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A Gendered Perspective on the Experience of Shame in Supervision

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A GENDERED PERSPECTIVE ON THE EXPERIENCE OF SHAME IN SUPERVISION

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Shame is a universal experience, in which one feels painfully exposed as defective. While the shame research has steadily increased, the experience of shame in supervision has been largely ignored in the self-conscious affect research. Shame research has primarily focused on the differentiation of shame and guilt, and the negative outcomes associated with shame-proneness. This study examined the experience of shame in supervision experience and explored the mediating roles of social support and self-compassion on the proneness and experience of shame. Furthermore, this study used a gender framework to explore potential gender differences in the shame process. This mixed methods study found moderate rates of shame occurring in supervision and revealed the feedback process as a potential trigger for shame. Furthermore, shame-proneness was found to predict self-compassion, social support and the experience of shame.

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CHAPTER I

INTRODUCTION

The Study of Shame in Supervision

Shame is an everyday and universal emotion. Shame is experienced in diverse situations, in which many examples of shame-inducing situations have been studied. Shame is relevant to therapy and supervision, but the operation of shame in supervision has limited research.

Shame

Shame is described as a universal self-conscious emotion, in which one feels exposed and at risk of negative judgment by others (Brown, 2004; Kaufman, 2004;Tangney, 1995). Shame has been frequently described as a painful experience, as it causes a negative judgment of the entire self. The shame experience includes the feeling of being small and exposed, both to judgment by the self and to the real or anticipated judgment of others. Shame has also been described as an exposure of the "unwanted" or deficient self to other people, thus resulting in the failure to meet one's ideals (Brown, 2007; Ferguson, Eyre, & Ashbaker, 2000; Teroni & Deonna, 2008). Shame consists of the experience of being seen by other people as bad or a failure, which is then generalized to one's whole identity as a person. This negative generalization of the self often results in the need to hide away, or can result in a desire to strike back and use shame as a weapon against others (Tangney, 1991, 1995). The experience of shame, and more specifically shame-proneness, has been found to be correlated with poorer mental health outcomes, lower self-esteem, and feelings of inferiority (Benetti-McQuoid & Bursik, 2005).

Shame-Proneness

Shame-proneness is defined as the tendency to experience feelings of incompetence, worthlessness, and helplessness across time and situations (Ferguson & Stegge, 1995). Tangney, Wagner and Gramzow (1992) found that shame-proneness was associated with a greater frequency of global self-attributions for negative events, and reduced self-attribution for positive events. Shame-proneness has been previously found to be associated with reduced capacity for other-oriented empathy and reduced problem-solving abilities (Covert, Tangney, Maddux & Heleno, 2003; Tangney, 1995). Thus, shame-proneness is associated with reduced quality of interpersonal relationships, as it inhibits one's ability to engage in perspective-taking and conflict resolution. Shame-proneness is linked to one's upbringing and attachment with parents, as more frequent negative global attributions of the child from the parent (i.e., "bad child") can result in one's predisposition to shame reactions. In general, caregivers who frequently identify a child (as opposed to a child's behaviors) as not adequate (i.e. in relation to expectations or values) will result in the development of negative emotions, a poor self-image, and greater shame-proneness (Ferguson & Stegge, 1995).

Supervision

The relationship between a supervisor (of a clinical student) and the student trainee is in some ways parallel to the parent child relationship, and may have similar potential to generate shame. Bernard and Goodyear (1992) defined supervision as the system of oversight provided by a senior member (supervisor) of the profession to a less senior member (trainee). The relationship between a supervisor and trainee extends over a period of time and is hierarchical, with an evaluative component. Furthermore, the

purpose of the relationship is to heighten the professional abilities and competency of the trainee, to oversee the quality of the services offered by the trainee, and to serve as a "gatekeeper" for people interested in joining the profession. While there are several tasks involved in supervision, the most important factor is protecting client welfare. Another important aspect of supervision is that the trainee is pursuing the same profession as the supervisor and in training programs, the supervisor is often imposed upon the trainee as opposed to being selected (Bernard & Goodyear, 2009).

While supervision may include components of teaching, consultation, and counseling, supervision is considered to be a distinct intervention (Bernard & Goodyear, 2009). Although supervision may be used to teach the trainee new skills and knowledge, it differs from teaching in that it is based on the needs of the trainee and client, rather than based on a curriculum. Supervision differs from consultation because of its hierarchical and evaluative component, as consultation is infrequent, between equal-standing co-workers, and does not include an evaluative component. Finally, supervision differs from counseling, as therapeutic interventions are often done within the framework of client welfare, as opposed to the supervisee's needs. Supervision also differs from counseling because of the evaluative nature of the supervision (Bernard & Goodyear, 2009).

Statement of the Problem: Why is it Important?

Shame is a universal emotion, and is often triggered by the feeling of being exposed as unworthy or defective to others (Tangney & Dearing, 2002). The exposure can be either real or imagined, but requires increased feelings of vulnerability and defectiveness. Shame is associated with increased rates of mental health struggles and

disorders, increased aggression and hostility towards others, increased self and other-oriented blame for negative events, and reduced empathy in interpersonal relationships. Tangney and Dearing (2002) discuss the complexity and depth of shame in human experiences, and the lurking nature of shame, as it can be triggered across interpersonal situations. While some people are more generally shame-prone, everyone has shame-vulnerabilities, which puts them at increased risk for experiencing the painful feeling of shame (Tangney & Dearing, 2002, 2011).

In the context of therapy and supervision, the experience of shame can be induced by the therapist's feelings of incompetency and exposure, and can result in further alienation and self-doubt about one's clinical skills and abilities (Tangney & Dearing, 2011). While therapy should provide a safe and open environment for the discussion, identification, and treatment of shame, several barriers exist that prevent clients and therapists from talking about shame (Tangney & Dearing, 2002; Gilbert, 2011). While shame may be a reason for clients starting therapy, clients may be hesitant to discuss their shame experience. The lack of discussion about shame in therapy may be due to the painful and exposing nature of talking about shame, or may be related to therapist's countertransference reactions to shame, which may result in the inadvertent shift of conversation away from the "dangerous" territory of shame (Tangney & Dearing, 2002).

In supervision, therapist shame can result in reduced self-disclosure about the therapeutic and supervisory process, while also resulting in avoidant, withdrawn, or blaming (self or other-oriented) reactions (Hahn, 2001; Yourman, 2003). Therapist shame can also result in the fear of criticism, exposure, judgment of inadequacy or inferiority, and the fear of being perceived as unhelpful from both clients and from one's supervisor

(Gilbert, 2011). The therapist's shame can be directed inward, through the self-reflection of one's limitations and skills, and/or can be expressed outward, through the worry about how one is seen by clients and supervisors. Because of the painful reaction induced by shame, it can be difficult for people to recognize their own experience as shaming (Dearing & Tangney, 2011; Morrison, 2011). Furthermore, the act of speaking shame requires insight into the experience and impact of shame on one's experience, which can further hinder one's ability to discuss their shaming experience. Instead, people often express their shame non-verbally, through nervous laughter or a lack of eye contact, thus the therapist and/or supervisor must be aware and looking for these shame clues (Morrison, 2011; Tangney & Dearing, 2002).

Potential for Shaming

The therapy and supervision process consist of ample opportunity for the experience of trainee shame (Tangney & Dearing, 2011). In supervision, the trainee wants to be found competent by the supervisor while also being at a high risk of feeling inadequate, as one's therapeutic skills and conceptualizations are in development. Due to the increased risk of shaming potential, it is highly important for therapists and supervisors to be knowledgeable about the signs of shame, and to help empower people to "speak their shame." Thus, therapists and supervisors must both create safe and open environments in which shame can be safely and non-defensively explored. While models of supervision may differ in their emphasis on supervisee self-disclosure and exploration, supervisees may still be at risk for shame. The psychodynamic model of supervision, which emphasizes supervisee's self-exploration and the therapeutic process, was

associated with increased rates of supervisee shame-proneness, as compared with other supervision models (Hemlick, 1997).

Missing From the Literature

While the general experience of shame has been increasingly studied and included in the self-conscious affect research, the research on the experience and impact of shame in supervision has been limited (Hahn, 2001; Dearing & Tangney, 2011). The shame in supervision literature primarily explores both the supervisor and supervisee reactions to shame, as well as the potential for shame to occur within the supervisory context. While shame has been theorized to be rife in the context of therapy and supervision, self-reports of shame in supervision are often dramatically less than what is anticipated or hypothesized (Hemlick, 1997; Yourman, 2003). The limited findings of shame in supervision may be indicative of a lack of shaming experiences, or could be related to difficulty with identification and measurement of shame, as well as the avoidant and hidden nature of shame reactions. Furthermore, while research has clearly indicated the gender differences in the experience and proneness to shame, limited research has discussed the gender differences in the experience of shame in supervision (Brown, 2004, 2006, 2007, 2008, 2009; Tangney & Dearing, 2002, 2011). The proposed study aims to further understand the experience and frequency of shame in supervision, as well as further explore gender differences in shame-proneness and self-reported shame in supervision.

