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"I had no idea this shame piece was in me": Couple and family therapists' experience with learning an evidence-based practice

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Abstract: This study reports on the experience of shame while learning an evidence-based approach to working with couples or families. Couple and family therapists were interviewed about their experience with learning and using an evidence-based practice (EBP) and the data was analyzed using a phenomenological approach called interpretative phenomenological analysis. The theme of shame emerged from a number of research participants as part of their development with the EBP they were integrating into their practice. Starting with an exploration of the participants' experiences and the impact of shame, the paper will then link these experiences with the psychological and sociological research literature about shame.

Subjects: Education & Training; Evidence-based Mental Health; Family Therapy; Marriage & Couples Therapy; Marriage & Family Counseling; Phenomenology; Professional Resources & Reference

Keywords: marriage and family therapy; phenomenology; evidence-based practice; qualitative research; couple and family therapy; shame

1. Introduction

Engagement with evidence-based practice (EBP) is growing across mental health care systems. As Hunsley (2007) noted, "Initially developed and promoted within medicine, the EBP model is now being applied in a broad range of health and human service systems, including mental and behavioral health care, social work, education, and criminal justice" (p. 113). The dialogue about the role of evidence-based approaches in the practice of couple and family therapy (CFT) and its research

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PUBLIC INTEREST STATEMENT

What do couple and family therapists experience while learning an evidence-based practice? This study reports on one of those experiences that of shame while learning an evidence-based approach to working with couples or families. We interviewed couple and family therapists about their experiences with learning and using an evidence-based approach to working with couples and families. We then analyzed the transcriptions of the interviews using a phenomenological approach which focuses on the research participants' experiences as opposed to a focus on developing theory. One of the experiences to emerge from this analysis was that of shame. This paper reports on these findings while integrating relevant research literature on the social experience of shame.

literature is also evolving (Sexton et al., 2011; Sprenkle, 2012). Though research is providing support for the best approaches to use with different populations and their presenting issues, there has been little research that explores the experience of CFTs themselves while learning and adopting an EBP. Using a hermeneutic-phenomenological approach called interpretative phenomenological analysis (IPA, Smith, Flowers, & Larkin, 2009), we explore the experiences of couple and family therapists learning and using an EBP.

This research aimed to explore the experiences of 14 couple and family therapists learning and using an evidence-based approach to working with couples and families. While three themes emerged from the analysis, the focus in this paper is the experience of shame. The focus on the theme of shame allows for a thick and rich description as suggested by the methodology where the "meanings or understandings or insights constitute the findings of the study" (Smith et al., 2009, p. 178). Starting with a description of EBP we then review different theoretical approaches to shame. Bringing in theory to explore participants experiences is part of IPA though secondary to the participants' experiences. "Broadly, one can say that most of the interpretive levels employed in IPA are more in keeping with … a hermeneutics centered on empathy and meaning recollection. However, IPA also allows a hermeneutics of questioning, of critical engagement" (Smith, 2004, p. 46). Accordingly, the analysis section of this paper reflects the methodology by providing quotes from the participants, the double hermeneutic called for with the authors interpretative comments, and a further engagement with the research literature, i.e. a hermeneutic of critical engagement or suspicion. IPA is not designed to attribute causality nor develop theory but focus on describing participants' experiences through the interpretative lenses of the researchers and related research.

1.1. Evidence-based practices

The American Psychology Association (APA) took steps to identify what constitutes an EBP in 1995 by defining criteria for empirically validated treatments. These criteria included at least two studies demonstrating efficacy, defined as being superior to a pill or to a psychological placebo or to another treatment, or equivalent to an already established treatment. Alternatively, a large series of smaller studies demonstrating efficacy was also acceptable. For either scenario, experiments had to be conducted with treatment manuals, the characteristics of the research participants had to be clearly specified (i.e. a single diagnosis), and the effects must have been demonstrated by at least two different investigators. The APA also defined "probably efficacious treatments" as two experiments showing that treatment is more effective than a wait-list control group or a larger study or a series of smaller studies meeting all of the previously mentioned criteria except the requirement to have the effects demonstrated by more than one investigator (American Psychological Association, 1995).

The field of CFT research has explored the role of EBPs for practitioners as well as developed EBPs. Sexton et al. (2011) proposed guidelines when working together on a sub-committee of APA's Division 43 (Family Psychology) that consisted of three levels of EBP ranging from "evidence-informed" to "evidence-based" (Sexton et al., 2011, p. 383). The three levels are intended to provide "both a hierarchical index of confidence that a treatment model 'works' and a comparative index of clinical applicability" (Sexton et al., 2011, p. 382). The third or highest level of EBPs in this model have three additional categories of evidence that are intended to further "demonstrate effectiveness by considering model-specific change mechanisms, superior performance when compared with other viable treatment options, and generalizability to a diversity of client populations and clinical settings" (Sexton et al., 2011, p. 382). The authors go on to suggest that the categories in the third level are intended to be more "contextual" than hierarchical and provide guidelines for researchers about what questions to consider regarding the use and implementation of a model.

