor mostly contained items representing the *mindfulness*, *common humanity*, and *self-kindness* components of Neff's (2003b) conceptualization of self-compassion. Naturally, the SC factor demonstrated strong convergence with the Self-Compassion Scale. Interestingly, the SC factor also demonstrated convergence with the TOSCA-3 *Guilt* subscale. Though unexpected, this finding fits with prior research findings that suggest guilt is an adaptive emotion, for which individuals more easily respond with self-understanding (Dearing & Tangney, 2011; Lewis, 1971). The SC factor discriminated from the CoSS *Attack on Self*, *Attack on Other*, and *Withdrawal* subscales, as well as the Other As Shamer and the TOSCA-3 *Shame* subscale. In sum, the SC factor emerged as a meaningful factor for representing the construct of shame resilience.

Fitting the SRMHT with Prior Theory and Research

The SRMHT scale provides a means for measuring shame and resilience among mental health trainees that aligns with and augments previously published research and theory. In the following text, the findings of this study will be fit with the domains of (a) shame resilience theory (SRT; Brown, 2006); (b) the contextualized nature of shame and application within the therapeutic training context; and (c) measurement of shame and shame resilience. This analysis

will provide insight into how the SRMHT can be integrated into the existing body of shame and resilience literature.

SRMHT and Shame Resilience Theory. Brown's (2009) shame resilience theory (SRT) posits that although shame is elicited in diverse and context-dependent manners, reactions to shame are generally consistent across individuals. Broadly, feeling shame is linked to interpersonal appeasement, avoidance, and aggression (Brown, 2009; Horney, 1945), as well as comparison and criticism (Brown, 2012). For the purpose of translating these constructs into the measurement of MHT shame, the concepts of comparison, and *moving toward*, *away*, and *against* [others] were used.

The construct of comparison was reinforced by the qualitative findings of this scale construction study. The items representing MHT comparison between self, peers, and other therapists were significant components of the *Shame Reactions* factor. Indeed, comparison arose as a frequent and prominent theme during the qualitative portion of this study.

In contrast, the *Moving Toward*, *Moving Away*, and *Moving Against* (MTAA) subscale of the SRMHT was eliminated during the process of exploratory factor analysis. During EFA, the MTAA items generally loaded with the two other subscales for capturing shame, namely the *Shame Response* and *Comparison* subscales. Despite this partial alignment with the hypothesized factor structure, the MTAA subscale also generated numerous cross loadings and low item loadings (< .30). One explanation for the poor factorability of the MTAA items is the diffuse and diverse nature with which these responses are employed. As noted by Brown (2009), individuals differ in their use of *moving toward*, *away*, and *against*, often using all three interpersonal responses in varying combinations. Hypothetically, it may be that individuals are reluctant to endorse *moving against*, as the aggression it entails is less socially acceptable. In fact, Brown

(2009) suggests that moving against is reserved for use in close relationships, suggesting that it may not be as applicable in the professional context. Therefore, *moving against* is difficult to assess via self-report and will likely elicit diverse responses when grouped with the more accepted methods of appeasement [*moving toward*] and avoidance [*moving away*].

As SRT is oriented toward the process of building resilience to shame, it clearly delineates steps for this development, through (a) building awareness of one's triggers and accepting the necessity of personal vulnerability; (b) engaging in critical awareness regarding the social and cultural expectations that drive shame; (c) forming mutually empathic relationships that diffuse isolation; and (d) developing language and emotional competence for speaking and deconstructing shame (Brown, 2009). Additionally, the *Connections* and *Daring Way ™* curriculums associated with SRT draw upon Neff's (2003b) self-compassion framework as another strategy for developing resilience. Of these, parts (c), (d), and self-compassion were integrated into the SRMHT. The ability to form close, mutually empathic relationships (c) in which one can describe their feelings of shame (d) were combined in items representing reaching out, speaking shame. Ultimately, these items primarily loaded on the *Seeking Support* factor. Items representing self-compassion loaded on a SRMHT factor of the same name.

The processes of building awareness of one's triggers, embracing vulnerability, and engaging in critical awareness were not directly assessed by the SRMHT. However, one could argue that the responses captured by the *Seeking Support* factor inherently account for acceptance of vulnerability, as it is a vulnerable act to disclose feelings of shame. In all, shame resilience theory was instrumental in generating the SRMHT, and many of its concepts were supported by the factor solution of this instrument.

SRMHT and the Therapeutic Training Context. Despite its many implications, shame is not often named or overtly explored during therapy (Dearing & Tangney, 2011). Researchers have suggested that this oversight occurs because shame is not sufficiently studied during mental health training and is thereby misunderstood by practitioners (Brown et al., 2011). In addition to a lack of training, practitioners are also apt to avoid shame in their therapeutic roles because of the especially vulnerable and relatable nature of this emotion. Working with the shame of others inevitably triggers thoughts about our own personal shame, thereby eliciting discomfort (Dearing & Tangney, 2011; Hahn, 2000) and requiring the personal reflection necessary for dealing with many other forms of countertransference (Brown, 2009; Dearing & Tangney, 2011).

Given these factors, shame is clearly an important issue for those who are training to become mental health providers. One aim of this scale construction study was to capture the essence of the MHT shame experience, through generating scenarios and items that reflect the unique trainee context. Indeed, Tangney (1996) asserted that for scenario-based instruments, it is important to reflect diverse settings and behaviors in order to resonate widely with participants. After the phases of item generation and reduction, it is interesting to consider which themes remained in the fourteen scenarios of the SRMHT. Broadly, the scenarios focus on client dissatisfaction, supervisory dynamics, peer processes, personal mental health struggles, academic underperformance, and difficulty fulfilling expectations.

These domains fit well with prior research regarding the steep learning regression of MHT training (Alonso & Rutan, 1988) and complexity of transitioning into the therapist role (Ladany et al., 2011; Watkins, 2012). The personal and professional integration that is necessary for working in the mental health field means that MHTs are being evaluated on personal characteristics that are often outside of their awareness (Alonso & Rutan, 1988; Bernard &

Goodyear, 2009; Sanfter & Tantillo, 2011). Additionally, interpersonal interactions among MHT peers are complex due to competitive dynamics (Kenneth et al., 2006) and social evaluative threat (Kemeny & Shestyuk, 2008). In sum, the scenarios included in the SRMHT are reflective of previous literature regarding the experience of shame in mental health training. The SRMHT builds upon this research by providing concrete scenarios that can be used for quantitative measurement of shame and resilience.

SRMHT and Prior Measurement of Shame and Resilience. As reviewed in Chapter 2, other instruments have characterized shame as trait proneness, state shame, externally imposed, and domain-specific. The SRMHT measures trait shame, or shame proneness within the MHT context. This means that rather than trying to capture a momentary shame state, the purpose of this instrument is to assess one's general predisposition to feeling shame when encountering a challenging scenario. The use of a scenario-based design for the SRMHT was considered especially beneficial for three reasons, as (a) scenarios help to contextualize challenges and emotions within the training environment; (b) situations can trigger mild emotional responses that promote accurate reporting; and (c) scenario-based instruments tend to elicit less defensiveness than other designs (i.e., global adjective checklists; Tangney, 1996). Despite these advantages, scenario-based instruments typically have lower internal consistency estimates, because the situational element of each item contributes unique variance to measuring the construct (Tangney, 1996). This limitation helped to inform the researcher's decision to eliminate scenarios prior to EFA, based on their relevance for eliciting shame. In the end, the final internal consistency reliability estimate for the SRMHT was strong, with $\alpha = .72$.

In Tangney's (1996) review of shame measurement, the author acknowledges that shame and guilt are close emotional relatives, and are thereby difficult to distinguish from one another

during the measurement process. The occurrence of "shame-fused guilt" (Dearing & Tangney, 2011) necessitates a clear distinction between a focus on self (shame) and a focus on behavior (guilt). Indeed, the closeness of shame and guilt is evident in the SRMHT scale construction results. In Study Four: Validity Estimates, the *Shame Reactions* factor converged with both the *Shame* and *Guilt* subscales of the TOSCA-3. Simultaneously, the *Guilt* subscales of the TOSCA-3 also converged with the *Seeking Support* factor of the SRMHT. This finding was unexpected, though not surprising, as guilt is associated with taking action and has been promoted as the more adaptive self-conscious emotion (Brown, 2009; Tangney & Dearing, 2011). Moving forward, it will be important to further study how shame and guilt are elicited and differentiated from one another in the mental health-training context.

Implications of the SRMHT for Research and Practice

The next step in development of the SRMHT will be to collect a second sample of MHTs and perform confirmatory factor analysis. At that time, the instrument's four-factor structure will be further examined and compared with additional shame instruments such as the Adapted Shame and Guilt Scale (ASGS; Harder & Zalma, 1990; Hoblitzelle, 1982;), the Internalized Shame Scale (ISS; Cook, 1996), the Experiential Shame Scale (ESS; Turner, 1998), and the Experience of Shame Scale (ESS; Andrews et al., 2002).