CHAPTER II

UNDERSTANDING SHAME

Distinguishing Between Shame and Guilt

Much of the existing shame research has been devoted to differentiating between shame and guilt. While shame and guilt are described as two negative self-conscious affective states with some overlap and similar triggers, these emotions promote different behaviors, self-evaluations, and result in different psychological outcomes (Tangney & Dearing, 2002). Barrett (1995) defined shame and guilt as social emotions due to their social construction, their connection with both real and imagined social interactions, the significant role they play in social communication, and their role in evaluations of the self and other people. Guilt is a negative, self-evaluative emotion that is characterized by a negative judgment about a specific behavior (Brown, 2004; Elison, 2005; Tangney, 1995; Teroni & Deonna, 2008). Thus, guilt is the emotional reaction to the belief, "I did something bad," whereas shame is the emotional reaction to the belief "I am bad." Guilt involves evaluating behavior against one's ethics, values and belief system, thus prompting corrective behavior (Brown, 2007). The phenomenological experience of shame is very painful, and is characterized by feelings of being small, helpless, and worthless. The experience of shame is universal, and involves the feeling of being exposed to others as defective, incompetent or bad (Tangney, 1995). In contrast, guilt is believed to be less painful than shame, and is characterized by motivating and reparative feelings of remorse and regret (Barrett, 1995; Tangney, 1995). Thus, feelings of guilt often result in action aimed at fixing a wrong-doing, which is then associated with a release in tension. In contrast, shame results in the inward evaluation of the self, and thus

spurs withdrawal and avoidant behaviors (Barrett, 1995; Hahn, 2001). Empathy is a key emotional component in the resolution of shame (Brown, 2004, 2006, 2007, 2008, 2009).

Empathy is defined as the secondhand understanding of another person's emotional experience, which involves the capability to take on the perspective of another person (Tangney, 1995). Empathy is first observed in children around the age of two, as they display an emotional reaction when they observe another person's distress (Kagan & Lamb, 1987; Zahn-Waxler & Robinson, 1995). Empathy also requires the ability to accurately understand another person's emotional experience to fully understand their perspective. Finally, empathy requires a person to have full emotional range and experience themselves, so that they are better able to relate and understand the emotions of other people. Empathic responses can be divided into two categories, "other-oriented" empathy and "self-oriented" empathy (Batson, 1990). "Other-oriented" empathy is the more traditional type of empathy, including perspective-taking and the attempt to affectively match with another person. In contrast, "self-oriented" empathy is the emphasis on the experience of the empathizer, rather than the person receiving the empathy. This is characterized by the empathizer stressing the degree of distress they are experiencing because of hearing the story from the other person.

Shame and guilt have differential impacts on the ability to empathically respond to another person. The experience of shame often results in an avoidance response, thus inhibiting interpersonal contact and the capability to engage in, or experience, other-oriented empathy (Tangney, 1995; Leith & Baumeister, 1998; Brown, 2007). Furthermore, shame involves a global negative assessment of the self, thus further inhibiting a shamed individual's ability to look outside of themselves and understand

another person's emotional experience. While Brown (2007) asserts that empathy is the antidote to shame, shame often results in the inability to connect and empathically understand another person's experience. In contrast, guilt motivates interpersonal contact, and promotes reparative actions, thus increasing the likelihood of other-oriented empathic responses when faced with a distressed individual (Tangney, 1995).

The experience of shame, and the predisposition to shame, have also been linked with anger responses and "humiliated fury." The hostility that is experienced in reaction to a shaming experience can be self-directed, as the anger further empowers the holistic, negative view of the self (Tangney, 1992). The shame response of anger can also be directed outwardly, as the shamed individual may defensively direct their hostility towards others through shaming or rejection. In this instance, hostility is projected onto the other individual in an attempt to protect the shamed person from further judgment and exposure. While this is done to protect the self and to redirect the painful feeling of shame into a more active hostile behavior, it often results in increased feelings of shame and guilt, as the person recognizes their hostile reaction is undeserved (Tangney, 1992). In a study of shame and guilt-proneness among college students, Tangney (1992) examined hostile and behavior actions and found significant associations between shame-proneness and hostility, anger, suspiciousness, irritability and blaming others for wrongdoing. In contrast, shame-free guilt was found to be inversely correlated with blaming others, anger, and hostility (Tangney, 1992).

Guilt has generally been described as an adaptive emotion, as it promotes reparative behaviors and is associated with a negative evaluation of a behavior without affecting one's view of their identity (Barrett, 1995; Teroni & Deonna, 2008; Tangney &

Dearing, 2002). In contrast, shame is largely considered to be maladaptive, as it involves a holistic, negative self-evaluation and is linked with poor psychological outcomes. Tangney and Dearing (2002) discuss the potential maladaptive nature of guilt when it is experienced with shame, thus resulting in a negative evaluation of a behavior, which is then generalized to the entire self. While guilt and shame are often discussed separately, the authors argue that many people are both guilt and shame-prone to negative interactions, and that this can result in a fusion of shame and guilt responses. They characterized the fusion between shame and guilt as negative or ruminative guilt, which resulted from people mistakenly taking responsibility for an action outside of their control, or when their guilt was unresolved (Tangney & Dearing, 2002).

Distinguishing Between Shame and Other Self-Conscious Emotions

Shame has also been compared to other self-conscious emotions, including humiliation and embarrassment. Humiliation is often described as the undeserved feeling of self-consciousness resulting from a negative interaction, in which the person feels attacked by another person (Brown, 2007). Humiliation differs from shame as it often motivates people to reach out and discuss their emotional experiences, whereas shame often results in the avoidance of social interactions. Embarrassment is considered to be a universal self-conscious emotion that often arises in social situations (Miller, 1995). After interviews with hundreds of women, Brown (2007) defined embarrassment as the least powerful self-conscious emotion because it is occurs normally in people's everyday lives and is a fleeting experience(i.e., tripping). She stated that embarrassment can be distinguished from guilt and shame, as the embarrassing event can often be recounted humorously with other people (Brown, 2007).

Miller (1995) described two theories of embarrassment, with the first stating that embarrassment arises when one's public image has been threatened, and the person becomes highly aware of the other's evaluation. The second theory states that embarrassment arises during awkward interactions, rather than from a fear of negative self-evaluation (Parrott, Sabini, & Silver, 1988; Miller, 1995). While both theories of embarrassment have empirical support, fear of social evaluation has been shown to be a strong trigger for reactions of embarrassment (Miller, 1995). Physically, people experiencing embarrassment may avert their gaze, display a small nervous smile, and blush. While shame also involves the physiological response of averting gaze, shame is better characterized by the physical desire to become small and the desire to withdraw from social situations (Brown, 2007; Tangney, 1995).

Ladany, Klinger and Kulp (2011) described experiences of shame, guilt, embarrassment and humiliation within the therapy relationship. The authors identified therapist shame "as an intense and enduring reaction of the therapist's physical, emotional or intellectual defects that occurs in the context of psychotherapy" (Ladany et al., 2011). Therapist shame can result in confusion, anxiety and increased difficulty in effective therapy with clients, as it can reduce one's confidence and clarity (Gilbert, 2011). Guilt was described as an emotional reaction due to a specific action which causes potential harm to the client, and results in the therapist experiencing remorse and tension (Ladany et al., 2011). Therapist embarrassment is most closely associated with shame, but tends to be brief and is considered a milder reaction than shame. Finally, the authors describe therapist humiliation as arising from the action of others, in which the person interprets another person's action as wrong, rather than making a global judgement of the

self. With humiliation, there is little disruption in the therapist's sense of identity, as opposed to experiences of shame (Ladany et al., 2011).

Theoretical Perspectives on Shame and Guilt Development

There are several theories regarding the development of shame and guilt. Five models of shame and guilt development are reviewed below.

Psychoanalytic Theories

Several theories exist regarding the development and mechanisms of shame and guilt. In Freud's psychoanalytic theory, he conceptualized guilt within his tripartite model, as it was a reaction to intrapsychic conflict between the id and superego (Freud, 1930/1961 as cited in Barrett, 1995). Specifically, Freud believed that guilt occurred when the ego was made aware of the conflict between the id's impulses and the superego's suppression of those impulses. Freud theorized that guilt is felt when the ego has a sense of punishment from the superego's dominance of the id's impulses. Freud (1930/1961) described guilt as a reaction to intrapsychic conflict of aggressive id impulses, which he differentiated from remorse as remorse was a reaction to acting out real aggression (as cited by Barrett, 1995). Because of the superego's involvement in the experience of guilt, Freud stated that guilt could not occur until the development of the superego around the age of five. Prior to the development of the superego, Freud equated guilt-like reactions to those of social anxiety (feared loss of relationships) and a fear of punishment from authority. In contrast, Freud believed that shame and disgust developed during the latency period of children six to eleven years old, and was a suppressing reaction to their sexual impulses (Freud, 1905/1965 as cited in Barrett, 1995). He

believed that guilt, shame, and disgust developed after the resolution of the Oedipus complex, but associated guilt with the resolution.

Other psychoanalytic theorists differed from Freud in his conceptualization of shame, as they conceptualized shame as a reaction to social anxiety and a feared loss of love in relationships (Barrett, 1995). Furthermore, some believed that shame preceded guilt developmentally and was the less mature affect. Adler (1933) conceptualized shame as resulting from inferiority and believed that shame played a fundamental role in personality development (Adler, 1933; Kauffman, 2004). Horney (1950) conceptualized shame as relating to pride, as anything that threatens to violate pride results in the feelings of shame and humiliation. Horney (1950) further characterized pride as the "enemy of love" and believed pride was intertwined with feelings of self-hate and self-contempt (as cited in Kauffman, 2004).