Interestingly, Sexton et al. (2011) suggest that evidence should include at least two outcome studies with research coming from multiple sites and go on to indicate that to be evidence-based, couple or family interventions should include:

(a) clear specification of the content of the treatment model (e.g. treatment manual);

(b) measures of model fidelity (therapist adherence and/or competence);

(c) clear identification of client problems;

(d) substantive description of the service delivery contexts in which the treatment is tested; and

(e) the use of valid measures of clinical outcomes (p. 385).

These criteria are very similar to the APA guidelines released in 1995, and while suggesting elsewhere that there are contextual factors that are important to attend to, they do not attend to how EBPs can design research to attend to these factors.

EBPs present a range of benefits, challenges, and social justice considerations for CFTs and researchers alike. Some of the benefits of EBPs that CFTs cannot ignore are that they are a given of present-day practice and research (Midgley, 2009). EBPs present an opportunity to improve service, training, and save money (Morago, 2006; Persons & Silberschatz, 1998; Plath, 2006; Sexton et al., 2011). The key challenges with EBPs are the lack of epistemic agility that informs them (Slife, Wiggins, & Graham, 2005; Staller, 2006; Wendt, 2006) and the lack of recognition of the role of the therapist and consumer in the therapeutic process (Coulter, 2011; Gilgun, 2005; Malterud, 2001). Social justice considerations meanwhile raise questions about whom EBPs serve and highlight the stark absence of research ability or actual research with non-English speaking populations and ethnic minorities (Chambless et al., 1996; Elliott, 1998; Gambrill, 2010; Holmes, Murray, Perron, & Rail, 2006).

While there is no single means that CFTs learn an evidence-based approach, the participants here shared many of the learning components that now seem to be prevalent in being recognized as knowledgeable or proficient in an EBP. A number of programs have been set up to train and certify CFTs in a specific therapeutic approach (e.g. see http://www.iceeft.com or http://pro.imagorelationships.org or https://www.gottman.com). Each program involves didactic training with an expert in the approach, additional experiential workshops, approved supervision specific to the therapeutic approach, and a review of live or video/audio therapy sessions by an approved supervisor. While there is variation among the therapeutic approaches, in general these trainings include at least eight days of didactic and experiential workshops, at least 10 h of supervision, and a review by the certifying body of recordings of therapy sessions demonstrating different skills.

1.2. Perspectives on shame

The functionalist perspective on shame is "based on Darwin's theory of evolution and the notion that emotions have an adaptive function and serve to increase the chances of survival" (Mills, 2005, p. 28). This approach to shame sees emotions as regulatory processes that serve a person's goals. The adaptive purpose of shame is to maintain the acceptance of others and preserve the self while maintaining social standards and submitting to others when it is functional to do so (Barrett, 1995). From this perspective, shame has three functions: to reduce exposure to evaluation by withdrawing or disengaging, to focus attention on social standards and self in that context, and to communicate deference to others. Another category of developmental theories of shame is the cognitive attributional approach to shame and what follows is a brief description.

Possibly the more common of the categories of shame research, cognitive attributional approaches address cognitive evaluation processes that elicit shame. "Overt shame involves a *feeling* of being ashamed, i.e. an awareness of autonomic reactions (e.g. rapid heart rate, blushing, sweating) with a subjective feeling (e.g. feeling small, helpless, unable to control the situation)" (Mills, 2005, pp. 29–30). From the cognitive attributional perspective, shame is believed to be activated by negative attributions that are internal and global. A person believes they are bad, not that they have done something bad. The entire self is viewed as undesirable, unworthy, or flawed (Levinson & Tangney, 2002). While both the cognitive attributional and functionalist perspectives on shame offer a means to further explore the experience of shame, there is something missing from these perspectives for these researchers.

The notion that we "think" our way into shame reflects the Cartesian approach to the mind-body question (Descartes, 1952). That we have thoughts about a situation while separately having a physical reaction according to the cognitive attributional approach to shame negates the role of the environment a person finds themselves in at the time, their history with significant people in their lives, and an understanding of the significance and role of who is observing us at any given time. The functionalist perspective on the other hand, with a focus on survival and preservation, limits the experience of shame while learning an EBP to a kind of "saving face" perspective. This would suggest that people would not be willing to take risks in their learning nor delve into difficult issues in their lives or clinical work when integrating an EBP. While this was the experience for a couple of participants with limited integration of the EBP we discussed, for the other participants, this limited perspective on shame did not take into account the tremendous risk and exploration they did while learning an EBP. A more useful conceptualization of shame for this research project is one that posits shame as a means to understand a threat to a social bond or alert a person to potential rejection.

This category of theories considers social relationships as a basic biological need and includes object relational and attachment-based approaches to shame (Bowlby, 1973; Kaufman, 1989; Nathanson, 1992) and sociological and social work approaches to shame (Brown, 2006; Scheff, 2000). These theoretical approaches to shame offer the opportunity to further explore participants' experiences of discussing shame as evolving out of an interpersonal context and always linked to relationships and connections. Also contributing to this paper is the theoretical understanding of shame as a social emotion.