Following confirmatory factor analysis, the SRMHT will be ready for use with the MHT population. This instrument has the potential to serve multiple functions, including (a) operationalizing the constructs of shame and shame resilience among trainees in a measurable form; (b) providing a tool for empirically studying this component of the training process; and (c) helping trainees and supervisors appraise the development of shame resilience.

In operationalizing shame and resilience, the SRMHT will help MHTS learn to recognize the interpersonal, intrapsychic, and behavioral manifestations of shame and resilience in their professional context. In this way, the SRMHT could be used as a training tool for building self-awareness about how and why shame is triggered on an individual basis. The process of learning to understand shame and apply this understanding in professional settings must begin with a personal exploration of how this emotion is experienced within oneself. As shame is a murky emotion and is difficult to verbalize (Brown, 2006; 2009), and is socially taboo to discuss or acknowledge, it is expected that trainees will not arrive in graduate school with ready understanding of this core emotion. In contrast, it seems more likely that individuals early in their training will react defensively to subconscious elicitors of shame as well as overt discussion of this emotion. Although it is natural for MHTs to enter training with little awareness of shame, it is a disservice to trainees, and the clients they will serve, for them to leave training with a similar degree of obliviousness. It can be argued that therapists are less equipped to lead clients across emotional "terrains" that they have not personally "traversed," and the here-and-now experiences of shame during training provide a rich opportunity for gaining experiential understanding. In sum, the SRMHT provides a quantitative and concrete tool for augmenting training about shame. It facilitates intellectual understanding through scenario and item examples, while also helping MHTs gain self-awareness about their own shame proneness and resilience behaviors.

Second, the SRMHT is a tool for studying the implications of shame and resilience in training, supervision, and learning environments. With the advent of shame resilience theory (Brown et al., 2006, Brown 2009), this is a somewhat novel area of research. However, it fits well with prior studies of shame in supervision, such as Ladany et al.'s (2005) critical events

model of supervision. Using the SRMHT, the impact of shame can be considered beyond the supervisory dyad, with greater investigation of shame as it relates to peer processes, personal struggles, and training methods. The directions for study in this regard are many. For example, it would be interesting to investigate the impact of faculty-modeled vulnerability on trainee resilience. Or to examine how acknowledging competitive or aggressive peer processes would impact willingness to seek support. Indeed, it would be fascinating to study how trainee shame and resilience are associated with therapeutic alliance quality, especially when working with challenging clients. In sum, the SRMHT will aid trainee development researchers in examining how members of the training community can promote healthy personal-professional integration for MHTs.

The final implication of the SRMHT is its usefulness for appraising the development self-awareness regarding shame of shame resilience. Given the painful and socially taboo nature of shame, it is unlikely that MHTs will initiate the dialogue about shame into their training process. This relates well with Alonso and Rutan's (1988) learning dilemma, which describes how MHTs navigate a precarious balance between acknowledging their limitations and maintaining a professional and competent veneer. Additionally, the unavoidable power imbalance between MHTs and their trainers suggests that shame-in-training should be introduced by the more powerful parties; specifically, supervisors, professors, and other mentoring figures. Therefore, the SRMHT could be a helpful tool for those who are guiding MHTS through this beneficial, though difficult, process of understanding shame.

Limitations of Current Study

This scale construction study had several limitations, including a relatively small sample size and unequal representation across mental health training fields. Furthermore, the SRMHT

has constraints in that it accounts for a limited amount of variance and is complex to score. These issues will be examined in the following text.

First, the sample size for this scale construction study was smaller than anticipated. According to Tabachnick and Fidell (2007), an ideal sample size for factor analysis is generally $N = 300$, as this number provides a sufficient $N{:}p$ ratio that ensures factorability. As described in Chapter 4, the final sample size for this study was $N = 170$, which is clearly below this criterion. Participant recruitment and data collection for this study proved difficult, as mental health trainees were harder to access than originally anticipated. Furthermore, the length of the online survey, estimated at 30-40 minutes, likely contributed to low response rates and study attrition.

Nevertheless, the participant-to-item ratio for this study was 1.7 – 1. Although this is much less than the desired ratio of 10-1, McCallum, Widaman, Zhang, and Hong (1999) found that when communalities are consistently high (> .60), even small sample sizes of $N < 100$ can yield a high-quality factor solution. Worthington and Whittaker (2006) also suggested that sample sizes of N=150-200 are sufficient for datasets with communalities higher than .50. Indeed, the communalities for the SRMHT items were high, with most at or above .60 (See Appendix I, Table 6) and a sample size of N=170. Furthermore, the EFA yielded a low number of factors and a high number of indicators per factor on the SRMHT, providing additional evidence of the quality of this factor solution (McCallum et al., 1999). In sum, although the low sample size of this scale construction study is less than ideal, it does not appear to be detrimental to the integrity of the factor solution.

Another limitation was that mental health trainee groups were unequally represented in both the qualitative and quantitative phases of this study. The SRMHT is intended to be applicable across several mental health-training fields, including Marriage and Family Therapy,

Clinical Social Work, School Psychology, Clinical Psychology, and Counseling Psychology. During the qualitative phase, five participants were from Counseling Psychology, one was from Clinical Psychology, and all other fields were not represented. During the survey portion of the study, the sample included members from every intended training program, though over half of the participants were from Counseling Psychology departments. This is likely due to the researcher being affiliated with Counseling Psychology and subsequently having stronger access to those graduate programs across the nation. As noted by Worthington and Whittaker (2006), the factor structure stability and generalizability can be diminished by samples that do not accurately represent the intended population. In future studies, such as the confirmatory factor analysis, it will be important to target a greater proportion of trainees from other mental health fields in order to ensure the generalizability and stability of the scale.

Finally, the SRMHT itself has limitations that are important to note. In this study, the SRMHT accounted for 39.5% of the total variance in the data, demonstrating respectable, though not superb explanatory power. This suggests that the constructs of shame and resilience among MHTs may not have been fully conceptualized and captured by the four-factor solution. Second, the factor solution of this instrument is imperfect, including three items with low loadings and four with high cross-loadings. As previously discussed, these items were retained due to the manner in which scenario-based items are grouped together, meaning that eliminating one sub-item would require the elimination of the entire scenario and a loss of significant content. Therefore, these few items were deemed necessary for inclusion. In scoring procedures, the items with low loadings are not added to any factor and the items with cross-loadings are only added according to their highest loading, or primary, factor. Finally, the SRMHT is somewhat complex to score, due to one of its factors. The *No Shame* factor is primarily comprised of negative

loadings, meaning that items need to be reverse-scored in order to total this subscale. Although complex scoring procedures are common, it is imperative that the negative loadings of the *No Shame* factor be verified through the process of confirmatory factor analysis.

Conclusion

This study provides empirical support for the generation of a shame and resilience scale within the mental health trainee context, the Shame and Resilience Among Mental Health Trainees scale (SRMHT). This scale demonstrated strong psychometric properties through estimates of internal consistency reliability, convergent validity, and discriminant validity. The SRMHT provides a significant and novel contribution to the studies of shame and shame resilience by examining them within the mental health-training context. It also provides an instrument for studying and better understanding the training process across academic, clinical, and supervisory domains. Furthermore, the SRMHT provides empirical support for several constructs from shame resilience theory (Brown, 2009) and yielded the *No Shame* concept that accounts for an absence of shame response. In these ways, it verifies prior research and theory while also contributing a new perspective. In sum, it is hoped that the SRMHT will be used on individual and systemic levels to grow understanding of MHT shame, as well as the processes for becoming more resilient professionals and persons.

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APPENDIX A
STRUCTURE OF SCENARIOS AND SUB-ITEMS

Scenario

How likely am I to do the following?	**Definitely Will Not**	**Probably Will Not**	**Probably Will**	**Definitely Will**
a) Move Toward/Away/Against				
b) Self-compassion				
c) Comparison				
d) Reach out/Speak shame				
e) Shame response				

* The order of sub-items *a-e* were randomized prior to dissemination

APPENDIX B
DISSEMINATED SRMHT ITEMS FOR EXPLORATORY FACTOR ANALYSIS

Directions: Read the numbered scenarios and respond to each of the accompanying four sub-items below. Please mark a response for EACH sub-item A-E, indicating how likely it is that you would respond in the described manner. There is no correct or best answer; just choose the option that resonates most with your self-knowledge and most likely reaction to the situation.

1) While in session, a client expresses dissatisfaction with your approach as a counselor.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Apologize repeatedly and promise to meet the client's expectations in future sessions.				
b) Tell yourself that every counselor has experienced this.				
c) Think that none of your peers have dissatisfied clients.				
d) Discuss your feelings about this feedback with your supervisor.				
e) Feel devastated immediately after hearing this feedback.				
2) You did not read any of the assigned readings for a class discussion.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Feel anger or blame toward your professor for assigning too much reading.				
b) Recognize that your uncomfortable feelings will not last forever.				
c) Compare yourself with classmates who are always prepared.				
d) Acknowledge to a trusted peer that you're not prepared for this discussion.				

e) Feel that you do not belong in your training program.				
3) Your peers are observing live while you conduct therapy with a client.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Ignore or suppress your anxious feelings.				
b) Tell yourself that everyone feels nervous while being observed.				
c) Think that at least you are more skilled than some other trainees.				
d) Acknowledge any nervous feelings to your peers.				
e) Feel exposed by the thought that others are judging your shortcomings as a counselor.				
4) You received a low grade on a class assignment.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Avoid this instructor outside of class.				
b) Generate kind and compassionate self-talk regarding this low grade.				
c) Ask around to compare your grades against others'.				
d) Discuss the grade and your feelings about it with the instructor.				
e) Feel like a complete failure.				
5) Your clinical supervisor gives negative feedback regarding your interpersonal style.				