Erikson (1950) theorized that there were eight stages of psychosocial and identity development starting in infancy and continuing throughout the lifespan. Erikson believed that shame is first experienced in childhood during stage two, and is associated with toilet training. During this stage, if the child achieves toilet training, the child achieves autonomy. Erikson (1950) hypothesized that if the child is unable to achieve autonomy through successful toilet training, the child will instead develop shame and doubt. Kauffman (2004) argues that shame is a common consequence to development across Erikson's stages, as it is the "affect most critical to the development of mistrust, guilt, inferiority, [and] isolation" (p. 10). Lynd (1958) expanded the role of shame in identity, and stated that the shame experience includes feelings of exposure and mistrust, and involves the whole self.

Piers and Singer's (1971) theory of shame and guilt differed from Freud, as they conceptualized shame and guilt as resulting from different types of superego functions (as cited in Barrett, 1995). They described guilt as a reaction to a transgression, in which the person acted in violation of the superego's rules (Piers & Singer, 1971 as cited in Barrett, 1995). This transgression results in the implicit fear of punishment, and more specifically, in the fear of castration (Kauffman, 2004). In contrast, shame was conceptualized as the failure to live up to the ego's ideal, and thus involved shortcomings that result in external sanctions or disappointment from authority figures. This shortcoming reflects a feeling of failure, and is accompanied by the implicit fear of abandonment (Kauffman, 2004). Piers and Singer's theory of guilt and shame differed from Freud, as they claimed that the superego's formation is not dependent on the resolution of the Oedipus complex, and thus guilt and shame can be experienced earlier in childhood (Piers & Singer, 1971 as cited in Barrett, 1995). They also argued that shame can arise from many situations in which the ego-ideal is threatened and that this can be independent of sexual urges and their subsequent suppression. While many differences exist between Piers and Singer's theory of shame and guilt development to that of Freud's theory, they agree that shame and guilt occur following intrapsychic conflict between the id, ego and superego, rather than as a consequence of actual behavior.

Tomkins (1987) outlined a theory of affect and motivation, in which he described nine innate affects, each associated with a related facial expression. Three affects described positive motivations, including interest-excitement, enjoyment-joy, and surprise-startle (Tomkins, 1987 as cited in Kauffman, 2004). Six affects were described

as having negative motivations and these included distress-anguish, fear-terror, anger-rage, shame-humiliation, dissmell, and disgust. Tomkins (1962) described the facial expressions associated with shame as putting one's head down and averting one's gaze. Fisher and Tangney (1995) further expanded on the physical signs of shame to include covering one's face, blushing, averting one's gaze, and being quiet. In contrast to Freud, Tomkins believed that the affect was the primary motivating mechanism of action and that this was more powerful and vital than acting on drives or acting to avoid physical pain (Tomkins, 1987 as cited in Kauffman, 2004). Tomkins stated that humans act to increase their positive affect, decrease their negative affect, reduce affect inhibition, and increase power to achieve the previous three reactions.

Schore's (1991) theory of shame development is an integration and expansion of Tomkins' (1987) affect theory on shame and guilt, as well as Mahler's (1968) theory on individuation and separation (as cited in Barrett, 1995). Schore theorized that shame develops before guilt, with shame being seen in preverbal children and guilt in verbal children. Shore's theory supports Tomkins' idea that shame inhibits excessive joy or interest in children and thus serves as an inhibitory mechanism for young children (Barrett, 1995; Tomkins, 1987; Schore, 1991). In his theory, shame serves to aid in the development of the child as it progresses through Mahler's phases of individuation, and that it results in the injury and subsequent depletion of narcissism in young children. Nathanson (1987) hypothesized that both guilt and shame are negative emotions that include intrapsychic conflict (as cited in Barrett, 1995). Guilt results from punishment of misconduct, while shame results in a negative evaluation of some quality within the self. Nathanson (1987) theorized that children as young as three months can experience

shame. He described a child with an intense emotional connection with its caregivers and asserted that the child may experience shame to inhibit excitation following a failed social interaction. Nathanson argued that shame assists the development of a child's sense of self, as it helps to differentiate the child from the caregiver (Nathanson, 1987 as cited in Barrett, 1995).

Cognitive Theories

Shame development has also been discussed and explained within cognitive theories, which argue that shame and guilt are characterized by certain cognitions, and that these patterns of thinking result in a person feeling either ashamed or guilty (Barrett, 1995). Buss (1980) argued that shame cannot be experienced until the age of five, as that is when children are cognitively able to understand rules of behavior and anticipate consequences and negative evaluation for breaking those behaviors (as cited in Barrett, 1995). Kagan (1984) argued that cognitive awareness of an emotional state can result in the experience of a different emotional state. While not required to experience an emotional state, he argued that it is of significant importance (Barrett, 1995). For example, Kagan theorized that a four-year-old does not have the cognitive awareness to recognize his/her misconduct, and thus is unable to experience guilt (Kagan, 1984 as cited in Barrett, 1995). Lewis (1991) conceptualized "self-conscious" emotions, consisting of shame, guilt, pride, empathy and "hubris" (as cited in Barrett, 1995). He described four cognitive acquisitions, including development of the self-consciousness, development of values, rules, and ambitions, evaluation of one's behavior in relation to the rules, and a self-focus, which can be of the whole self, or of a single aspect or behavior. According to Lewis, these cognitive abilities result in the development of the

self-conscious emotions or a metacognitive knowledge of oneself. He differentiated shame and guilt by their self-appraisal, as guilt involves a specific feature of behavior, and shame involves a whole self-evaluation (Lewis, 1991 as cited in Barrett, 1995).

Barrett's Functionalist Theory of Shame Development

Barrett (1995) outlines her functionalist theory of shame and guilt development which is based on appreciations and related emotional reactions. Barrett and Compos (1987) defined "appreciations," or appraisals, as the thoughts about the subjective meaning of the environment to the self, and thus serve to motivate or inhibit behavior. These appreciations are involved in any emotional process, but are not required to experience a specific emotion. Thus, Barrett and Compos differ from Buss (1980) and Kagan (1984), as they theorize that a child may experience an emotion within an emotion family before they are able to cognitively process a more developmentally sophisticated final emotion (i.e., a child will display behaviors within the self-conscious family of embarrassment, shame or guilt). Barrett (1995) described shame and guilt among seven principles, which are associated with the self-conscious emotion family. First, she described shame and guilt as social emotions, as they occur in the real or imagined presence of other people, and serve to facilitate human relationships. Shame and guilt are also expressed socially, as they result in observable changes of voice, posture, demeanor and action. Second, Barrett outlined the effect of shame and guilt on behavior regulation, as well as interpersonal and intrapersonal functioning. She described guilt as a motivator for reparative action following misbehavior. In contrast, shame aids in increasing interpersonal distance, to protect the individual from judgment. Specifically, a person experiencing shame physically hides by lowering their head, slumping their body, and

avoiding eye contact to reduce their interpersonal exposure (Barret, 1995; Kauffman, 2004).

A third characteristic that differentiates shame and guilt is their differing appreciations (Barrett, 1995). Shame is associated with a whole-self appreciation that one is a bad person, and that other people also know that one is a bad person. In contrast, guilt's appreciation is more specific and is related to engaging in a wrongful act in which a standard or rule was violated. The fourth characteristic related to the differentiation between shame and guilt is that they each result in specific action tendencies based on the function and appreciation of the self-conscious emotion. These action tendencies describe relevant patterns of behavior during shame and/or guilt-inducing situations. Those that are guilt-prone tend to engage in "amending" behaviors, while those that are shame-prone tend to engage in "avoidant" behaviors (Barrett, 1995).

The fifth principle for shame and guilt development states that they contribute to the development of the self, as they serve an inhibitory interpersonal function. Shame results in self-evaluation, as the person tries to understand how others see them as a person, and thus updates their own self-concept. Barrett (1995) states that infrequent shame experiences can result in the child learning to avoid the pain of shame through decreasing future misconduct, and can result in a deeper exploration of one's values compared to the values of the larger society. In contrast, more frequent shame reactions can result in the internalized acceptance that one is bad. The experience of guilt contributes to a child's development of agency, as it teaches consequences of action, as well as spurs reparative action. Frequent guilt reactions result in increased understanding of one's control of one's behavior, thus learning how one's behavior can affect other

people (i.e., cause pleasure, discomfort, anger). Barrett (1995) stresses the importance of socialization on shame and guilt development, and theorizes that cognitive development plays a more minor role.

In the sixth principle, Barrett (1995) stated that while cognitive development is important in shame and guilt expression, general cognitive abilities (i.e., object permanence) are not necessary to experience shame and guilt. Barrett argues that sophisticated cognitive development is not a prerequisite for shame and guilt, as young children can develop a self-concept (i.e., good, bad), and learn consequences of their behavior. Furthermore, children as young as three months learn interpersonal patterns, and have expectations for their parents' reaction to their behavior (Barrett, 1995; DeCasper & Fifer, 1980). Lewis, Alessandri and Sullivan (1990) described mastery pleasure as the feeling of joy associated with completing a task. Mastery pleasure has been observed in children as young as two months old, suggesting that infants are able to recognize their own mastery. Infants also experience distress when they are unable to perform a task, thus suggesting that they are also aware of their own lack of mastery (Lewis et al., 1990). Barrett (1995) argues that while children may not have the cognitive development to understand shame and guilt, they do have the cognitive ability to experience mastery, and thus children are able to experience these emotions in interpersonal situations. Finally, Barrett's seventh principle of shame and guilt development states that socialization is a crucial factor. Socialization results in the learned significance of standards, morals and values, as well as teaches children the importance of obeying these standards. Barrett argues that early childhood interactions are of vital significance in a child's learning of adherence to societal standards, and that

as children learn the consequences of misconduct, they engage in appreciations regarding their badness as a person (shame) or the badness of the action (guilt) (Barrett, 1995).