Understanding shame as a social emotion emerges from a category of theories that assumes that social relationships are a basic biological need (Greenberg & Mitchell, 1983) and understand shame as a threat to the social bond (Scheff, 2000). Bowlby (1973) for example, wrote that a child rejected by their parents "is likely not only to feel unwanted by his parents but to believe that he is essentially unwantable, namely unwanted by anyone" (p. 238). Shame can alert an individual to potential rejection and can motivate a person to prevent the rejection from occurring (Nathanson, 1992). Scheff's approach to shame incorporates both a negative sense of the word as well as its positive intentions, for example having a sense of shame, adhering to social norms. While Brown (2006) defines shame as "an intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging" (p. 45). Each of these theoretical approaches to shame suggests that the mechanisms of shame are social which is the focus used for the interpretation in this chapter. What follows is a description of the research project.

2. Overview of the research

The aim of this qualitative research project was to explore couple and family therapists' experiences with learning and using an EBP with the use of IPA. IPA "represents an epistemological position, offers a set of guidelines for conducting research, and describes a corpus of empirical research" (Smith, 2004, p. 40). IPA was first identified as a distinctive method in the mid-1990s in an article that appeared in *Psychology and Health* (Smith, 1996). Smith (1996) drew on the work of a psychology phenomenologist (Giorgi, 1985), on hermeneutics (Palmer, 1969), and on an engagement with subjective experience and personal accounts (Smith, Harre, & Van Langenhove, 1995).

The key elements of IPA are that: (1) It is an inductive approach. (2) The participants are experts on their own experience and are recruited because of their expertise in the phenomenon being explored. (3) Researchers analyze data to identify what is distinct (idiographic study of persons) while balancing that with what is shared in the sample. (4) The analysis is interpretative, grounded in examples from the data, and plausible to the participants, supervisors, and general public. Much of the early research using IPA was in the health psychology field (Smith, 2011a) and the introduction of IPA has made phenomenological research more accessible for those who do not have a philosophical background (Willig, 2008). Yet, that does not negate the relevance of the philosophical traditions of phenomenological research and the onus on the researcher to be authentic to aspects of these traditions.

IPA is particularly suitable for this research project and the exploration of CFT's experience with learning and using an EBP. As Shaw (2001) outlines, the focus is on the each participant's experiences and how meaning manifests within the context of the participant and their many roles. Smith et al. (2009) identify three key areas of the philosophy of knowledge that IPA draws on: "phenomenology, hermeneutics, and idiography" (p. 11). Through an idiographic, detailed analysis of participants' experiences with learning an EBP, the experience of shame emerged as a theme in this research project and will be examined further.

3. Method

3.1. Participants

Purposeful sampling, consistent with qualitative research (Creswell, 2007), was used to select participants on the basis that they can speak to the experience of learning and using a CFT EBP. Homogeneity is recommended for IPA studies and there is a need to speak to what situations these CFTs practice in, such as: how they vary, how they are similar, and how the contexts shape their practice. The focus, however, was on the CFT's experience with adapting an EBP, the practice of CFT as a cultural frame, and the potential for theoretical transferability. A total of 14 participants were interviewed and details of the research participants are summarized in Table 1. The focus in IPA is a detailed account of the phenomenon being explored. As Smith et al. (2009) note, the issue is quality and not quantity with a recognition that the complexity of human phenomena benefits from a focus on a small number of cases.

3.2. Procedure

Data were collected through interviews with CFTs who have at least a Master's degree in a mental health field such as counseling, psychology, social work, or marriage and family therapy. These professions were targeted for interviews because it is these professionals that are recognized as offering CFT. The selection criteria were CFTs who were, or had been, actively engaged in learning about and using an evidence-based couple or family therapy practice that included the following elements:

Table 1. Description of research participants

Anonymized name	Age range	Gender	Location	Profession	Length of time in practice (years)
Jessica	40–49	F	Canada	Counseling	8
Ken	60–69	M	Canada	Social Work	40
Cassandra	40–49	F	United States	Marriage and Family Therapy (MFT)	4
George	60–69	M	Canada	Mental health professional	33
Kathy	60–69	F	Canada	Social Work	20
Louise	40–49	F	Canada	Counseling	12
Beth	30–39	F	Canada	Psychology	10
Helen	40–49	F	Canada	Social Work	28
Sally	40–49	F	Canada	Psychology	20
Raylene	60–69	F	United States	MFT	25
Mary	30–39	F	United States	MFT	3
Tina	40–49	F	Canada	MFT	5
Peter	50–59	M	United States	MFT	25
Eric	30–39	M	Canada	Counseling	1

the EBP has a treatment manual; the clinicians received training specific to that practice; the clinicians received supervision specific to that approach; and the EBP has a theory of change that clinicians were required to relate their practice to. Participants were recruited via professional listservs, snowball sampling, email, and direct requests from the research team.