How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Focus on concealing this part of your personality.				
b) Notice your hurt feelings without judgment.				
c) Worry that your supervisor does not like you as well as other trainees.				
d) Acknowledge to your supervisor that you are struggling after receiving this feedback.				
e) Feel that you are too flawed to be counseling others.				
6) You notice that a fellow student has many more accomplishments on their CV/resume than you.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Feel irritated or contemptuous toward this peer for being an overachiever.				
b) Acknowledge that you are experiencing painful feelings, such as envy or inadequacy.				
c) Feel that this person is a much better student than you.				
d) Talk with a trusted peer about your reactions to this situation.				
e) Feel like there is something wrong with you as a student.				
7) During group supervision, your peers give you a lot of suggestions about how to work with a particular client.				

How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Decide not to share as much again in supervision.				
b) Remind yourself that everyone needs feedback from time to time.				
c) Pay close attention to whether other trainees are also given critical feedback.				
d) Openly acknowledge that it is hard to be the one in the "spotlight."				
e) Feel totally unfit to work with this client.				
8) Your supervisor makes a dismissive comment about a central part of your identity.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Conceal your negative reaction and pretend to be unfazed.				
b) Be accepting toward the strong emotions that you are feeling.				
c) Think that other trainees are supported, whereas you are not.				
d) Talk about this experience with someone who will understand your perspective.				
e) Feel small, as though you do not matter.				
9) A client no-shows for your second session.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**

a) Feel very irritated with this person's lack of consideration.				
b) Remind yourself that every therapist experiences client no-shows.				
c) Worry that you will never be able to maintain a client load the way others can.				
d) Discuss your feelings about this with your supervisor.				
e) Feel that there must be something wrong with you as a counselor.				
10) You feel unsure of how to complete a class assignment correctly.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Avoid asking questions in order to appear more competent.				
b) Try to notice any stress without becoming overwhelmed.				
c) Think that you are the only student who is struggling to understand this assignment.				
d) Admit to your instructor or a classmate that you are in need of help.				
e) Feel that you are intellectually deficient.				
11) You miss a deadline for turning in a paper to your advisor.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Avoid your advisor until you have completed the paper.				
b) Remind yourself that everyone misses deadlines occasionally.				
c) Think that you are less responsible than other students.				

d) Describe your feelings about this with a trusted peer.				
e) Feel that you are unfit to be in graduate school.				
12) While discussing culture in class, your perspective is different from what is being expressed by others.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Stay silent to avoid the disapproval of others in the class.				
b) Treat yourself with warmth and understanding.				
c) Think that you must be missing something, compared to your peers.				
d) Process this experience with someone who will listen to your point of view without judgment.				
e) Feel separate from the others; as though you do not belong.				
13) You notice that a faculty member seems to praise a peer more than you.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) "Go above and beyond" to gain this faculty member's approval.				
b) Try to accept any difficult emotions that arise.				
c) Think a lot about the ways that you are inferior to this peer.				
d) Describe your feelings about this to someone you trust.				
e) Feel that you are not worthy of praise.				
14) Your supervisor suggests that you attend therapy to work through a personal issue.				

How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Feel irritated with this intrusion into your personal life.				
b) Remind yourself that everyone has areas for growth.				
c) Worry that your personal problems make you less capable than other trainees.				
d) Acknowledge any vulnerable feelings about needing therapy to your supervisor.				
e) Feel like something is wrong with you.				
15) Regarding a paper, your advisor gives feedback that "this isn't your best work."				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Do whatever it takes to regain your advisor's approval.				
b) Allow yourself to feel disappointed with this feedback.				
c) Think that other trainees are always able to give 100%.				
d) Make plans to discuss your feelings about this with a peer whom you trust.				
e) Feel that you are a bad student.				
16) You feel tired during a counseling session and have difficulty focusing on what the client is saying.				

How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Try to make up for this by allowing the client to schedule a session when you were supposed to be out of the office.				
b) Remind yourself that you can't always be the perfect therapist.				
c) Feel good that at least you showed up. A therapist with less commitment would have stayed home to rest.				
d) Talk about your feelings regarding this in supervision.				
e) Feel like you're unfit to be a counselor.				
17) You misremember a client's history and the client notices.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Try to smooth this over by acting like it did not happen.				
b) Recognize that every counselor makes this mistake from time to time.				
c) Think that at least you didn't call the client by the wrong name, which some of your peers have done.				
d) Process this experience with your peers or supervisor.				
e) Feel completely incompetent in your role as a therapist.				

18) A new client states that their past counselor was "life changing."				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Feel irritated with this client for setting you up for failure.				
b) Notice your feelings of insecurity without judgment.				
c) Assume that your client's previous counselor was more skilled than you.				
d) Describe any vulnerable feelings that arise from this with your supervisor.				
e) Feel small; as though you will never measure up.				
19) You overhear some fellow trainees discussing the strengths and weaknesses of other students in your program.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Join in to ensure that they aren't talking about you.				
b) Notice that overhearing this brings up feelings of insecurity.				
c) Worry that they think less of you than other trainees.				
d) Describe your reactions to this with someone you trust.				
e) Feel mortified as you realize that they have inevitably noticed your weaknesses.				
20) A peer reviews your paper and gives more critical feedback than you had expected.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**

a) Feel resentful toward this person for being so critical.				
b) Remind yourself that feedback is normal and necessary.				
c) Compare the quality of your work with this peer's.				
d) Talk about any difficult feelings that you're having with someone who will empathize.				
e) Feel completely incapable as a writer.				
21) While discussing a counseling case, you have a very different perspective than your fellow trainees.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Avoid sharing your perspective, unless someone else says it first.				
b) Notice your feelings of discomfort without judging yourself.				
c) Wish that you thought about things the way other trainees do.				
d) State that it feels risky to share an alternative perspective.				
e) Feel very alone and isolated from the rest of the class.				
22) Your client says that they felt "abandoned" when you were sick and cancelled their prior appointment.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Apologize repeatedly and explain why you had to cancel in as much detail as possible.				
b) Think that most therapists have probably worried about this at some point.				
c) Think that other counselors would never let a client down in this way.				

d) Express any difficult feelings regarding this in supervision.				
e) In the moment, feel unfit to be a therapist.				
23) You are deciding whether to attend a social hour at a professional conference.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Skip the social hour because gatherings like this are pointless.				
b) Treat your feelings of anxiety with warmth and understanding.				
c) Think that you will not "do well" in this setting compared to other students.				
d) Share your feelings of apprehension with a trusted peer.				
e) Feel deeply inadequate.				
24) In group supervision, you notice that you are the only therapist whose client is not making progress.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Avoid talking about your client in group supervision.				
b) Remind yourself that it is normal to feel unsure in the counseling process.				
c) Question why other trainees are so much more effective than you.				
d) Use group supervision to process your feelings about this.				
e) Feel unworthy to be counseling others.				
25) During your final year in training, you are unable to answer a question during a comprehensive exam.				

How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Feel indignant that you are being asked a random question.				
b) Notice your feelings of failure without judgment.				
c) Think that others would never make such a mistake at this point in the training process.				
d) Describe any pain you felt in this situation to someone who will "get it."				
e) In the moment, feel overwhelmed by incompetence.				
26) After you disclose a personal struggle, your supervisor seems uncomfortable and avoids the topic.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Resolve not to make a personal disclosure in supervision again.				
b) Practice self-kindness when you sense this person's discomfort.				
c) Worry that your supervisor will now think less of you in comparison with other trainees.				
d) Acknowledge any vulnerable feelings that you're having about this to your supervisor.				
e) Feel that you have exposed an unacceptable part of yourself.				
27) You feel unsure about how to proceed on a project, while your peers seem to know what to do.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**

a) Conceal your uncertainty by "taking a back seat" in the project tasks.				
b) Remind yourself that others are probably feeling unsure too.				
c) Worry that you will never be as competent as other trainees.				
d) Describe any feelings of inadequacy to someone you trust.				
e) Feel defeated, like you are completely incapable as a student.				
28) After asking a question in class, you realize that everyone else already "gets it."				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Avoid contributing to the class discussion for awhile.				
b) Feel compassionate toward your feelings of self-doubt.				
c) Think that you are not as smart as your classmates.				
d) Talk about this experience with someone you trust.				
e) In the moment, feel very unworthy to be in this class.				
29) You are feeling apathetic and struggling to get your work done.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Conceal your struggle so that others aren't able to see your weakness.				
b) Remind yourself that it's normal to "run out of steam" sometimes.				
c) Believe that your peers would never be as lazy in their studies.				