Brené Brown's Theory of Shame Development

Brown (2004, 2006, 2007, 2008) conceptualizes shame as a "silent epidemic" that develops based on expected societal demands and values. Following numerous interviews with men and women, Brown described shame as the "intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging" (Brown, 2008). Shame can be self-inflicted, or can result in the perception that one is exposed to others as defective. Consequences of shame include self-hatred, a fear of rejection, and isolation from others due to a fear of judgment. The interpersonal distance that results from shame increases self-blame and self-judgment, which further drives the shame epidemic. Shame's power comes from its ability to stay hidden and prevent people from "speaking shame," as Brown argues that the antidote to shame is empathy (Brown, 2008, 2012). Brown (2004, 2008) argues that shame is organized by gender and gender-based expectations. For men, Brown described shame as a box, in which societal expectations of masculinity and emotionlessness governs their behavior. For women, Brown described a web of tangled expectations about race, age, religion, and sexual orientation. The web is based on societal expectations of how women should be, what women should be, and who women should be, which can spur intense feelings of disconnection, insecurity and inferiority (Brown, 2008).

Shame: Trait v. State

The experience of guilt and shame can be reactionary and thus triggered by guilt/shame-inducing events. State-like emotions are considered to be adaptive, as they

provide a person with feedback from the environment and therefore increases one's understanding of a situation in order to change their behavior accordingly (Ferguson & Stegge, 1995). The authors describe the positive function of state-like shame, as it helps to reduce arrogance, as well as increase humility and compliance with societal and moral standards. Additionally, the feeling of shame can help a person to realize the difference between their behavior and their ideal-self, thus motivating increased embodiment of the characteristics of their ideal self. State-like guilt works as a moral compass, as the feeling of guilt prompts acceptance of responsibility for misconduct, other-oriented empathy, and reparative action (Ferguson & Stegge, 1995).

Emotions can also be described as trait-like in which people develop specific emotional patterns that affect self-evaluation, self-regulation, and how one perceives their environment. These emotional patterns can accumulate which results in a developed predisposition towards an affectual style, thus affecting one's interpersonal and environmental perceptions, and behaviors (Covert, Tangney, Maddux, & Heleno, 2003; Ferguson & Stegge, 1995). Ferguson and Stegge (1995) define guilt-proneness as the tendency to wrongly attribute personal responsibility to negative situations, and is characterized by repeated and failed reparative attempts, which results in further distress and guilt. True guilt-proneness, in which a person is dispositionally free of shame, has been found to be inversely associated with pathology and interpersonal maladjustment (Covert et al., 2003; Tangney, Burggraff & Wagner, 1995). Tangney (1995) hypothesized that the adaptiveness of the guilt-proneness affective style and the resulting lack of pathology and interpersonal conflict is due to the person's focus on the negative behavior, rather than negatively evaluating the self.

Shame-proneness is defined as the tendency to experience feelings of incompetence, worthlessness, and helplessness across time and situations (Ferguson & Stegge, 1995). Shame-proneness has been linked to several psychological disorders, including mood (depression, bipolar) and addiction disorders (Tangney et al., 1995). Shame-proneness is also associated with increased hostility and anger, as well as a reduced capacity for other-oriented empathy (Covert et al., 2003). Tangney, Wagner and Gramzow (1992) found shame-proneness was positively correlated with frequent, global self-attributions for negative events and negatively correlated with global self-attributions for positive events. The authors concluded that shame-prone people more frequently attribute self-blame and then make a negative whole-self evaluation in response to ambiguous or negative situations (Tangney et al., 1992). Tangney et al. (1995) asserted that shame-proneness is associated with low-self-esteem, as well as increased social anxiety and self-consciousness due to the pattern of negative global self-evaluations, as well as the fear of judgment associated with shaming experiences.

Covert et al. (2003) examined interpersonal problem-solving abilities among shame and guilt-prone people. Based on Bandura's (1986) Social Cognitive Theory, the authors hypothesized that shame-prone individuals generate fewer and less effective solutions to interpersonal conflict, and have decreased feelings of self-efficacy (belief in their capability to solve a problem) because of the intense negative self-focus associated with shame. Covert et al. (2003) also hypothesized that shame-prone individuals have less confidence that they can successfully implement any problem-solving strategy, including self-generated strategies and strategies offered by other people. In contrast, the authors hypothesized that guilt-prone individuals would generate more interpersonal

solutions, would have greater self-efficacy, and would have greater confidence that they can implement the strategy to produce the desired goal. Covert et al. (2003) found that while there were no differences in the number of solutions generated by shame and guilt-prone people, the expected differences regarding quality of solutions, belief in self-efficacy, and confidence in successful implementation were found between the two populations. The authors concluded that the impaired self-efficacy, quality of solutions, and low confidence in one's ability to effectively manage interpersonal conflict helps to explain the impaired interpersonal functioning found among shame-prone individuals (Covert et al., 2003).

A Developmental Model of Shame-Proneness

Ferguson and Stegge (1995) describe a developmental theory of shame and guilt-proneness, emphasizing the role of caregivers and socialization in the development of self-conscious and self-evaluative emotions. The authors argue that the self-evaluative nature of shame and guilt is modeled and experienced through the socialization process, beginning with caregivers. They identify four ways in which socialization influences a child's development of self-conscious emotions. First, parents provide direct modeling of affective styles, which can be traced across generations of parent-child interactions. Second, the authors highlight the importance of parental feedback during emotion-provoking experiences. The parents direct and indirect emotional feedback to the child, as well as their communication of expectations for the child's behavior and reactions can greatly influence the development of shame and/or guilt-proneness. Third, parents shape their child's affective style through the communication of how they currently perceive the child to be acting, as compared to their expectations of how the child should ideally

behave. Finally, the authors state that the parent's own emotional, attributional, and behavioral feedback to the child following misconduct communicate a violation of standards and expectations (Ferguson & Stegge, 1995).

In general, Ferguson and Stegge (1995) state that caregivers who frequently identify a child's behavior that does not meet expectations or values, will result in the development of negative emotions, a poor self-image, and greater shame-proneness. Love withdrawal and power assertion as disciplinary actions often result in increased emotional arousal in the child, and inhibit a child's ability to understand consequences of their action. This can result in fear-based guilt, and shame-proneness, as the child repeatedly perceives themselves as not meeting the parental ideals and expectations. Maladaptive fear-based guilt is often seen in children whose parents demand complete obedience, and engage in disciplinary actions without explanations of a child's wrong-doing. In contrast, induction, or the parents' explanation of the misdeed, as well as the explanation of the consequences of the child's actions for other people, has been shown to promote the development of other-oriented empathy and guilt-proneness, as it focuses the child's evaluation on the behavior and its consequences, rather than on the self. Ferguson and Stegge (1995) found that shame-proneness was predicted by the lack of positive parental discipline (induction), and by the absence of positive parental perceptions of the child.

Shame: Identification and Measurement

Shame has historically been described as difficult to identify due to the high degree of avoidance associated with shame. Below is a review of the literature regarding the identification and measurement of shame.

Recognizing Shame

In the literature, shame has frequently been described as difficult to identify due to an active avoidance of potential judgment from others and from the self that is associated with shame. Brown (2007) asserts that the difficulty with identifying shame is due to the painful and overwhelming emotions associated with shame, including confusion, anger, judgment, fear, and the desire to isolate oneself. Shame can also be defensively hidden through the expression of other emotions, including anger, contempt, and envy (Herman, 2011; Morrison, 2011). Tangney (1995) describes the preverbal nature of shame, and that this can also hinder people's ability to identify and express their experience as shame. Furthermore, the verbal expression of shame can result in further shaming experiences, as one is at risk of evaluation, blame and judgment by others (Brown, 2007; Tangney, 1995).

Avoiding Shame

In therapy, shame is frequently avoided despite the association between shame-proneness and psychological pathology. The discussion and labeling of experiences as shaming is often avoided by both the client and the therapist because of the avoidant nature of shame (Tangney & Dearing, 2002). While shaming experiences are often important clinical issues that should be discussed in therapy, fear of judgment and the intensely painful feeling of shame often result in clients avoiding those topics. Because clients will often avoid discussing shame directly, the therapist must be alert for any verbal and non-verbal indicators of shame (Tangney & Dearing, 2002).

Nonverbal Communication of Shame

When clients express global and negative self-evaluations, it is important for the therapist to voice and explain the shaming experience to clients, in order to help them to better understand their experience (Brown, 2007; Tangney, 1995; Tangney & Dearing, 2002). Clients will often provide non-verbal shame clues, including nervous laughter, lack of eye contact, self-deprecating comments, and slumping in their chair (Morrison, 2011; Tangney & Dearing, 2011). Therefore, therapists must be aware of possible signs of shame, as well as recognize themes of shame that are expressed by the client, and openly discuss shame with their clients. However, a barrier to "speaking shame" in therapy is the therapist's unintended avoidance of shame-related discussions with clients because of their own experience with shame and countertransference (Tangney & Dearing, 2002).