Ethical approval was secured for the research and the appropriate information and consent forms were administered. Individual interviews with 14 CFTs occurred either face-to-face or via Blackboard Collaborate (a secure online learning and communication system) and had a semi-structured format. The interviews were focused on their experience of learning and using an evidence-based couple or family therapy practice. Participants were able to discuss what influenced their decision to learn an evidence-based CFT practice, how they went about learning this new practice, what they found most helpful and not, and what impact this has had on their day-to-day clinical practice. The interviews were guided by semi-structured interview guide.

The interviews lasted 60–100 min and the interview guide was designed to promote the research participants' comfort starting with a descriptive question (Smith et al., 2009). Interviews were audio-recorded and transcribed to capture the specific text of the interview as well as the intonation, utterance and other components of speech which may lend themselves to further interpretation. In general, IPA moves from the particular to the shared, from the descriptive to the interpretative, it maintains a commitment to understanding the participant's point of view, and has a psychological focus on personal meaning making in particular contexts. Smith et al. (2009) outline a six-step process for the analytical process which we used in this research. These six steps included: (1) Reading and re-reading the transcripts and noting anything of interest. (2) Initial noting of the participant's content, linguistic interpretations, and conceptual comments. (3) Developing emergent themes. (4) Searching for connections across emergent themes and identifying the purpose a theme may play in a therapist's life. (5) Moving to the next case and repeating the same analytical process. (6) Beginning to look for patterns across transcripts and identifying the most important things to say about participants. The transcripts were primarily analyzed by the first author and reviewed by the second and third authors. Further data were collected by the first author through journaling and feedback was provided by the other authors as part of the iterative development of the research. These reflexive processes included both epistemological and personal reflections as suggested by Willig (2008).

The theme explored in this paper best reflects IPA's commitment to an ideographic perspective where an in-depth analysis of each case can, at times, lead to a focus on a particular passage from a research participant. Smith (2011b) reflected on his own experience of conducting IPA-based research and noted that he is "aware of the pivotal role played by single utterances and small passages of the analysis of a research corpus" (p. 6). It is this recognition of the significance of a passage that is disproportionate and that he refers to as a "gem" in the research. A question arises as to how to assess the value of these kinds of findings in an IPA research study. One measure of quality is a greater focus on the particulars. As Smith outlines (2011b), it has "to do with the utterance that stands out and has added value to the analysis as a whole" (p. 7). One such example that we encountered was when Raylene noted the following:

> And I'm just like oh my god, that's it, that's it, and then I begin to tell them the story about how I had put this together through my supervision, the shame piece, my sister's suicide and me feeling responsible and this is what I was hitting inside myself and having that line-up with the emotion was incredibly powerful and it was very dysregulating. I was actually pretty disassociated there.

The experience from our work as trainers and supervisors and from the research literature indicates that it is very rare to have someone encounter a moment in their learning that they link so clearly to an event that happened 30 years earlier in their life. This, for us, was a gem, a pearl in the midst of

the sea of data and an important opportunity to explore further as a means to illuminate this issue for the group of participants as a whole.

3.3. Analysis

Participants were asked to talk about their experiences with learning and using an evidence-based couple or family therapy practice in their day-to-day clinical work. An evocative theme emerged which was the experience of shame while learning an EBP which will be presented in detail below.

As noted, it was Raylene's transcript in particular that evoked this theme and provided the opportunity to illuminate the experience for the group of participants as a whole. Raylene who is very experienced in the field and had done a lot of her own therapy was surprised at the challenges she experienced in learning a new therapeutic approach:

> I had done a ton of my own personal work but I had no idea that this shame piece was in me. I felt responsible … I was really tapping into how ashamed I felt that I wasn't getting this model down.

Raylene used the words "shame piece" to describe an aspect of her experience of learning a new EBP five times during the interview. She also described herself as "ashamed" at some point during her learning four times during the interview and used various other descriptors such as describing herself as "shameful", "my shame", "filled with shame", and "my shame experience" 14 times during the interview. The evocative passage from Raylene noted above was an entry into an experience shared with other research participants. Raylene's descriptions were what Smith (2011b) described as a "shining" gem where there is a clear presence and description of that experience by the research participant. In fact, Raylene's perspective about the shame that she experienced while learning an EBP evolved. She described how "the whole shame piece has been extraordinary to me", that it illuminated an experience earlier in her own life (her sister's suicide) that was exposed while learning an EBP. Once exposed, she was able to process and integrate the experience with the help of supervision, further training, and peers to develop a more coherent narrative which enriched not only her learning of the EBP we discussed but her life in general. With that coherence developed, Raylene offered an experience that we draw on throughout this paper.

There's nothing like family practice to push people into a bit of a corner

The nature of the training that the participants did in this research project seemed to reflect a general understanding that learning about CFT is more personal (i.e. challenges the self-of-the-therapist) than learning about individual approaches to therapy. George who trained as a family therapist in the 1970s and has since been responsible for training and supervising others learning family therapy noted:

> We had a lot of problems with residents in training, not just residents but whoever, who come up against their own personal difficulties quite quickly. I think there's nothing like family practice to push people into a bit of a corner.