d) Talk about your feelings of apathy with a supportive friend.				
e) Feel like you do not belong in your program.				
30) You are short on time and have not finished a paper or project that is due.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Make an excuse to miss class so that you can finish the project and avoid this failing.				
b) Remind yourself that this single assignment will not ruin your career.				
c) Think that you don't belong in training if you can't keep up the way others do.				
d) Acknowledge the missed deadline and any feelings of regret to your instructor.				
e) Feel intense self-judgment and a sense of failure.				
31) During a busy week in training, you forget to call a friend on their birthday.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Avoid contacting this friend until you have a good explanation to offer.				
b) Recognize that you fell short of being the kind of friend you want to be.				
c) Think that others are able to balance their personal and professional lives much better than you.				
d) Talk about any feelings of failure with someone who will empathize.				

e) Feel that you are unworthy of this person's friendship.				
32) Peers give you surprising and difficult feedback about your interpersonal style.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Try to appear unfazed; as though you are completely fine with hearing this.				
b) Use self-kindness to move through feelings of insecurity.				
c) Worry that you have less self-awareness than other trainees.				
d) In the moment, acknowledge that it feels vulnerable to learn about how you are perceived by others.				
e) Feel defective and wish that you could change your entire personality.				
33) After giving feedback to a peer during group supervision, you later worry that you seemed "harsh."				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Be sure to give this person extra praise during the next supervision session.				
b) Recognize that you cannot always be the ideal version of yourself.				
c) Think that a good therapist would have found the perfect way to give this feedback.				
d) Talk with someone close to you about any worries regarding how you are perceived.				
e) Feel intense self-reproach.				

34) After listening to a difficult client story, you are unable to feel an emotional response.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Avoid talking about this session during supervision.				
b) Notice this experience with curiosity, rather than judgment.				
c) Think that other therapists would never feel this disconnected from a client's story.				
d) Use supervision to process your concerns or worries regarding this experience.				
e) Feel defective; as though something is wrong with you.				
35) After consulting with your advisor, you realize that it will take more time to finish your training/graduate program than you expected.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Feel resentful toward your program or advisor.				
b) Try to be present with your feelings of disappointment.				
c) Criticize yourself for not being as efficient as other students.				
d) Talk with a trusted peer about any feelings of disappointment.				
e) Feel that you are unfit to be in training.				
36) Although you are doing well in your classes, you are falling behind in another area of training (e.g., research, clinical work, etc.).				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Try to conceal from others that you are having a difficult time.				

b) Remind yourself that everyone struggles to meet all the demands of training.				
c) Think that other trainees seem to have it all together.				
d) Describe any difficult feelings about this to someone you trust.				
e) Feel inadequate.				
37) After working with a client for many sessions, you begin to dread appointments with this person and wish that they would not show-up.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Since you aren't working well together, guide this client toward referral or termination.				
b) React to these negative feelings with curiosity rather than self-judgment.				
c) Think that good therapists are able to feel positively toward all of their clients.				
d) Use supervision to process any feelings you are having regarding this person's visits.				
e) Believe that you are a bad counselor for feeling this way.				
38) After you make a comment in class, you notice that all of your peers seem to disagree with what you said.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Lay low and avoid making any comments for the rest of the class period.				
b) Remind yourself that everyone feels like an outsider sometimes.				

c) Feel like you aren't respected the way that other trainees are.				
d) Describe any pain from this experience to a trusted friend.				
e) Feel that there is something wrong with you.				
39) You have been working with a client for several sessions when your supervisor suggests that you refer this person to a more experienced practitioner.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Act as though you agree wholeheartedly with your supervisor, in order to seem compliant.				
b) Act compassionately toward yourself and any hurt feelings.				
c) Think about the reasons that you don't "measure up" to the more experienced counselor.				
d) Process your feelings or reactions to this with your supervisor.				
e) Feel that you are useless as a therapist.				
40) Your supervisor bluntly tells you that you made a big mistake with a client.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Emotionally "check-out" until the supervision session is over.				
b) Remind yourself that mistakes are inevitable.				
c) Think that this would never happen to a trainee who works hard enough.				
d) Share any difficult feelings about this with someone you trust.				
e) Feel really terrible about yourself.				

APPENDIX C
INFORMED CONSENT DOCUMENTS

FOCUS GROUP STUDY

IRB# 20140714464 EX
Date Approved: 07/22/2014
Valid Until: 07/21/2019

COLLEGE OF EDUCATION AND HUMAN SCIENCES
Educational Psychology

Hello! You are invited to participate in a focus group discussion regarding experiences in graduate mental health training. The title of this project is Shame and Shame Resilience Within the Mental Health Trainee Population: A Scale Construction Study. The following information is provided to help you make an informed decision about whether or not you want to participate in this study. Please feel free to ask questions at any time.

PURPOSE OF THE STUDY
The purpose of this study is to collect information from current mental health trainees about their observations of how shame and resilience are experienced by members of their professional peer group. Participants will be asked to reflect upon and share the aspects of training that elicit role-specific shame, inadequacy, or "imposter syndrome" as well as the coping mechanisms that trainees use to persist when feelings of shame arise. The information derived from this focus group research will be used to generate items for a quantitative measure of shame and shame resilience within the mental health trainee population.

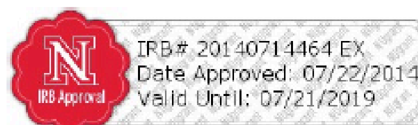
BASIS FOR PARTICIPANT SELECTION
You are eligible to participate in this study because you are a mental health trainee in one of the following graduate programs: clinical social work, marriage and family therapy, school psychology, clinical psychology, or counseling psychology. It is assumed that you are 19 years of age or older and are able to write and speak English. Eligible participants have been recruited from mental health training programs in the Lincoln, Nebraska geographic area.

This study includes both focus group and survey research components. Participation in the focus group phase of this study excludes individuals from participating in the survey research component of the study.

EXPLANATION OF PROCEDURES
Focus group participation will require a one-time, two-hour time commitment, held at a private on-campus location. Each group will include four to eight participants, and will be lead by the primary investigator and a co-facilitator. Upon arrival of all participants, the primary investigator will obtain informed consent for participation from each individual and verbally inform participants about their right to withdraw at any time. Participants will complete the informed consent document and indicate if they would like to be entered in a prize drawing.

As participants will be recruited from local programs, it is possible that individuals may be in focus groups with other students from their program or individuals they know in other contexts. If preexisting relationships create any form of discomfort, individuals are encouraged to withdraw from the study prior to the beginning of the focus group discussion. Individuals are encouraged to speak with the primary investigator or focus group co-facilitator if this or any other form of discomfort arises.

The focus group discussion will follow a written outline and will be lead by the primary investigator and co-facilitator. A hard copy of the outline will be provided for each participant. Participants are instructed answer questions and offer information only if they are fully comfortable doing so in a public format. Participants are asked to refrain from naming or identifying other individuals when discussing their observations about shame and shame resilience in the training experience; this includes faculty members, peers, clinical supervisors, or other persons involved in the training process. It is suggested that participants discuss shame and shame resilience in the mental health trainee population from the perspective of community observers, rather than engaging in self-disclosure about their own experiences of shame. The aim of this suggestion is to protect participant's emotional and professional well-being. Participants are reminded that this focus group experience is not intended to be therapeutic, but instead to more fully understand how shame and shame resilience operate within mental health



training experiences.

Focus group participants will also be asked to provide feedback about the planned methodology for recruiting survey data participants, including the title of the survey study, amount of prize drawing compensation, and amount of time required for participation.

The focus group discussion will end when all discussion topics have been covered, or at the conclusion of the two-hour time limit.

POTENTIAL RISKS AND DISCOMFORTS
The following are risks and discomforts you could potentially experience from participating in this study: (a) individuals sometimes experience emotional distress when discussing shame; and (b) participants may experience some temporary distress if they choose to share their emotions or experiences in a group of professional peers. If you should feel distressed at any time during this study, you may choose to verbally or physically withdraw from the focus group discussion without any consequences to you or your relationship with the researchers.

PRECAUTIONS TAKEN TO MINIMIZE RISKS
In order to minimize risks to focus group participants, the primary investigator and co-facilitator will structure the discussion according to the written outline and will encourage participants to speak from the perspective of observers. The focus group facilitators will also verbally remind individuals that they are encouraged to exercise caution regarding the type and amount of information that they are willing to share. Facilitators will respect the right of participants to pass, or not contribute to any given discussion topic.

POTENTIAL BENEFITS TO PARTICIPANT
There are no direct benefits to participating in this study. Focus group participants may benefit from having a forum to discuss their training experiences, thereby gaining a sense of universality among other mental health trainees. Participants may also benefit professionally from the experience of being a member of a focus group, thereby becoming more familiar with research methods that they may employ in their own studies.

COMPENSATION
Participants will have the opportunity to enter a drawing for one of two $25 gift certificates to a local coffee house. A minimum of 8 and maximum of 16 focus group participants will be recruited, meaning that the odds of winning range from 1/4 to 1/8.

POTENTIAL BENEFITS TO SOCIETY
Your participation in this study will contribute to the construction of a quantitative instrument for measuring shame and shame resilience within the mental health trainee population. It is expected that such an instrument would be useful for research regarding the mental health training process by identifying antecedents, covariates, and outcomes of trainee shame and shame resilience.