Measuring Affective States

In addition to the difficulty associated with everyday identification of shame and shaming experiences, shame and guilt assessment has been found to be similarly difficult due to the affective overlap between shame and guilt (Tangney & Dearing, 2002). Shame and guilt assessment is further complicated by the inability to directly measure the two affective states, and the layperson's limited ability to identify and distinguish between shame and guilt experiences. While shame and guilt are both considered self-conscious affects, they impact behavior, motivation, and interpersonal functioning in very different magnitudes, and often in different directions. Thus, if a person is reporting both shame and guilt reactions, or if a measure is confounding shame and guilt variables, it can frequently result in a non-significant result (Tangney & Dearing, 2002).

Adaptiveness of Shame and Shame-Resilience

While guilt is considered adaptive, as it promotes interpersonal connectedness and maintenance of relationships, there has been considerable debate regarding the potential adaptiveness of shame. A prominent assumption regarding the adaptiveness of shame is that it assists in the learning from wrong-doing, as the painful emotional experiences helps people to identify and correct misconduct (Ferguson & Stegge, 1995; Barrett, 1995). Thus, they assert that shame serves an inhibitory function, as it results in the reduced excitement and activity in a person, and a shift in the person's focus towards the self. Gilbert (2004) discusses the evolutionary purpose of shame, as it is often triggered by rejection or the perceived reduction of rank within a group. Gilbert hypothesizes that the painful experience of shame can be adaptive, as potential rejection inhibits the current behavior, and spurs an attempt to mediate the experience. While shame reactions may help a person to inhibit their current behavior, guilt is found to be more strongly associated with interpersonal connectedness and adherence to moral standards (Tangney & Dearing, 2002). Furthermore, shame-proneness is considered a maladaptive reaction, as it results in frequent, whole-self negative evaluations, which can result in increased anger, isolation, and psychopathology.

Shame: Building Resilience

Based on her numerous interviews of men and women about their shaming experiences, Brown defines shame resilience as a person's ability to identify and understand shame, move through the experience without losing authenticity, and then one's ability to use their experiences of shame to increase feelings of compassion, connection, and courage (Brown, 2007; Brown, Hernandez & Villarreal, 2011). People

with high shame resilience have been found to share high levels of understanding of their shame experiences, and of their triggers of shame. Furthermore, high shame resilience is associated with practicing critical awareness, reaching out for social connections, and speaking shame (Brown, 2007). While state shame is a universal experience, shame resilience can help to protect people from the more debilitating, chronic shame-proneness that has been found to be associated with low self-esteem, increased anger and hostility, and psychological pathology.

CHAPTER III

SHAME IN SUPERVISION

Supervision

Bernard and Goodyear (1992) defined supervision as the system of oversight provided by a more senior member (supervisor) of the profession to a less senior member (trainee). The supervisor has three main responsibilities, as one serves as the gatekeeper for the profession, oversees the work done by the trainee, and fosters the trainee's development of professional skills and theoretical understanding. The supervisory working alliance is believed to be the foundation of effective supervision, and is based on three core components (Bernard & Goodyear, 2009; Bordin, 1983; Ladany, Klinger, & Kulp, 2011). The first component of the supervisory working alliance includes the shared agreement on the goals of supervision between the supervisor and supervisee, such as increased therapist insight or increased conceptualization skills. Second, a strong supervisory alliance includes the shared agreement on the tasks of supervision between the supervisee and supervisor, including the process of supervision and method of feedback. The third aspect of the supervisory working alliance is an emotional bond of respect, trust, and caring between the supervisor and supervisee, that develops from the shared tasks and goals of supervision (Bernard & Goodyear, 2009; Bordin, 1983; Ladany, Klinger & Kulp, 2011). Ellis and colleagues (1994) argued that shared expectations and goals are more important to the outcome of the supervisory alliance than the expectations of either the supervisor or supervisee. The supervisory alliance research suggests that discussion and agreement on goals and tasks are an important aspect of supervision, and provide a potential framework for identifying and working through shame.

Previous research has examined the role of supervisor and supervisee qualities on the quality of the working alliance. Supervisor qualities that have been found to predict the quality of the supervisory alliance include the style of supervision, the use and frequency of self-disclosure, the evaluative practices used by the supervisor, the supervisor's ethical behavior, the expertise of the supervisor, and the attachment style of the supervisor (Bernard & Goodyear, 2009). Supervisors who exhibit an interpersonal and consultative style were associated with high ratings of the alliance across agreement on goals and tasks, as well as having a strong emotional bond with supervisees (Bernard & Goodyear, 2009; Ladany et al., 2001). In contrast, supervisors that take on more of a teaching role were found to be associated with greater agreement on tasks, with weaker associations regarding an emotional bond. While skill-building is an important aspect of supervision, supervisors who are more attuned to the process of supervision, the relationship, and helping the supervisee as problems come up appear to be more strongly predictive of a strong supervisory alliance. This alliance is also likely to be conducive to discussing shame and building shame resilience, as it allows the space for a supervisee to explore shaming experiences, their impact on the therapeutic and supervisory work, as well as identify patterns and triggers for their shaming experiences. Moderate rates of self-disclosure were found to predict a strong supervisory alliance, and feedback that was perceived to be fair and clear both predicted greater trust and strength of the alliance (Bernard & Goodyear, 2009). Self-disclosure by the supervisor, as well as explicit feedback may help a supervisee to feel more comfortable working through experiences of shame, and may help the supervisee to attribute mistakes to the behavior as opposed to their worth as a person.

Trainee factors that were found to predict the quality of the alliance included the trainee's attachment style and any prior history of negative supervision (Bernard & Goodyear, 2009). For both the supervisor and trainee, secure attachment was found to predict stronger supervisory alliances. A previously negative supervisory experience was associated with less satisfaction in the process of supervision, as well as the trainee's belief that one is falling behind in therapeutic skill, knowledge, and theory as compared to their peers (Bernard & Goodyear, 2009). A prior negative experience may create an atmosphere of potentially shaming-experiences, as the trainee may already be experiencing some shame-related feelings associated with therapy and supervision. Furthermore, if the trainee feels as though they are behind developmentally, they may be more likely to interpret future problems as indicative of a global-self failure, rather than attributing a problem to a specific behavioral problem. If a trainee is at an increased risk to feel shame, and reports a weakened supervisory alliance, this may reduce the trainees' ability to develop shame resilience and to speak their shame.

Supervision: Increased Emphasis in Training Programs

While training in supervision is not yet mandatory in clinical psychology training programs, many accreditation and governing boards encourage the training of future clinicians as both practitioners and supervisors (Bernard & Goodyear, 2009). Current options for the training of supervision include a formal course of supervision during a training program, or training through internship programs and other specific supervisor training programs. While there are different avenues for the training of supervision, Bernard and Goodyear (2009) identify two key components for effective supervision training. First, it was recommended that the training involve didactic and practical

experiences in supervision, so that trainees can learn about supervision theory and practice. Furthermore, these learning experiences should include consistent feedback from a more experienced supervisor in order to facilitate growth as a supervisor. The authors recommended that supervisors have at least one year of practicum completed prior to supervising another student, and should have supervision of supervision in order to protect client welfare and to receive adequate feedback on their supervision (Bernard & Goodyear, 2009).

Models of Supervision

Several models of supervision are described below. While there are different emphases and approaches in the provision of supervision, there are also several goals that are common across models of supervision.

Across Different Models: Common Goals of Supervision

The purpose of supervision is to provide a supportive and educational context for the fostering of a trainee's professional development, while also maintaining a focus on client welfare (Bernard & Goodyear, 2009). While there are different theories regarding the process of supervision, all theories of supervision share several common goals. McNeill, Stoltenberg and Romans (1992) identified eight common domains of trainee professional development in supervision including increased competence in intervention skills, assessment techniques, and improved client conceptualization. Furthermore, they included growth in self and interpersonal assessment, as trainees better understand their role in understanding, conceptualizing, and treating clients. Other areas of professional development include an increased understanding of individual differences in presentation of psychological symptoms and treatment, as well as the development of professional

ethics. Finally, they identify progression in treatment planning, and the development of one's theoretical orientation as other key components of trainee growth in supervision (McNeill et al., 1992).

Psychodynamic Model of Supervision

The psychodynamic model of supervision emphasizes the relationships and interpersonal processes between the supervisor, clients, and trainee as the primary teaching opportunity for the trainee (Bernard & Goodyear, 2009). Thus, psychodynamic supervision is trainee-focused, with greater time spent exploring trainee processes and dynamics, rather than focusing on case management or client concerns. Frawley-O'Dea and Sarnat (2001) outline a psychodynamic model of supervision consisting of three dimensions. First, the supervisor's authority within the supervisory relationship is based on the supervisors' expertise in theory and technique, as well as from the supervisor's active role in the interpersonal process of supervision. Second, the supervisor's focus is on the trainee, the client's welfare, and on the supervisory alliance. The third dimension of psychodynamic supervision is the supervisors many roles within the supervision hour, including roles of teacher, explorer, and consultant (Bernard & Goodyear, 2009; Frawley-O'Dea & Sarnat, 2001). Hemlick (1997) found that psychodynamic supervision was positively related with increased shame-proneness, as compared to other supervision orientations.