As an experienced therapist and trainer, George reported both the personal "difficulties" that arose during training as well as the image of being cornered. He evokes a sense of an individual isolated, confronted, exposed, and stuck at the same time. George offers a picture of individuals in family therapy training confronted by their own "personal difficulties" as if long lost secrets or personal foibles that had long been hidden away rear up and snap a trainee into attention. George received and conducts family therapy training in group settings. When these personal difficulties arise, they expose an individual not only to themselves but other trainees, supervisors, and trainers. The trainers and supervisors in this case have a great deal of authority over a trainee's future career so the possible implications for being exposed are both personal and professional.

At the same time that George paints a picture of trainees exposed and confronted, he also suggests they are isolated and stuck at the same time or backed "into a bit of a corner". This push into a corner suggests there is nowhere to turn and that trainees are edged deeper into a corner by their "personal difficulties", isolated from and unable to reach for supports, resources, or other people. George went on to describe a situation with one trainee where:

> We had a particular participant in one of our groups who clearly had had an abusive experience in her childhood and she'd been going along with this nicely contained. Into this family arena and the whole thing just (throws hands up), and she was in a mess for quite some months.

This trainee was confronted by her early in life injuries with the people she most trusted at that time. Once the abuse history was exposed, this trainee was in a "mess", not only backed into a corner but one gets a sense of huddled and sobbing in a corner unable to see any options for sorting the experience. This kind of experience where one is flooded with overwhelming emotion leaves one isolated and feeling unwanted.

For some of the participants though, the opportunities for aspects of their families and relationships to be exposed, re-ignited, or illuminated during CFT training was not a function of previous lack of self-exploration or therapy. As previously noted by Raylene, she "had done a ton of [her] own personal work", and was surprised at the challenges she experienced in learning a new therapeutic approach. For Raylene, the personal difficulties she was confronted with while learning a new EBP were not a function of a lack of self-of-the-therapist work or previous personal therapy she had done. George on the other hand described how he "had done a lot of work previously on myself because of my psychotherapy training so you know it didn't really affect me quite so much". George noted that in comparison to a trainee who "was in a mess for quite some months" he was not affected "quite so much" but this did not mean he was not also confronted. In his own words, George went to mention that "I certainly you know found myself not sure what, you know what, how to view my own family" when he had started his own family therapy training. The research participants not only discussed how they were personally confronted and exposed but also how that confrontation happened professionally while learning a new EBP.

One of the research participants, Mary, was a therapist in a clinical trial for a new approach to working with families. Part of the clinical trial was a measure of fidelity to the therapeutic approach and a constant monitoring of her work. Mary described the process as follows:

> I mean the other challenge, it has been … that feeling of being scrutinized because every single session that I do is recorded and every single session that I do … is reviewed by somebody, and that person is giving me a score, and if there's something that I'm doing that is not therapeutic or that involves another model, they will point that out to me and as much as I have been benefitting from that, somehow there's also a feeling of being exposed. So that, it was somehow difficult to adapt to that, to be so scrutinized.

In reflecting back, Mary could identify how this helped to develop her abilities as a therapist though she described how "it was somehow difficult to adapt to that, to be so scrutinized". While Mary experienced this scrutiny as helping to develop her therapeutic skills, the experience of being scrutinized is an element of learning an EBP for the participants in this research project. All of the participants had to submit to the scrutiny of supervisors, trainers, and peers during training and supervision sessions. They had to submit to the gaze of several others in person, with video of their therapy sessions during supervision, during role plays in training, some participants had live supervision, and at many other times during the process of learning an EBP.

One reaction to this scrutiny that Helen noted was the negative qualities about the trainer. Despite agreeing to do the interview and knowing the recruitment criteria, Helen had not done a lot of follow-up in her learning and was clearly struggling during the interview to discuss how she had

integrated the new EBP into her therapy practice. She agreed with much of the ecological model to working with families that she was learning but seemed to have a series of excuses for her lack of follow-up with supervision, videotaping her work, and other tasks that could have contributed to her integrating this new EBP. One of the things Helen did instead, was she spoke at length about the challenges she had with the trainer, externalizing her struggles, with little reference to the content, her own process of learning, and her adaptation of the information into her clinical work:

> So the other person, so it's interesting to me … it seemed to be a lot about like, where they had travelled, a lot of names of people they had worked with, and, not that, the teaching part wasn't happening, but where I see this approach is, it's definitely telling you, it's not, it's taking you out of being an individual, and what I saw was, it was very much about an individual. (From my perception)

Helen seemingly acknowledges both that teaching was happening and that she did not like the style of teaching. At no point did she go on to discuss how she integrated this information into her therapy work but she did return to the theme of what she found wrong with the way a person facilitated or delivered training of which she was part. In the context of the rest of her interview, Helen reflected a combination of confusion, fear, and judgment often associated with the experience of shame (Brown, 2006). Her fear of exposing herself or her work led to a protective strategy whereby she did not have to talk about what her experience was of not being successful at integrating a new EBP into her clinical work. Other participants also discussed times where their challenges in their training led them to experience a range of shame-like emotions such as humiliation, guilt, and anger. What follows is a brief review of some of these experiences.