VOLUNTARY PARTICIPATION AND WITHDRAWAL
You may decide not to participate in this study or to withdraw at any time without negatively affecting your relationship with the researchers or the University of Nebraska-Lincoln.

ASSURANCE OF CONFIDENTIALITY & AUDIO TAPING
All information disclosed during focus group discussions is considered confidential, and therefore should not be shared outside of this setting; however, the researchers cannot guarantee that all focus group participants will act in accord with this.

Focus group sessions will be audio taped using the Primary Investigator's personal computer and iMovie software. Although this software has the capacity to video record, this function will not be utilized during data collection. Audio files will be used for the purpose of transcription and will be deleted immediately after transcriptions are completed. If individuals are uncomfortable with being audio taped, they are encouraged to withdraw from the study prior to beginning the focus group discussion; however, individuals also have the right to

revoke consent at the conclusion of the focus group, meaning that their comments would not be included in the transcription or analysis of focus group data. The primary investigator and focus group co-facilitator pledge to maintain participant confidentiality during data analysis by using pseudonyms rather than participant names during the transcription and content analysis processes.

RIGHTS OF RESEARCH PARTICIPANTS

Your rights as a research participant have been explained to you. If you have any additional questions about this study, please contact the Principal Investigator, Claire T. Hauser, M.S., (515) 291-3122 or the Secondary Investigator, M. Meghan Davidson, Ph.D., (402) 472-1482 at the Department of Educational Psychology, 114 Teachers College Hall, Lincoln, NE 68588-0345. If you have any questions concerning your rights as a research participant that have not been answered by the Principal Investigator, or to report any concerns about the study, you may contact the University of Nebraska-Lincoln Institutional Review Board at (402) 472-6965.

DOCUMENTATION OF INFORMED CONSENT

YOU ARE VOLUNTARILY MAKING A DECISION WHETHER OR NOT TO PARTICIPATE IN THIS RESEARCH STUDY. YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION PROVIDED IN THIS FORM AND THAT YOU MAY WITHDRAW FROM THIS STUDY AT ANY TIME. YOUR SIGNATURE ALSO INDICATES THAT YOU HAVE HAD ALL YOUR QUESTIONS ANSWERED TO YOUR SATISFACTION. IF YOU THINK OF ANY QUESTIONS DURING THIS STUDY, PLEASE CONTACT CLAIRE HAUSER, THE PRINCIPAL INVESTIGATOR OF THIS RESEARCH STUDY.

____

PRINT NAME

____________________________________ ____________________

SIGNATURE DATE

☐ **I agree to be audio recorded** *(please check)*

APPENDIX C
INFORMED CONSENT DOCUMENTS (cont.)

SURVEY STUDY

COLLEGE OF EDUCATION AND HUMAN SCIENCES
Educational Psychology

Hello! You are invited to participate in a survey study regarding experiences in graduate mental health training. The following information is provided to help you make an informed decision about whether or not you want to participate in this study.

PURPOSE OF THE STUDY
The purpose of this study is to collect survey data from current mental health trainees about their perceptions and experiences regarding challenging emotions (i.e., shame, vulnerability, "imposter syndrome") and coping with these emotions during the training process. Participants will be asked to complete survey items, and then answer a brief set of questions about demographic characteristics and training experiences. The information derived from this survey research will be used to construct a quantitative measure of shame and shame resilience among mental health trainees.

BASIS FOR PARTICIPANT SELECTION
You are eligible to participate in this study because you are a mental health trainee in one of the following graduate programs: clinical social work, marriage and family therapy, school psychology, clinical psychology, or counseling psychology. It is assumed that you are 19 years of age or older and are able to write and speak English.

EXPLANATION OF PROCEDURES
After indicating consent, participants will first answer survey items pertaining to training experiences and perceptions of challenging emotions. Participants will then answer questions regarding their demographic characteristics and training experiences. It is expected that completion of survey items will take 30-40 minutes. Following the completion of these items, participants will have the option of entering into a prize drawing.

POTENTIAL RISKS AND DISCOMFORTS
Potential risks and discomforts are considered minimal for participation in this survey study. Individuals may experience some emotional discomfort due to thinking about challenging emotions, perceptions, and experiences during the mental health training process.

POTENTIAL BENEFITS TO PARTICIPANT
There are no direct benefits to participating in this study. Participants may benefit from study participation through gaining awareness of the universal nature with which mental health trainees experience challenging emotions.

COMPENSATION
Participants will have the opportunity to enter a drawing for one of four $50.00 Amazon.com gift cards. Overall odds of receiving a gift card are dependent on how many participants complete the study. This survey will include a minimum of 300 participants; at best the odds of receiving a gift card are 1 in 75.

VOLUNTARY PARTICIPATION AND WITHDRAWAL
You may decide not to participate in this study or to withdraw at any time without negatively affecting your relationship with the researchers or the University of Nebraska-Lincoln.

RIGHTS OF RESEARCH PARTICIPANTS
Your rights as a research participant have been explained to you. If you have any additional questions about this study, please contact the Principal Investigator, Claire T. Hauser, M.S., (515) 291-3122 or the Secondary Investigator, M. Meghan Davidson, Ph.D., (402) 472-1482 at the Department of Educational Psychology, 114

Teachers College Hall, Lincoln, NE 68588-0345. If you have any questions concerning your rights as a research participant that have not been answered by the Principal Investigator, or to report any concerns about the study, you may contact the University of Nebraska-Lincoln Institutional Review Board at (402) 472-6965.

DOCUMENTATION OF INFORMED CONSENT
YOU ARE VOLUNTARILY MAKING A DECISION WHETHER OR NOT TO PARTICIPATE IN THIS RESEARCH STUDY. BY CONTINUING WITH THE SURVEY AND SUBMITTING YOUR RESPONSE, YOUR CONSENT TO PARTICIPATE IS IMPLIED. PLEASE PRINT A COPY OF THIS PAGE FOR YOUR RECORDS.

IF YOU WISH TO PARTICIPATE IN THIS STUDY, PLEASE CHECK THE BOX BELOW TO INDICATE YOUR CONSENT. AFTER CHECKING THE BOX, CLICK THE "PROCEED" BUTTON AND YOU WILL BE DIRECTED TO THE FIRST PAGE OF THE SURVEY.

☐ **I consent to participate in this study** *(please check)*

APPENDIX D
SURVEY STUDY DEMOGRAPHIC QUESTIONS

Shame & Shame Resilience Among Mental Health Trainees: A Scale Construction Study

Survey Study Demographic Questions

- Age: *(check)*
  - 19-29 years old
  - 30-49 years old
  - 50-64 years old
  - 65 years and over
- Gender identity: *(enter)*
- Racial identity: *(enter)*
- Ethnic identity: *(enter)*
- Religious or spiritual preference: *(enter)*
- Type of training program: *(check)*
  - *School Psychology*
  - *Marriage & Family Therapy*
  - *Clinical Social Work*
  - *Counseling Psychology*
  - *Clinical Psychology*
- Model of training program: *(check)*
  - *Scientist*
  - *Scientist-Practitioner*
  - *Practitioner-Scholar*
- Number of years completed of graduate training: *(check)*

  1 2 3 4 5 6 7+
- Number of years of clinical training during graduate training: *(check)*

  1 2 3 4 5 6 7+
- Approximate number of clients you have worked with: *(check)*

  2-10 11-20 21-30 31+
- Throughout the course of your training, have you ever:
  - Received a negative evaluation regarding your clinical work: Yes No
  - Received negative feedback regarding your academic work: Yes No
  - Received negative feedback regarding your work in research: Yes No
  - Been given a remediation plan in any domain of training: Yes No

Shame & Shame Resilience Among Mental Health Trainees: A Scale Construction Study

    - Been given individualized behavioral objectives to meet in any domain: Yes No
    - Obtained less than a B in a course? Yes No
- Throughout the clinical, academic, and research domains of your graduate training, have you studied the construct of *shame*? Yes No
- Are you at all familiar with *Shame Resilience Theory*? Yes No

APPENDIX E
COMPASS OF SHAME SCALE
(VERSION 3)

Directions: Below is a list of statements describing situations you may experience from time to time. Following each situation are four statements describing possible reactions to the situation. Read each statement carefully and circle the number to the left of the item that indicates the frequency with which you find yourself reacting in that way. Use the scale below. Please respond to all four items for each situation.

SCALE

0	1	2	3	4
NEVER	**SELDOM**	**SOMETIMES**	**OFTEN**	**ALMOST ALWAYS**

SCALE

A. When an activity makes me feel like my strength or skill is inferior:
0 1 2 3 4 1.1 act as if it isn't so.
0 1 2 3 4 2.1 get mad at myself for not being good enough.
0 1 2 3 4 3.1 withdraw from the activity.
0 1 2 3 4 4.1 get irritated with other people.

B. In competitive situations where I compare myself with others:
0 1 2 3 4 5.1 criticize myself.
0 1 2 3 4 6.1 try not to be noticed.
0 1 2 3 4 7.1 feel ill will toward the others.
0 1 2 3 4 8.1 exaggerate my accomplishments.