Humanistic Model of Supervision

Rogers (1942) described the person-centered model of supervision as being similar to person-centered therapy, with the emphasis on increasing the trainee's self-confidence and self-awareness about their role in the therapeutic process (as cited in

Bernard & Goodyear, 2009). Rogers emphasized the importance of supervisors' genuineness, empathy and warmth as facilitative conditions to assist in trainee development. Furthermore, a supervisor must have great trust in the trainee's growth potential, as well as an understanding of process within the context of the supervisory relationship. While the person-centered model of supervision is rarely used, aspects of person-centered theory are often emphasized in training programs and used across models of supervision. Rogers' emphasis on the facilitative conditions serve as the foundation for basic interviewing techniques taught to trainees, and serve the basis of the emotional bond emphasized in the supervisory working alliance (Bernard & Goodyear, 2009).

Cognitive-Behavioral Model of Supervision

The cognitive-behavioral model of supervision primarily strives to assist trainees in the adoption and implementation of cognitive-behavioral techniques and conceptualizations when working with clients (Bernard & Goodyear, 2009; Rosenbaum & Ronen, 1998). Supervision is viewed as a collaborative experience, as the trainee and supervisor work together to help the trainee achieve one's goals. Cognitive-behavioral supervision emphasizes the development of skills as the primary objective, as this model asserts that skills knowledge is more important in the proficiency of a therapist than personality fit or relational abilities. The development of skills in supervision is based on mutually agreed upon tasks and goals of supervision, in which the supervisor plays an active role in the teaching of the cognitive-behavioral skills. Thus, the goal of the cognitive-behavioral model of supervision differs from that of a psychodynamic or person-centered model, as it stresses the development of knowledge and skills, as

opposed to the relational and self-awareness stressed in the more interpersonally-based theories. In cognitive-behavioral supervision, the trainee is the primary focus of supervision with the goals of supervision related to the development in technique and understanding of cognitive-behavioral theory. The supervisors define the trainee's potential in terms of ability to learn, rather than in personality characteristics or relational abilities (Bernard & Goodyear, 2009; Rosenbaum & Ronen, 1998). In a study of shame-proneness and supervision theoretical orientation, Hemlick (1997) found the cognitive-behavioral group to be significantly less shame-prone than the psychodynamic supervision group.

Critical Events Model of Supervision: Identification of Shame in Supervision

Ladany, Klinger & Kulp (2011) outline a critical events model of supervision that provides a framework for identifying and working through incidences of therapist shame. The authors assert that this model provides a useful framework for the identification and exploration of shame, based on five assumptions that underlie the model. First, this model is pantheoretical, and thus is appropriate for the supervision of various theoretical approaches to psychotherapy. This model also acknowledges the emphasis of the interpersonal relationship in supervision, and thus strives to include contributions of both the supervisor and trainee in understanding the relationship. The third assumption of the critical events model is that the emphasis of supervision is on trainee growth, rather than case management. Fourth, the critical events model states that supervision can be categorized into a series of events, which can span a single supervision session, or across several supervisory sessions. Finally, this model asserts that the events, as well as the

series of events, are related with certain supervisory outcomes (Ladany, Klinger & Kulp, 2011).

Within the critical events model, events may include increasing multicultural awareness, managing boundaries, facilitating trainee insight, and exploring trainee shame experiences (Ladany, Klinger, & Kulp, 2011). The authors assert that all events include four core components, including the supervisory working alliance, the marker, the task environment, and the conclusion. For a trainee to feel comfortable or safe while discussing experiences of shame, a strong working alliance must exist between the trainee and supervisor. The exploration of shame requires a strong emotional bond between the supervisor and trainee, as well as agreed tasks and goals of supervision that allow for time to be spent discussing the shaming experience. The marker identifies the beginning of a critical event (i.e., shaming experience), and can consist of statements made by the trainee, or observations of physical changes that alert the supervisor or trainee that the trainee is experiencing shame (Ladany, Klinger & Kulp, 2011).

The task environment consists of the setting in which the critical event is explored, and the time in which the supervisor engages with the trainee (Ladany, Klinger & Kulp, 2011). During this time, a variety of interactions may occur including a focus on the working alliance (empathy, reflection), exploring parallel process (when experiences in therapy or supervision are recreated in the other), or a focus on the exploration of trainee feelings and countertransference. When shame is identified, and explored in the context of supervision, the task environment will also include an exploration of the trainee's feelings, normalization of the shaming event and reaction from the supervisor, and an emphasis on building the trainee's self-efficacy. The conclusion of an event can

range from no resolution to complete resolution, and is often examined within four dimensions (self-awareness, skills, knowledge, and the supervisory working alliance). During a shaming event, the trainee's self-awareness is most affected, as it changes their understanding of their own feelings, behaviors and cognitions within the framework of their work in psychotherapy. If one's self-awareness is increased, they would gain further insight into the shaming event, their triggers, and their own patterns of reactions. However, if a shaming experience occurs and one's self-awareness is unchanged, they will lack the insight into their own emotional reaction, and thus will not feel any relief from the painful shame feeling. When shaming events are discussed in supervision, and the trainee feels supported and helped by their supervisor, this can have a positive impact on the supervisory working alliance. However, if the trainee feels increased shame from the supervisor, this can have a strong negative impact on the alliance (Ladany, Klinger & Kulp, 2011).

Shame in Supervision

Tangney and Dearing (2011) discuss the impact of shame on the therapeutic process, as therapy provides ample opportunity for the experience of shame. Talbot (1995) and Graff (2008) describe the supervisory hour as another prime opportunity for the experience of shame, as the trainee wants to be perceived as competent to the supervisor, while also engaging in new and anxiety-provoking behaviors. While supervision can be a shame-inducing experience, it also presents the opportunity for trainees to work through their shame and guilt emotions with their supervisor. However, the discussion of shame in supervision is often absent, and thus limits trainees' abilities to understand their experience, get feedback from their supervisor, and reduce the power of

shame (Alonso & Rutan, 1988). Talbot (1995) describes the trainee admitting weaknesses or perceived failures to a supervisor can be very shame-inducing, and argued that supervisors must react in a way that helps trainees to understand and work through their shame.

While supervision is not therapy, supervisors must provide an environment in which trainees feel safe admitting their shame, as well as trusting in the supervisor to help them work through those experiences (Hahn, 2001). A potential source of shame in supervision may be the experience of parallel process, in which the therapist has a countertransference reaction to a client which is then mimicked in the supervisory hour (Alonso & Rutan, 1988; Hahn, 2001). Hahn (2001) describes the painful nature of shame in supervision, as the trainee wants to be liked and viewed as competent by their supervisor, and thus to admit faults, mistakes, and anxieties can be highly shame-inducing. The power difference between the supervisor and trainee also results in increased risk of shame, as the trainee respects the supervisor's knowledge and authority, while also wanting to be seen as worthy of their time and attention (Hahn, 2001).

Alonso & Rutan (1988) identify four contributing factors to shame in supervision, including the learning regression, the supervisor's management style, the patient population, and the transference and countertransference reactions. The learning regression is characterized as the process of retraining a trainees' thinking to help them be more successful as therapists. However, this process can result in trainees feeling exposed and distressed, as they must tolerate confusion, reduced self-efficacy, and reduced confidence in their clinical skills. The supervisor's management style can influence the trainees' shame experience, as supervisors must navigate counselor, teacher

and consultant roles. Furthermore, the supervisor must balance creating a supportive environment for the trainee to learn, while also serving as a gatekeeper and evaluator for the field. This inherent difficulty for supervisors may result in unintentional shaming of the trainee, thus supervisors must be cognizant of potential shaming reactions from trainees. Alonso and Rutan (1988) also discuss the impact of the patient population on the potential shame-proneness of the trainee. When clients drop out of therapy, or experience extreme emotional distress, trainees are not only worried about the clients' welfare, but also how their clients' wellbeing can impact the supervisor's view of their identity as a clinician. Finally, the experience of transference and countertransference can impact the atmosphere of supervision, as newer supervisors are more likely to be harsh, and thus potentially shame the trainee due to their own lack of security in identity as a supervisor (Alonso & Rutan, 1988).

Holloway (1984) described trainees' vague understanding of the expectations for their role in supervision and that this role ambiguity places them at increased risk of shame. Furthermore, this role ambiguity may contrast with supervisors' clear expectations for trainees and the supervisees' clear expectations for themselves while in supervision (Holloway, 1984). Bernard and Goodyear (2009) emphasize the importance of communicating clear expectations to trainees, as it can reduce trainee anxiety and potentially reduce one's proneness to shame in the context of supervision. Clear expectations can help trainees to react with guilt, as opposed to shame, in ambiguous or negative situations as it provides trainees with well-defined rules regarding behavior. Furthermore, it is important for supervisors to address trainee anxiety as it occurs so that the supervisor can better assist the trainee in their professional development (Bernard &

Goodyear, 2009; Holloway, 1984). Treese (1989) reported that the experience of shame is prevalent among trainees and that shame can negatively affect therapeutic work and the supervisory alliance (as cited in Hemlick, 1997).

Trainee Responses to Shame

Shame in supervision is a painful, isolating, and potentially harmful affect that can result in the trainees' feelings of inadequacy, condemnation for their faults, and exposure (Hahn, 2001). While shame can be adaptive as a reactionary emotional experience that can help to inhibit one's behaviors in interpersonal relationships, frequent shame experiences beginning in childhood can result in a shame-prone affect. With shame-proneness, a person is more likely to experience shame across situations and is at increased risk for disconnection in interpersonal relationships. When trainees experience shame in supervision, it can result in the feeling of incompetency, failure, helplessness, exposure, and powerlessness. Hahn (2001) identifies three reactions that a trainee may experience after shame is triggered in supervision. First, a trainee can self-identify their experience as shaming and subsequently work through it alone. However, due to the difficulty in identifying and understanding one's own shame experiences, this can be very difficult and likely an inadequate reaction following the experience of shame. Second, a trainee can report the feelings of inadequacy and shame to the supervisor. However, this is often avoided, as the supervisee anticipates further shame and exposure from the supervisor. Additionally, while speaking shame can help a trainee to work through their experience, it is very difficult for a trainee to admit feeling incompetent to their supervisor, as trainees want to be valued by their supervisor. Third, the trainee can attempt to separate themselves from the shaming experience through avoidance,

withdrawal, self-directed anger or outward-directed anger to protect oneself from the painful and global experience of shame (Hahn, 2001).