I could have said this, I could have said that

Research participants discussed moments in their training and learning where they experienced shame, pain, and a general sense of themselves as bad or wrong. Cassandra for example, beautifully illustrated an experience of in-the-moment shame:

> One girlfriend of mine I love what she said … she said you know I am the absolute best EFT therapist in the car driving home, you know you always have this oh I could have said this, I could have said that, I wish I would have done this, and you know, so that was painful.

Cassandra described what any therapist might do when reflecting about a session but her addition of the experience being "painful" situates the experience differently than a simple reflection. Cassandra used the word "painful" six times during the interview to describe how she was feeling during moments in her learning a new approach to working with couples. One of these moments she described how she was "really struggling with you know I know what I want to do, why can't I do it in the moment?". Cassandra's experience in that moment and the "pain" she described is one where she sees herself as incapable. Not just that she does not know how to do a therapy technique but she is in "pain" because she experiences herself as flawed. The experience of oneself as flawed is central to the feeling of shame (Brown, 2006) and the process of learning an EBP for the research participants presented different opportunities for this to emerge.

Among the experiences that participants discussed of perceiving themselves as flawed, Raylene mentioned an element of learning an EBP that was shared with other participants who were more senior in their field. Raylene said:

> It was already humiliating enough to be a seasoned therapist back in training and having to pay for supervision and being in these study groups with all these very young, inexperienced people that are just, they're still in school, they're like interns and it was pretty humiliating for me.

The experience of feeling humiliated because she was in learning situations with colleagues who were new or had yet to enter the field reflects an understanding she had about what it means to be a "seasoned therapist". While not a barrier for Raylene, this kind of understanding of what it means to be experienced in the field may serve as a barrier for others learning an EBP. Helen, for example, provided an example of how she shut down when challenged in her learning.

Helen reported an incident during training where she was struggling with the material and did not want to participate in the discussion being facilitated by the trainer. "If I feel like I'm being pushed, I will push back, and as much as I said I wouldn't, I did. Cause I wasn't saying anything". A possibility Helen did not mention was to ask questions, explain that she was struggling with the material, request additional information, and other options that may have facilitated her learning. She did not describe the facilitator as intimidating nor disrespectful of learners. For Helen, however, the tendency to turn inward and hide in such a moment reflects a tendency noted in the shame literature (Brown, 2006; Dearing & Tangney, 2011; Tangney, Stuewig, & Hafez, 2011), that is, she was motivated to hide or escape the shame-inducing discussion. Smith (2011b) described this as a "secret gem" where a participant "may not be consciously aware of the meaning" (p. 14) of what they have said. Other research participants had some awareness (suggestive gem) or were very clear that they were experiencing shame as part of learning an EBP and what follows is a description of some of their experiences.

Tapping into this feeling of shame

For some of the participants who spoke about the experience of shame, there came a time in their learning where they openly acknowledged that they did not know what they were doing. As Cassandra explained:

> And then you get into a room with a couple and even if I felt like I had a decent idea of what I wanted to do you know I thought I did, at this point I realized that like what it looks like on paper and what it looks like in the room and what you're really trying to do, that translation in and of itself takes a lot of the time.

This open and honest assessment of her ability with the new EBP she was learning belies the painful path Cassandra took to this statement. She spoke of her experience of feeling incompetent at not being able to learn a new EBP:

> ... tapping into this feeling of shame that I would get over and over again because I wasn't getting the EFT and I would feel so incompetent and otherwise I felt so competent as a therapist. So it was like really hard for me and when I would tap into it.

Cassandra described her experience as if shame was on tap ready to be released into her when she struggled with her integrating an aspect of the EBP she was learning. For some, "tapping" into the experience of shame while learning an EBP can spill over, as it did for Raylene.

As previously noted, of the participants interviewed for this research project, Raylene provided the most evocative experience of shame while learning an EBP. Her experience centered around the suicide of her sister 30 years prior. Raylene described that she first started to make the connection between her struggles in her learning and the suicide of her sister during a supervision session. She said, "I left that supervision session, I was completely dysregulated, all I wanted to do was, eat sugar [laughter] and I leave but I'm, but my mind, I'm watching, I'm going wow, this is really significant. This is huge". While "dysregulated" she was "watching", curious, she had an awareness that there was something significant about feeling that way as she left that supervision session. Note that she does not blame the supervisor for making her feel that way nor discuss what strategies she used to stop feeling that way but is aware that all she wanted to do was "eat sugar". Raylene later linked the experience noted earlier of her sister's suicide and "and me feeling responsible and this is what I was hitting inside myself" and linking that to the challenges she was experiencing while learning and

using a new evidence-based approach to working with couples and families. Raylene described the shame she experienced and the feeling of being responsible for not preventing her sister's suicide. How was she to learn a new approach to working with couples rooted in attachment theory if she was not able to save someone 30 years prior with whom she had a significant attachment? The "shame piece" emerged from moments of overwhelm and "dysregulation" and the desire to integrate a new approach to working with couples that required her to confront this shame. While Raylene was confronted, as other participants were, with an aspect of herself that was shame inducing, she found a means to make meaning of that experience in the midst of learning a new EBP. There were a few key resources that assisted Raylene with that process.