C. In situations where I feel insecure or doubt myself:
0 1 2 3 4 9.1 shrink away from others.
0 1 2 3 4 10.1 feel others are to blame for making me feel that way.
0 1 2 3 4 11.1 act more confident than lam.
0 1 2 3 4 12.1 feel irritated with myself.

D. At times when I am unhappy with how I look:
0 1 2 3 4 13.1 take it out on other people.
0 1 2 3 4 14.1 pretend I don't care.
0 1 2 3 4 15.1 feel annoyed at myself.
0 1 2 3 4 16.1 keep away from other people.

E. When I make an embarrassing mistake in public:
0 1 2 3 4 17.1 hide my embarrassment with a joke.
0 1 2 3 4 18.1 feel like kicking myself.
0 1 2 3 4 19.1 wish I could become invisible.

0 1 2 3 4 20.1 feel annoyed at people for noticing.

F. When I feel lonely or left out:
0 1 2 3 4 21.1 blame myself.
0 1 2 3 4 22.1 pull away from others.
0 1 2 3 4 23.1 blame other people.
0 1 2 3 4 24.1 don't let it show.

G. When I feel others think poorly of me:
0 1 2 3 4 25.1 want to escape their view.
0 1 2 3 4 26.1 want to point out their faults.
0 1 2 3 4 27.1 deny there is any reason for me to feel bad.
0 1 2 3 4 28.1 dwell on my shortcomings.

H. When I think I have disappointed other people:
0 1 2 3 4 29.1 get mad at them for expecting so much from me.
0 1 2 3 4 30.1 cover my feelings with a joke.
0 1 2 3 4 31.1 get down on myself.
0 1 2 3 4 32.1 remove myself from the situation.

I. When I feel rejected by someone:
0 1 2 3 4 33.1 soothe myself with distractions.
0 1 2 3 4 34.1 brood over my flaws.
0 1 2 3 4 35.1 avoid them.
0 1 2 3 4 36.1 get angry with them.

J. When other people point out my faults:
0 1 2 3 4 37.1 feel like I can't do anything right.
0 1 2 3 4 38.1 want to run away.
0 1 2 3 4 39.1 point out their faults.
0 1 2 3 4 40.1 refuse to acknowledge those faults.

K. When I feel humiliated:
0 1 2 3 4 41.1 isolate myself from other people.
0 1 2 3 4 42.1 get mad at people for making me feel this way.
0 1 2 3 4 43.1 cover up the humiliation by keeping busy.
0 1 2 3 4 44.1 get angry with myself.

L. When I feel guilty:
0 1 2 3 4 45.1 push the feeling back on those who make me feel this way.
0 1 2 3 4 46.1 disown the feeling.
0 1 2 3 4 47.1 put myself down.
0 1 2 3 4 48.1 want to disappear.

APPENDIX F
OTHER AS SHAMER SCALE (OAS)

We are interested in how people think others see them. Below is a list of statements describing feelings or experiences about how you may feel other people see you.

Read each statement carefully and circle the number to the right of the item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below.

0 = NEVER 1 = SELDOM 2 = SOMETIME 3 = FREQUENTLY 4 = ALMOST ALWAYS

1.	I feel other people see me as not good enough.	0 1 2 3 4
2.	I think that other people look down on me	0 1 2 3 4
3.	Other people put me down a lot	0 1 2 3 4
4.	I feel insecure about others opinions of me	0 1 2 3 4
5.	Other people see me as not measuring up to them	0 1 2 3 4
6.	Other people see me as small and insignificant	0 1 2 3 4
7.	Other people see me as somehow defective as a person	0 1 2 3 4
8.	People see me as unimportant compared to others	0 1 2 3 4
9.	Other people look for my faults	0 1 2 3 4
10.	People see me as striving for perfection but being unable to reach my own standards	0 1 2 3 4
11.	I think others are able to see my defects	0 1 2 3 4
12.	Others are critical or punishing when I make a mistake	0 1 2 3 4
13.	People distance themselves from me when I make mistakes	0 1 2 3 4
14.	Other people always remember my mistakes	0 1 2 3 4
15.	Others see me as fragile	0 1 2 3 4
16.	Others see me as empty and unfulfilled	0 1 2 3 4

17. Others think there is something missing in me 0 1 2 3 4

18. Other people think I have lost control over my body and feelings 0 1 2 3 4

APPENDIX G

Test of Self-Conscious Affect, Version 3

Below are situations that people are likely to encounter in day-to-day life, followed by several common reactions to those situations.

As you read each scenario, try to imagine yourself in that situation. Then indicate how likely you would be to react in each of the ways described. We ask you to rate all responses because people may feel or react more than one way to the same situation, or they may react different ways at different times.

For example:

A. You wake up early one Saturday morning. It is cold and rainy outside.

a) You would telephone a friend to catch up on news. 1---2---3---4---5
not likely very likely

b) You would take the extra time to read the paper. 1---2---3---4---5
not likely very likely

c) You would feel disappointed that it's raining. 1---2---3---4---5
not likely very likely

d) You would wonder why you woke up so early. 1---2---3---4---5
not likely very likely

In the above example, I've rated ALL of the answers by circling a number. I circled a "1" for answer (a) because I wouldn't want to wake up a friend very early on a Saturday morning -- so it's not at all likely that I would do that. I circled a "5" for answer (b) because I almost always read the paper if I have time in the morning (very likely). I circled a "3" for answer (c) because for me it's about half and half. Sometimes I would be disappointed about the rain and sometimes I wouldn't -- it would depend on what I had planned. And I circled a "4" for answer (d) because I would probably wonder why I had awakened so early.

Please do not skip any items -- rate all responses.

1. <u>You make plans to meet a friend for lunch. At five o'clock, you realize you have stood your friend up.</u>

	not likely very likely
a) You would think: "I'm inconsiderate."	1---2---3---4---5
b) You'd think you should make it up to your friend as soon as possible.	1---2---3---4---5
c) You would think: "My boss distracted me just before lunch."	1---2---3---4---5

2. <u>You break something at work and then hide it.</u>

	not likely very likely
a) You would think: "This is making me anxious. I need to either fix it or get someone else to."	1---2---3---4---5
b) You would think about quitting.	1---2---3---4---5
c) You would think: "A lot of things aren't made very well these days."	1---2---3---4---5

3. <u>At work, you wait until the last minute to plan a project, and it turns out badly.</u>

	not likely very likely
a) You would feel incompetent.	1---2---3---4---5
b) You would think: "There are never enough hours in the day."	1---2---3---4---5
c) You would feel: "I deserve to be reprimanded for mismanaging the project."	1---2---3---4---5

4. <u>You make a mistake at work and find out a co-worker is blamed for the error.</u>

	not likely very likely
a) You would think the company did not like the co-worker.	1---2---3---4---5
b) You would keep quiet and avoid the co-worker.	1---2---3---4---5
c) You would feel unhappy and eager to correct the situation.	1---2---3---4---5

5. <u>While playing around, you throw a ball, and it hits your friend in the face.</u>

	not likely very likely
a) You would feel inadequate that you can't even throw a ball.	1---2---3---4---5
b) You would think maybe your friend needs more practice at catching.	1---2---3---4---5
c) You would apologize and make sure your friend feels better.	1---2---3---4---5

6. <u>You are driving down the road, and you hit a small animal.</u>

	not likely very likely
a) You would think the animal shouldn't have been on the road.	1---2---3---4---5
b) You would think: "I'm terrible."	1---2---3---4---5
c) You'd feel bad you hadn't been more alert driving down the road.	1---2---3---4---5

7. <u>You walk out of an exam thinking you did extremely well, then you find out you did poorly.</u>

	not likely very likely
a) You would think: "The instructor doesn't like me."	1---2---3---4---5
b) You would think: "I should have studied harder."	1---2---3---4---5
c) You would feel stupid.	1---2---3---4---5

8. <u>While out with a group of friends, you make fun of a friend who's not there.</u>

	not likely very likely
a) You would feel small...like a rat.	1---2---3---4---5
b) You would think that perhaps that friend should have been there to defend himself/herself.	1---2---3---4---5
c) You would apologize and talk about that person's good points.	1---2---3---4---5

9. <u>You make a big mistake on an important project at work. People were depending on you, and your boss criticizes you.</u>

	not likely	very likely
a) You would think your boss should have been more clear about what was expected of you.	1---2---3---4---5	
b) You would feel as if you wanted to hide.	1---2---3---4---5	
c) You would think: "I should have recognized the problem and done a better job."	1---2---3---4---5	

10. <u>You are taking care of your friend's dog while they are on vacation. and the dog runs away.</u>

	not likely	very likely
a) You would think, "I am irresponsible and incompetent."	1---2---3---4---5	
b) You would think your friend must not take very good care of her dog or it wouldn't have run away.	1---2---3---4---5	
c) You would vow to be more careful next time.	1---2---3---4---5	