Hahn (2001) further describes these four coping strategies that trainees may experience, as they relate to the hope of reducing further vulnerability to shame in supervision. First, withdrawal is described as the classic and most frequent response to shame, and withdrawal is primarily characterized by passivity in supervision. A trainee withdrawing because of shame may be late and forgetful during supervision and may engage in behaviors that protect the trainee from the interpersonal nature of supervision. While the trainee may maintain one's intellectual curiosity and investment in supervision, the supervisee will withdraw emotionally from the process to reduce any further potential exposure to the supervisor. When trainees react to shame through withdrawal, they often experience their supervisor as highly punitive, intrusive, and judging, while they view themselves as incapable and inadequate (Hahn, 2001).

Second, a trainee may engage in avoidant behaviors to protect oneself from further exposure and shame in supervision (Hahn, 2001). While withdrawal is a passive reaction in supervision, avoidance is more active, and reflects the trainee's hypervigilance regarding potentially shameful experiences in supervision. In supervision, an avoidant trainee may discuss one case at length to prevent the discussion of another, or may ask the supervisor numerous questions with the goal of maintaining control of the supervisory hour. These trainees will often spend more time discussing areas in which they feel knowledgeable and competent, while also attempting to prevent the discussion of any potential areas of incompetency or perceived failure. Supervisees may also engage in perfectionistic behaviors as another method of shame avoidance, which can be more

difficult for supervisors to identify and challenge in supervision. Extreme investment in a theoretical orientation can be another form of shame avoidance, as the trainee will focus on the intellectual conceptualization of a client's presenting problem with the intention of avoiding emotional expression or processing the relationship in supervision. Hahn (2001) emphasizes that while theoretical knowledge is important in psychotherapy training and treatment, this should not come at the expense of emotional understanding and connection between therapists and their clients, as well as between trainees and their supervisors.

A third option when experiencing shame in supervision is to attack others, which is also described in the literature as "humiliated fury" (Hahn, 2001; Lewis, 1987). Hahn (2001) asserts that shame in supervision is due to the lack of mirroring in the relationship, as well as the subsequent failure to have one's needs met within the supervisory relationship. While the feelings of inadequacy, powerlessness, or inferiority can occur within the supervision hour, the experience of shame can result in the further exacerbation of these emotions. This other-oriented attack response to shame can result in the feeling of empowerment, as one makes other people feel lesser or weaker in response to their own feelings of shame, weakness, and inferiority. The goal of this reaction is to shift the negative focus from the self onto others, and thus reduce one's feeling of devaluation or inferiority. In supervision, this could be characterized by a supervisee's dismissive attitude when receiving feedback from the supervisor, or by challenging the supervisor's knowledge and recommendations. Outside of supervision, this response may be displayed through talking badly about the supervisor to others, or by minimizing their supervisor's professional knowledge and standing (Hahn, 2001).

Hahn's (2001) final reaction to shame experienced in supervision is an attack on self, in which the trainee agrees with the supervisor's feedback or preemptively identifies one's own faults in order to appease or agree with the supervisor. This reaction is more commonly seen in people who fear alienation, and in those who have repeatedly experienced failed interpersonal situations due to an affective misalignment that resulted in their lack of need fulfillment. Attack on self is likely experienced because of one's fear of losing interpersonal connectedness, and thus results in the preemptive self-attack in order to create agreement with the supervisor. In supervision, this may be expressed by the supervisee's exclusive focus on negative experiences or mistakes in psychotherapy, or by their consistent agreement with any feedback provided by the supervisor. In minor cases, the trainee may grow to feel more confident in their own abilities as time passes, and thus feel less pressure to defer, accept and mirror the supervisor's critical feedback. However, in more extreme cases, the supervisee may become increasingly more severe, as the threat of disconnection and helplessness increase. Thus, an obsessive focus on acceptance from the supervisor may be expressed through the trainee's intense self-criticism. Because the supervisee readily accepts, agrees, and even offers their own negative feedback regarding their work, this can result in the increased likelihood of experiencing shame as it empowers the supervisor to evaluate, criticize, and further condemn the trainee (Hahn, 2001).

Shame in supervision has also been found to have an impact on trainee's self-disclosure to their supervisor, as trainees may be more likely to avoid sharing information as a method of protection from further shame (Yourman, 2003). Trainee self-disclosure is an essential aspect of supervision, and is expected by the supervisor for the purpose of

case management, maintaining client welfare, and for the growth of the supervisee (Bernard & Goodyear, 2009; Yourman, 2003). Because supervision is a requirement for trainees and is therefore unavoidable, shame withdrawal and avoidant reactions may instead take the form of non-disclosure and reduced involvement in the supervisory process. Ladany et al. (1996) and Yourman and Farber (1996) found that supervisee non-disclosure is a common process in supervision, with this disclosure ranging from telling the supervisor what the trainee perceives they want to hear to avoiding disclosure of interactions in psychotherapy due to the fear of the supervisor disapproving. In instances of high-shame, supervisee non-disclosure has been shown to increase, and was found to be greater than the non-shamed supervisees (Ladany et al., 1996; Yourman & Farber, 1996). In experiences of shame in supervision, trainee self-disclosure about clinical matters appears to be unchanged, as the trainee can avoid the more painful aspects of their experience by focusing on theoretical conceptualizations or details of the session (Hahn, 2001; Yourman, 2003). Instead, shame appears to reduce the supervisee's disclosure about the supervisory process, as disclosure would require the supervisee to identify and acknowledge their shame reactions, which increases their risk for further shame (Yourman, 2003).

Supervisor Responses to Shame

While supervisors hold most of the responsibility in terms of creating an environment in which trainees can work through shame experiences, supervisors often have difficulty identifying their own experiences of shame, and thus may avoid the discussion of shame in supervision altogether (Hahn, 2001). To increase empathy and understanding, supervisors should remember the difficulty of being in a training program,

and the feelings of exposure, evaluation and fear of failure that accompany the learning process in psychotherapy training (Alonso & Rutan, 1988; Hahn, 2001; Yourman, 2003); Talbot, 1995). Much of the recommendations listed in the literature emphasize the importance of creating a safe and supportive supervision atmosphere, such that trainees feel comfortable discussing errors, feelings of inferiority and shame, as well as their relationship with the supervisor. Furthermore, Hahn (2001) emphasizes the importance of supervisor self-disclosure and normalization of the training process and the existing hurdles in graduate training and in psychotherapy more generally, as it can help to reduce trainee's feelings of shame, inferiority and vulnerability.

While it is important to help a supervisee understand their shaming experience and to provide a safe and supportive environment for supervisees to work through shame, it is also important for supervisors to avoid confronting shame prematurely, as this can increase a trainee's feeling of shame (Alonso & Rutan, 1988; Hahn, 2001; Talbot, 1995). Due to the difficulty with identifying shame, it is important for supervisors to be aware of the physical indicators of shame and to create an environment in which supervision processes can be openly discussed. Talbot (1995) stresses that supervisors should be alert to supervisee's disguised shame in supervision (i.e., boredom, dismissiveness, focusing on theoretical orientation at expense of building the supervisory connection), and to help supervisees to understand the process occurring within supervision. To reduce the experience and vulnerability to shame in supervision, Alonso and Rutan (1988) recommend that supervisors play an active role in case management, and provide consistent positive reinforcement of supervisee growth and skill in psychotherapy. Talbot (1995) expands on the importance of positive reinforcement, and recommends that

supervisors model the skills and activities that they want from their trainees, to more explicitly communicate their expectations and reduce trainee confusion. Altogether, the recommendations for reducing shame experiences in supervision appear to be largely centered on creating a supportive atmosphere in which supervisees can more safely disclose mistakes, fears, and feelings of shame as they occur.

Supervisor: Shaming v. Non-Shaming Feedback

Despite the importance of feedback in the process of supervision and its role in trainee development, the shame in supervision literature failed to discuss the role of feedback in the experience of shame. In supervision, the supervisor performs potentially opposing roles including evaluator and gatekeeper for the trainee, while also building rapport so that trainees can discuss mistakes, areas of growth and potential struggles (Bernard & Goodyear, 2013). Thus, feedback can serve as an important context for shame, as the supervisor is attempting to fulfill all these roles, and the trainee is at increased risk of feeling exposed and vulnerable to the supervisor. While critical feedback is an important aspect of trainee growth and development, it is important for supervisors to be aware of potential shame reactions, and to discuss the process with the trainee. Because feedback was not specifically addressed in the shame in supervision literature, research from the parenting literature can be applied in order to help supervisors create and express feedback that reduces the risk of trainee shame.