Like other research participants, Raylene talked about seeking connection, seeking to build social bonds as a means to deal with shame. Raylene mentioned how exchanges on a listserv began to lift the isolation and seed an understanding of what she was experiencing. "And so there was a lot of talk on the listserv which was also helpful, about shame and I went to a shame workshop ... I began to understand this whole thing about shame". She described developing a coherent narrative of the "shame piece" in the context of seeking connections. George emphasized the importance of being able to explore and discuss the "personal difficulties" that come up in family therapy training as mentioned earlier. He described the need as follows:

> I think one has to have openings, people available to discuss on a personal level with trainees, encourage them to use their training group for support and help and guidance in whatever they may be going through. So, although some of it is so personal it can't be shared easily in public, you know they may need to go somewhere else for it but you have to be prepared for that. So these are the things that you know one is challenged with personally and I certainly found that when I was training.

For George, an experienced trainer, he assumed that there was a need to discuss things on a "personal level", that learning family therapy is also about learning about one self, one's family, and one's relationships. In addition, George's experience is that some of that learning will be with "personal difficulties" that are not "shared easily in public" or, in other words, might be considered shaming or shameful. Both Raylene and George are aware of the need for supports and connections while learning a new approach to working with couples and families based on their experiences as well as the potential for shameful experiences to be transformed.

In fact, Raylene went on to discuss part of why she chose to do an interview for this research project. "So you can hopefully help other people along the way, so they won't be so surprised [laughter] and so ashamed. It's like a journey". With the benefit of experience and the ability to reflect back, Raylene recognized that shame was a part of her learning an EBP and may be for others as well. While acknowledging that shame was part of her learning process, Raylene was able to recognize the integral part this took in her learning a new EBP, how it actually was bound up and contributed to her ability to integrate a new EBP into her practice. She did not want people to be "surprised" that they may become "dysregulated" and possibly "dissociated" while learning a new approach to working with couples and that it may very well just be part of their "journey". If shame is to be part of the learning of an EBP for some therapists, it is important to explore what the impact of shame on people is and for therapists during their clinical work.

4. Discussion

4.1. The impact of shame

Shame proneness is linked in the empirical research literature to problems with hostility, anger, aggression, and a propensity to externalize blame (Ahmed & Braithwaite, 2004; Bennett, Sullivan, & Lewis, 2005; Harper & Arias, 2004; Levinson & Tangney, 2002). The frequent experience of shame has been linked to individual vulnerability (Dearing & Tangney, 2011) as well as poor collaborative skills and conflict avoidance (Lopez et al., 1997). Dearing and Tangney (2011) point out that "the

immediate action tendency when faced with shame is to hide or escape from the trigger that elicited the painful emotion" (p. 5). Other subsequent action tendencies, such as lashing out in anger or blaming others, are attempts to alleviate the discomfort associated with shame. One of the consequences of shame is the negative impact on interpersonal relationships.

Shame is negatively related to perspective taking and the focus of cognitive and emotional energy when in a shame experience is directed inwards. Leith and Baumeister (1998) outline the impact on perspective taking as follows: "the globality of shame could make perspective taking highly aversive: if one assumes that the particular misdeed reveals oneself to be a bad person, one will not wish to contemplate oneself from one's victim's perspective." (p. 7). The impact on perspective taking can be seen in this and other research projects. Brown (2006) described her research participants' experience of shame as follows:

> When the participants experienced shame ... they were taken off guard, flooded with overwhelming emotions, and were unclear about what they were feeling or why they were feeling it. The shame experience often produced some combination of confusion, fear, and judgment. Closely following these feelings were often strong feelings of anger, rage, and/or blame. (p. 48)

Some of the research participants talked about the struggles to learn a new approach and the inward direction of their questioning. None of the participants spoke more clearly about their struggles than Raylene when she mentioned being "dysregulated" and "dissociated" during and after a supervision session. Other participants also spoke to experiences of overwhelm, shame, and the related secondary behaviors that come with these feelings such as anger. For example, Cassandra clearly spoke of her experience of feeling incompetent at not being able to learn a new EBP when she discussed "tapping into this feeling of shame that I would get over and over again because I wasn't getting the EFT". While Helen, who had spoken with a certain kind of anger about the struggles she had with a trainer, mentioned that "it was very much about an individual" as a means to reflect about her experience of integrating an EBP while completely deflecting from her own lack of efforts or inabilities. In either case, directed inward or focused on what the problems are with the trainer, one's attention is taking away from the content being presented, the issue being explored in supervision, or the possible learning from a video or live session review. These experiences take a trainee away from learning about an EBP or can block them from integrating an aspect of an EBP into their practices.