11. <u>You attend your co-worker's housewarming party, and you spill red wine on a new cream-colored carpet, but you think no one notices.</u>

	not likely	very likely
a) You would stay late to help clean up the stain after the party.	1---2---3---4---5	
b) You would wish you were anywhere but at the party.	1---2---3---4---5	
c) You would wonder why your co-worker chose to serve red wine with the new light carpet.	1---2---3---4---5	

APPENDIX H

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

(Self-Compassion Scale)

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost never				Almost always
1	2	3	4	5

_____ 1. I'm disapproving and judgmental about my own flaws and inadequacies.
_____ 2. When I'm feeling down I tend to obsess and fixate on everything that's wrong.
_____ 3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.
_____ 4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.
_____ 5. I try to be loving towards myself when I'm feeling emotional pain.
_____ 6. When I fail at something important to me I become consumed by feelings of inadequacy.
_____ 7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.
_____ 8. When times are really difficult, I tend to be tough on myself.
_____ 9. When something upsets me I try to keep my emotions in balance.
_____ 10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
_____ 11. I'm intolerant and impatient towards those aspects of my personality I don't like.
_____ 12. When I'm going through a very hard time, I give myself the caring and tenderness I need.
_____ 13. When I'm feeling down, I tend to feel like most other people are probably happier than I am.
_____ 14. When something painful happens I try to take a balanced view of the situation.
_____ 15. I try to see my failings as part of the human condition.
_____ 16. When I see aspects of myself that I don't like, I get down on myself.
_____ 17. When I fail at something important to me I try to keep things in perspective.
_____ 18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.
_____ 19. I'm kind to myself when I'm experiencing suffering.
_____ 20. When something upsets me I get carried away with my feelings.
_____ 21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.
_____ 22. When I'm feeling down I try to approach my feelings with curiosity and openness.
_____ 23. I'm tolerant of my own flaws and inadequacies.
_____ 24. When something painful happens I tend to blow the incident out of proportion.
_____ 25. When I fail at something that's important to me, I tend to feel alone in my failure.
_____ 26. I try to be understanding and patient towards those aspects of my personality I don't like.

APPENDIX I
Quantitative Data Results

Table 1

Scenarios Retained Based Upon Shame Response Frequencies

Scenario/Item	Mean	Mode	Std. Deviation
1	2.41	3	.80
3	3.05	3	.79
4	2.36	2	.85
6	2.26	2	.86
8	2.66	3	.79
12	2.62	3	.83
14	2.36	3	.94
15	2.45	2	.86
19	2.40	2	.86
21	2.29	2	.78
25	3.01	3	.88
26	2.72	3	.85
28	2.50	3	.83
29	2.35	2	.91
30	2.65	3	.89
32	2.46	3	.90
33	2.40	3	.89
36	3.02	3	.82
39	2.43	3	.88
40	3.34	4	.72

Note. Scenarios retained for $M \geq 2.25$ or Mode ≥ 3

APPENDIX I
Quantitative Data Results (cont.)

Table 2
SRMHT Factor Solution with Loading Coefficients

Item	Factor 1 Shame Reactions α = .92	Factor 2 Seeking Support α = .86	Factor 3 No Shame α = .84	Factor 4 Self-Compassion α = .86
29_ShRe	.76	-	-	-
29_Comp	.76	-	-	-
30_Comp	.75	-	-	-
36_Comp	.69	-	-	-
29_SeCo	-.64	-	-	-
40_Comp	.64	-	-	-
15_Comp	.63	-	-	-
30_ShRe	.61	-	-	-
28_Comp	.55	-	-	-
15_ShRe	.52	-	-.35	-
36_ShRe	.52	-	-.36	-
33_Comp	.50	-	-	-
30_SeCo	-.49	-	-	.31
1_Comp	.49	-	-	-
25_Comp	.48	-	-	-
1_ShRe	.39	-	-	-
40_ShRe	.38	-	-	-
33_ShRe	.31	-	-	-
36_RoSs	-	.75	-	-
29_RoSs	-	.73	-	-
15_RoSs	-	.71	-	-
28_RoSs	-	.68	-	-
40_RoSs	-	.65	-	-
12_RoSs	-	.62	-	-
33_RoSs	-	.60	-	-
25_RoSs	-	.59	-	-
8_RoSs	-	.46	-	-
14_RoSs	-	.32	-	-
30_RoSs*	-	-	-	-
1_RoSs*	-	-	-	-
26_Comp	-	-	-.64	-
26_ShRe	-	-	-.56	-

Item	Factor 1 Shame Reactions α = .92	Factor 2 Seeking Support α = .86	Factor 3 No Shame α = .84	Factor 4 Self-Compassion α = .86
25_ShRe	-	-	-.55	-
32_ShRe	-	-	-.52	-
32_Comp	-	-	-.52	-
14_ShRe	-	-	-.51	-
25_SeCo	-	-	.37	-
26_RoSs	-	-	.32	-
8_Comp*	-	-	-	-
26_SeCo	-	-	-	.60
12_SeCo	-	-	-	.59
14_SeCo	-	-	-	.59
40_SeCo	-	-	-	.57
28_SeCo	-.31	-	-	.55
36_SeCo	-	-	-	.52
32_SeCo	-	-	-	.52
32_RoSs	-	-	-	.50
1_SeCo	-	-	-	.43
8_SeCo	-	-	-	.43
33_SeCo	-	-	-	.39
12_Comp	-	-	-	-.35
15_SeCo	-	-	-	.32

Note. Loadings $\geq$.30 represented. Items with two loadings listed yielded a primary loading and cross loading. (*) Denotes items that failed to load significantly on any factor.

Key. ShRe = Shame Response item; Comp = Comparison item; SeCo = Self-Compassion item; RoSs = Reach out/Speak shame item

APPENDIX I
Quantitative Data Results (cont.)

Table 3
SRMHT Normative Information

	M	*SD*	Skewness	Kurtosis
Total Scale	139.15	10.62	-.29	.65
Factor 1: *Shame Reactions*	45.16	10.39	-.03	-.03
Factor 2: *Seeking Support*	31.35	4.91	-.44	.46
Factor 3: *No Shame*	25.50	5.77	.28	.08
Factor 4: *Self-Compassion*	37.05	5.77	.14	-.11

Table 4
Convergent & Discriminant Validity Estimates

Instrument	Factor 1 *Shame Reactions*	Factor 2 *Seeking Support*	Factor 3 *No Shame*	Factor 4 *Self-Compassion*
CoSS *Avoidance*	.16	-	-.29*	-
CoSS *Withdrawal*	.50*	-.20	-.59*	-.45*
CoSS *Attack Self*	.71*	-	-.66*	-.41*
CoSS *Attack Other*	.17	-	-.22*	-.18
TOSCA-3 *Shame*	.58*	-	-.57*	-.24*
TOSCA-3 *Guilt*	.22	.23*	-.18	.18
TOSCA-3 *Blame*	-	-	-	-
Other As Shamer	.55*	-	-.52*	-.31*
Self-Compassion Scale	-.70*	.21	.64*	.64*

Note. * p <.01. Only significant correlations are included.

APPENDIX I
Quantitative Data Results (cont.)

Table 5
SRMHT Factor Intercorrelations

	Factor 1 *Shame Reactions*	Factor 2 *Seeking Support*	Factor 3 *No Shame*	Factor 4 *Self-Compassion*	Total SRMHT
Factor 1 *Shame Reactions*	1	-.09	-.66*	-.50*	.14*
Factor 2 *Seeking Support*	-.09	1	.13	.48*	.67*
Factor 3 *No Shame*	-.66*	.13	1	.50*	.21*
Factor 4 *Self-Compassion*	-.50*	.48*	.50*	1	.51*
Total SRMHT	.14*	.67*	.21*	.51*	1

Note. All significant correlations are designated by (*). All correlations are significant at $p < .01$.

APPENDIX I
Quantitative Data Results (cont.)

Table 6
SRMHT Communalities

Item	Communalities	Item	Communalities	Item	Communalities
1_ShRe	.47	**25_ShRe**	.69	**32_RoSs**	.59
1_RoSs	.33	**25_SeCo**	.65	**32_ShRe**	.66
1_SeCo	.49	**25_RoSs**	.61	**32_SeCo**	.70
1_Comp	.59	**25_Comp**	.72	**32_Comp**	.57
8_ShRe	.47	**26_SeCo**	.63	**33_SeCo**	.57
8_RoSs	.54	**26_Comp**	.67	**33_Comp**	.61
8_SeCo	.59	**26_RoSs**	.49	**33_RoSs**	.58
8_Comp	.52	**26_ShRe**	.68	**33_ShRe**	.60
12_Comp	.55	**28_RoSs**	.62	**36_Comp**	.68
12_ShRe	.56	**28_ShRe**	.64	**36_RoSs**	.75
12_RoSs	.65	**28_SeCo**	.75	**36_SeCo**	.75
12_SeCo	.62	**28_Comp**	.66	**36_ShRe**	.67
14_ShRe	.62	**29_Comp**	.72	**40_ShRe**	.59
14_RoSs	.54	**29_RoSs**	.69	**40_Comp**	.73
14_Comp	.69	**29_ShRe**	.74	**40_RoSs**	.67
14_SeCo	.62	**29_SeCo**	.68	**40_SeCo**	.70
15_RoSs	.58	**30_Comp**	.70		
15_Comp	.67	**30_SeCo**	.68		
15_SeCo	.46	**30_ShRe**	.63		
15_ShRe	.69	**30_RoSs**	.49		

APPENDIX J
SRMHT Final Scale

Directions: Read the numbered scenarios and respond to each of the accompanying four sub-items below. Please mark a response for EACH sub-item A-E, indicating how likely it is that you would respond in the described manner. There is no correct or best answer; just choose the option that resonates most with your self-knowledge and most likely reaction to the situation.

1) While in session, a client expresses dissatisfaction with your approach as a counselor.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Tell yourself that every counselor has experienced this.				
b) Think that none of your peers have dissatisfied clients.				
c) Discuss your feelings about this feedback with your supervisor.				
d) Feel devastated immediately after hearing this feedback.				
8) Your supervisor makes a dismissive comment about a central part of your identity.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Be accepting toward the strong emotions that you are feeling.				
b) Think that other trainees are supported, whereas you are not.				
c) Talk about this experience with someone who will understand your perspective.				
d) Feel small, as though you do not matter.				

12) While discussing culture in class, your perspective is different from what is being expressed by others.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Treat yourself with warmth and understanding.				
b) Think that you must be missing something, compared to your peers.				
c) Process this experience with someone who will listen to your point of view without judgment.				
d) Feel separate from the others; as though you do not belong.				
14) Your supervisor suggests that you attend therapy to work through a personal issue.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Remind yourself that everyone has areas for growth.				
b) Worry that your personal problems make you less capable than other trainees.				
c) Acknowledge any vulnerable feelings about needing therapy to your supervisor.				
d) Feel like something is wrong with you.				

15) Regarding a paper, your advisor gives feedback that "this isn't your best work."				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Allow yourself to feel disappointed with this feedback.				
b) Think that other trainees are always able to give 100%.				
c) Make plans to discuss your feelings about this with a peer whom you trust.				
d) Feel that you are a bad student.				
25) During your final year in training, you are unable to answer a question during a comprehensive exam.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Notice your feelings of failure without judgment.				
b) Think that others would never make such a mistake at this point in the training process.				
c) Describe any pain you felt in this situation to someone who will "get it."				
d) In the moment, feel overwhelmed by incompetence.				

26) After you disclose a personal struggle, your supervisor seems uncomfortable and avoids the topic.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Practice self-kindness when you sense this person's discomfort.				
b) Worry that your supervisor will now think less of you in comparison with other trainees.				
c) Acknowledge any vulnerable feelings that you're having about this to your supervisor.				
d) Feel that you have exposed an unacceptable part of yourself.				
28) After asking a question in class, you realize that everyone else already "gets it."				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Feel compassionate toward your feelings of self-doubt.				
b) Think that you are not as smart as your classmates.				
c) Talk about this experience with someone you trust.				
d) In the moment, feel very unworthy to be in this class.				

29) You are feeling apathetic and struggling to get your work done.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Remind yourself that it's normal to "run out of steam" sometimes.				
b) Believe that your peers would never be as lazy in their studies.				
c) Talk about your feelings of apathy with a supportive friend.				
d) Feel like you do not belong in your program.				
30) You are short on time and have not finished a paper or project that is due.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Remind yourself that this single assignment will not ruin your career.				
b) Think that you don't belong in training if you can't keep up the way others do.				
c) Acknowledge the missed deadline and any feelings of regret to your instructor.				
d) Feel intense self-judgment and a sense of failure.				

32) Peers give you surprising and difficult feedback about your interpersonal style.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Use self-kindness to move through feelings of insecurity.				
b) Worry that you have less self-awareness than other trainees.				
c) In the moment, acknowledge that it feels vulnerable to learn about how you are perceived by others.				
d) Feel defective and wish that you could change your entire personality.				
33) After giving feedback to a peer during group supervision, you later worry that you seemed "harsh."				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Recognize that you cannot always be the ideal version of yourself.				
b) Think that a good therapist would have found the perfect way to give this feedback.				
c) Talk with someone close to you about any worries regarding how you are perceived.				
d) Feel intense self-reproach.				

36) Although you are doing well in your classes, you are falling behind in another area of training (e.g., research, clinical work, etc.).				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Remind yourself that everyone struggles to meet all the demands of training.				
b) Think that other trainees seem to have it all together.				
c) Describe any difficult feelings about this to someone you trust.				
d) Feel inadequate.				
40) Your supervisor bluntly tells you that you made a big mistake with a client.				
How likely am I to do the following?	**Definitely Would Not (0)**	**Probably Would Not (1)**	**Probably Would (2)**	**Definitely Would (3)**
a) Remind yourself that mistakes are inevitable.				
b) Think that this would never happen to a trainee who works hard enough.				
c) Share any difficult feelings about this with someone you trust.				
d) Feel really terrible about yourself.				

APPENDIX K
Qualitative Data Results

Table 1

Inductively Developed Thematic Categories

Thematic category	Key terms	Characteristic responses
Defining shame	Synonyms used	Embarrassed, inadequate, unworthy, not good enough, self-doubt, lack of worth, not belonging, "I almost shouldn't be here"
Shame triggers	General triggers	Feeling constantly scrutinized, in the "spotlight," evaluation of personal characteristics, "I'm the tool," unclear performance expectations
	Internal processes	Expecting self to be perfect in every role, wanting to be invulnerable, feeling rigid and totally invulnerable, discomfort with ambiguity, balancing introspection with self-consciousness, having history and identity of being an achiever, wanting to be extraordinary
	Clinical work	Feeling responsible for client outcomes, pressure from client expectations, perceiving that a client is skeptical of your ability
	Peer processes	Viewing peers as "having a handle on it," being compared to peers by faculty, peer gossip & comparison, comparing ability with peers, lacking the courage to give honest feedback
	Training concerns	Feeling multiculturally incompetent, outsider to academic culture, imposter syndrome at each successive benchmark, moving quickly through training process
	Faculty interactions	Noticing differential treatment from faculty to students, dissonance between internal perceptions and faculty responses, feeling that you've let a faculty member down
	Course & task issues	Not completing all tasks, missing deadlines, having to ask a question when everyone else "gets it," receiving any grade less than an "A"
	Research	Lack of research productivity in comparison to

		peers, feeling that you are supposed to know things that you haven't yet learned
	Supervision issues	Having a supervisor who is blunt or too direct, feedback that is unexpected and negative, getting a lot of negative feedback in group supervision, being vulnerable in supervision and then having it dismissed
	Identity	Experiencing microaggressions about salient identity, dissonance between self-concept and perceptions/feedback from others, having personal issues or mental health problems that impact ability as trainee
Internal experience of shame	Distraction	Unable to focus on learning, feeling that shame is "the elephant in the room"
	Wanting to conceal or withdraw	Concealing parts of oneself, self-editing, secret keeping, wanting to hide things from others (supervisors, peers, faculty), Withholding input or feedback in training settings, isolating in training program
	Pain and hurt	Feeling victimized, feeling blindsided
	Exposure	Feeling that others can see you, feeling scrutinized as a person, lacking privacy, realizing you "don't know what you don't know"
	Questioning	Imposter syndrome, not trusting your abilities or perceptions
What shame looks like externally	Avoidance	Avoiding accountability, avoiding tasks related to domain (i.e., research), procrastination, not following through on directives, discomfort with process aspects of training, not audio/video taping
	Guardedness	Filtering authentic self, not sharing vulnerabilities, seeming reluctant to share, minimization of difficulties
	Withdrawal	Not speaking in class, not participating in social activities, body language (head down), "checked out," unspoken tension
	Aggression	Defensiveness, justification, attacking others or being highly critical of others

	Overcompensation	Over-committing or over-promising on projects, being overly apologetic, dwelling on what went wrong
	Interpersonal maneuvers	Giving advice to others, over-sharing, seeking reassurance, acting as though “everything is fine,” constant reframing, “puffing up” (self-aggrandizement), passive-aggressive actions
Markers of shame resilience	Openness	Talking about difficult feelings in training spaces, acknowledging current struggles
	Integrity	Willingness to admit fault or mistakes (i.e., “Okay, I did this.), Asking the question rather than “shutting down”
	Faith in the process	Trusting the skill and knowledge that you have built so far, exercising patience with process of reflection and feedback, learning that you don’t have to know how to do everything
	Peer relationships	Getting peer support, being able to talk honestly and openly with peers, getting perspective from peers further along in training, establishing safety in training relationships, seeking support from peers who can challenge you in helpful ways
	Empathy	Hearing “I know what you’re going through. I’ve been there,” having validation
	Perspective taking	Asking, “What’s my supervisor trying to do? What are people reacting to?”
	Inner processes	Trying to honestly reflect on your thoughts, feelings, actions, managing expectations, tolerance for discomfort, acknowledging and accepting discomfort, using “reservoir” of positive experiences to move through new challenges
	Contextualization	Framing struggles within context of growth process
	Program culture	Training culture of authenticity and vulnerability, gradual pacing of feedback in supervision, being able to trust confidentiality of program members, having feedback modeled by faculty and supervisors, mentoring