Talbot (1995) writes of the need for an active approach to uncovering shame by both supervisors and therapists. "Unexplored shame begets *passivity* and *hiding*" (p. 339). The importance of a therapists' need to explore their experiences of shame is highlighted by the impact it may have on clients. "Embarrassing and shameful moments reveal unacknowledged, uncomfortable feelings of which the therapist is unaware that will likely have unknown effects on clients" (Ladany, Klinger, & Kulp, 2011, p. 307). Research participants spoke of the transition to new approaches in their practice and the lag between an idealized therapist-self and the reality of their experience with a couple or a family. As Cassandra mentioned, "what it looks like on paper and what it looks like in the room and what you're really trying to do, that translation in and of itself takes a lot of the time". Like other participants, Cassandra started her learning of a new EBP with a sense of being able to integrate a new therapy approach into her practice with more ease than she experienced. All of the participants in this research project had a minimum of a masters' degree and a sense of competency about their clinical work. Identifying therapists' shame and working through it is critical given the impact it may have on clinical work. As simple as this may sound, the research participants' experiences spoke to the tremendous challenges this presents.

As Brown (2006) noted, "shame often produces overwhelming and painful feelings of confusion, fear, anger, judgment, and/or the need to hide" (p. 46). This experience was reflected by the participants in this research project. Raylene for example mentioned being "completely dysregulated";

Cassandra discussed "tapping into this feeling of shame"; Kathy talked about wanting to "feel like you have something to offer"; Ken reviewed how it has been "harder for me to not go into that inner critic and think I'm really stupid"; Jessica reflected that "the actual practice or implementing of the theory is a little bit harder" than she had anticipated and this lead to her questioning her abilities as a therapist; and Tina relayed an experience with a supervisor who offered feedback about her work and she "felt really overwhelmed by that and I felt wow am I up to the level of expectation at this time in my life?". These are just a few examples of shame related experiences while learning an EBP from the research participants. Underpinning all of these experiences was a great desire to be effective and the need to demonstrate this efficacy to clients, peers, supervisors, and trainers when learning an EBP. While not the focus of this research, what follows is a brief exploration of one option for working with shame in supervision.

4.2. Shame in supervision and training

Ladany et al. (2011) define therapist shame as "an intense and enduring reaction to a threat to the therapist's sense of identity that consist of an exposure of the therapist's physical, emotional, or intellectual defects that occurs in the context of psychotherapy" (p. 308). The desire to hide or get angry at anyone exploring those exposures is a common reaction when experiencing shame; as Talbot (1995) noted, "shame is associated with the hidden parts of ourselves, buried deeply enough to avoid scrutiny by others and, in many cases, by ourselves" (p. 339). For couple and family therapists there are a number of potential sources of shame.

Talbot (1995) reported these sources in psychotherapy as the shame that: evolves from the relationship between therapist and clients, that arises from the therapist's fears or experience of not being approved by a supervisor, and are inherent in discussing personal material in a supervisory session. The options for exploring the impact of shame for a therapist are further complicated by the cultural norms and action tendencies when in shame. For example, Dearing and Tangney (2011) report that the word "shame" is often avoided, that the action tendency of shame is to hide, and that therapists inadvertently avoid discussing shame related issues. The focus of therapists' experience of shame to date has been while they are providing therapy, not while they are learning. The research literature has noted that the progression that therapists go through in their development may expose a therapist to the experience of shame.

Ward and House (1998) for example, report that supervisees progress "through a sequence of definitive stages while experiencing increased levels of emotional and cognitive dissonance" (p. 23). This dissonance can lead some to feelings of guilt while others experience shame. Guilt however leads to a reparative action while shame does not (Smith, Webster, Parrott, & Eyre, 2002). Talbot (1995) noted that "interpersonally, shame is the emotion associated with the humiliating revelation of personal failure to another" (p. 339). It is difficult to imagine a learner or supervisee who experiences shame finding a means to explore that experience. As Chao, Cheng, and Chiou (2011) report, "one's self-image is questioned in a state of shame" (p. 203). An important goal for a therapist learning a new EBP while experiencing shame is "to seek an effective means of buttressing a threatened social self" (p. 203). There is a need to further research how to work with supervisees' experiences of shame while learning an EBP.

The limitations of this study include the small sample size. On the one hand we do not assume that similar findings would come from all CFTs in a similar situation. On the other hand, the fact that participants spoke with such clarity indicates the strength of the experience for these individuals which might be seen in other CFTs in similar situations. It is also possible for the reader to think in terms of theoretical generalizability, that is, to consider the results in the light of their own professional practice when assessing the potential prevalence of the phenomenon.

5. Conclusion

The experience of shame emerged in this research project as an important experience while learning an evidence-based couple or family therapy practice. This theme was evoked by a passage from one

participant, or what Smith (2011b) described as a gem, that resonated across the sample in different forms. The value of a gem is that it offers "analytic leverage, they shine light on the phenomenon, on the transcript and on the corpus as a whole" (p. 7). Smith goes on to note that he sees it as an extension of Husserl's urging to the thing itself, where "the gem can offer one entrée into that experience" (p. 7). Therapists are increasingly encouraged to use EBPs and the experience of shame may be considered as part of the learning of such practices for some therapists. The supervisory relationship is a central factor to develop for successful supervision (Todd & Storm, 2014) and takes on a greater emphasis when dealing with a supervisee in shame. The importance of taking an intersubjective stance that provides safety and support for a supervisee or trainee facilitates possibilities for exploring shame-related experiences.

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