Tangney and Dearing (2002) emphasize the importance of parenting behaviors and interactions for a child's affective and moral development. They outline six recommendations for parents that can assist in emphasizing guilt reactions in children, as opposed to inducing shame. First, Tangney and Dearing (2002) recommend that parents

emphasize the child's negative behavior when disciplining a child, as opposed to placing a negative emphasis on the child, as this provides a model of guilt and reparative action for children. In supervision, supervisors should also emphasize the behavior that they are providing feedback for (i.e., pattern of tardiness, passivity in therapy), and thus, their feedback should provide specific examples of this behavior. Second, the authors suggest parents focus on the consequences of the child's action for other people, as this helps children to understand how their behavior impacts others, and helps children to develop other-oriented empathy (Tangney & Dearing, 2002). In supervision, this could include exploration of how the trainee's actions in therapy are affecting the therapeutic alliance, their client, or the supervisory process. This exploration can help trainees to better understand the therapeutic process and can also provide an environment in which they feel safe to practice new skills. Furthermore, this exploration can provide supervisors with the chance to model their expectations for the trainee in supervision, and provide them with further feedback regarding the supervisory process (Tangney & Dearing, 2002).

Tangney and Dearing (2002) recommend that when disciplining children, parents should emphasize reparative action. Parents must assist children in identifying the interpersonal consequences of their actions and possible avenues to apologize, or correct their behavior. While the authors stress the importance of teaching children the consequences of their behavior, they also emphasize the importance of helping children to resolve their feelings of guilt through reparative action. In supervision, this could include helping the trainee to hypothesize future scenarios in which similar processes may occur, and discuss how to implement their new skills and understanding to these

client situations. Tangney and Dearing's (2002) fourth recommendation is to avoid public humiliation when disciplining children, as that is more likely to result in a child's shaming reaction due to the exposure and evaluation involved in a more public display of discipline. Supervisors should be aware of the potential difficulty trainees will experience when receiving critical feedback, and thus provide a private atmosphere that can help to reduce their feelings of exposure and vulnerability. The authors also recommend that parents avoid teasing or sarcastic humor with children, as this can be another source of shame for a child if the child feels mocked for their behavior. Finally, the authors recommend that discipline should be done within a nurturing context by providing the child with positive and negative feedback, as well as helping the child to resolve their guilt and shame feelings that may have resulted from their behavior (Tangney & Dearing, 2002). This is an important aspect of the feedback process in supervision, as supervisors can help trainees to feel empowered in resolving their shame feelings, as well as in their ability to incorporate the feedback into their future work.

CHAPTER IV

SHAME AND GENDER

Gender Differences in the Experience of Shame

Brown (2004, 2006, 2007, 2008) describes the differential impact and triggers involved in the experience of shame for men and women. Based on hundreds of interviews with women about shame, Brown (2004, 2007) concluded that women experience shame in a layered web, that dictates who, what and how women should be. These gendered expectations are enforced in societal norms and fuel the feeling of disconnection, fear and judgment experienced with shame. While women are faced with balancing nuanced and sometimes conflicting expectations, men experience a single social expectation of hiding any perception of weakness (Brown, 2007). For men, shame is experienced through the failure to live up to the masculine ideal of being powerful, fearless, and tough. Rather than a web of shame, Brown (2007) describes male shame as a small box, in which they are confined through the expectations of toughness, strength, and invulnerability. Brown, Hernandez & Villarreal (2011) argued that while the shame experience may be similar for men and women, shame triggers for men and women differ based on feminine and masculine norms, expectations, and messages.

In a study discussing anger-inducing events in couples, Tangney Barlow, Borenstein & Marschall (2001) found that anger responses were more often associated with shame-related events, as opposed to non-shaming events (as cited in Tangney & Dearing, 2002). The authors also found gender differences in how the shame and anger was expressed. Men were more likely to direct their aggression towards their girlfriend, while also engaging in a ruminative, other-oriented thinking pattern (i.e., thinking about

the situation and becoming angrier with the girlfriend). In contrast, women were more likely to displace their shamed-anger towards other people and to themselves, as opposed to directing the anger towards the boyfriend (Tangney et al., 2001 as cited in Tangney & Dearing, 2002). The difference in shame-anger reactions illustrates the protective nature of shame reactions, as in both cases, the person is trying to limit their exposure and push the focus away from their own feelings of shame and inadequacy. In the study of shame in supervision, shamed trainees may engage in attack-of-others or attack-of-self behaviors in reaction to the experience of shame, and thus supervisors should be vigilant for shame-anger patterns of reactions in order to better help trainees identify, explore and process their shame experiences (Hahn, 2001).

Women have been found to experience greater shame-proneness than men across the lifespan, from early childhood to late adulthood (Tangney & Dearing, 2002). In contrast, men appear more likely to experience and display externalizing behaviors (i.e., blaming others) in response to negative events. Men and women also appear to have different reactions when experiencing shame, as men are more likely to react with outward aggression as compared with women (Tangney & Dearing, 2002). This was consistent in Meulman and McHugh's (2017) study of shame and guilt proneness in relation to gender role stress among college students. Women reported significantly greater rates of shame-prone reactions as compared to men, and gender role-stress was found to be associated with greater shame-prone reactions in women. In contrast, men reported significantly higher rates of externalizing behaviors as compared to women, and increased rates of masculine gender role stress were only associated with increased externalizing behaviors (Meulman & McHugh, 2017). In open-ended questions about

shame experiences, men frequently reported shame for under-performing, whereas women emphasized failing as a cause of their shame experiences. Furthermore, both men and women self-reported experiencing shame for being "called out," as they felt exposed to other people (Meulman & McHugh, 2017). In supervision, men and women may experience failure, under-performance, or exposure related to their work, to a supervisor and/or other students, and thus may have a greater vulnerability to shame. The proposed stud aims to better understand the experience of shame in supervision, and to better understand shame vulnerabilities as influenced by gender.

Gender Role Stress and Shame

While men and women may have different triggers for shame, previous research has found that women are more likely to experience shame and guilt than men across many situations (Benetti-McQuoid & Bursik, 2005; Brown, 2007; Efthim, Kenny & Mahalik, 2001). In general, women have been found to be more shame-prone than men, as they are more likely to internalize their experiences, and they are more likely to generalize them into a negative self-concept (Benetti-McQuoid & Bursik, 2005; Efthim, et al., 2001). Benetti-McQuoid and Bursik (2005) examined gender differences in shame and guilt-proneness, as well as the effect of gender role conformity and non-conformity on self-reported shame and guilt. The authors found that women reported greater rates of shame and guilt proneness as compared to men, while men reported greater rates of experienced guilt. Furthermore, individuals who fit a feminine gender role reported significantly more shame and guilt-proneness as compared to those who identified with androgynous, undifferentiated or masculine gender roles. Men who endorsed a more feminine gender role were found to have significantly heightened guilt-proneness, which

Benetti-McQuoid and Bursik (2005) interpreted as an increased ability for empathic guilt. Their heightened empathic guilt is considered adaptive, as it has been associated with interpersonal connectedness, maintenance, and reparative action after a wrong-doing. Women who endorsed more masculine gender roles were found to be less shame-prone than their feminine counterparts, and women who endorsed more androgynous gender roles appeared to have greater rates of empathic guilt (Benetti-McQuoid & Bursik, 2005).

Efthim et al. (2001) examined gender differences in shame and guilt-proneness, as well as the impact of gender role stress on reported shame, guilt and externalizing behaviors. The authors also found higher rates of shame and guilt-proneness among women, as compared to men. In general, for men, masculine gender role stress, including expression of vulnerability and inferiority to women, was associated with externalizing behaviors (i.e., blaming others) and had an inverse relationship with guilt-proneness. The authors hypothesized that men use externalization and other-oriented blame as a defense against shame, as they focus the negative feelings outward instead of internalizing them. Men who endorsed feeling intellectually inferior to women were found to have increased shame-proneness, while physical inadequacy and work performance were found to be associated with shame, guilt and blaming others. For women, all the gender role stress dimensions, including physical unattractiveness, emotional detachment, victimization, failed nurturance and unassertiveness were strongly associated with shame-proneness and moderately associated with externalizing behaviors. For women, gender role stress was not found to be associated with guilt-proneness, which is considered to be a more adaptive affectual response (Efthim et al., 2001). When in situations that induce self-conscious emotions, guilt is uniformly considered to be the more adaptive response, as it

helps the person to place the evaluative judgment on the behavior, as opposed to on the worth of the self. For women who experience gender-role stress, they are more likely to report shame and shame-proneness, such that they experience themselves as failures, rather than experiencing guilt because of the failed, "unfeminine" behavior (Efthim et al., 2001). In the context of therapy and supervision, male therapists may be more emotionally expressive and better able to reject the limitations of traditional masculinity on emotional expression than the general population, and thus may exhibit differences related to shame vulnerabilities and gender-role stress. This study examined the role of gender on shame-proneness and the experience of shame in supervision.

Shame and Supervision: Gender Differences

Treese (1989) found women to have significantly greater vulnerability to shame, as well as reported professional shame in comparison with men. However, these findings have since been questioned due to the disputed validity of the shame measures used in his study of shame differences among men and women (Hemlick, 1997). Furthermore, findings related to gender differences in shame and supervision have been largely absent from the literature (Hemlick, 1997; Hahn, 2001; Yourman, 2003). It remains unclear if gender differences have not been explored, or if no differences have been found in previous studies. Conceptually, it is theorized that women experience greater shame-proneness than men, and thus may be at an increased risk for the experience of shame in supervision. This study aims to better understand the general frequency and context of shame in supervision, while also examining if any gender differences emerge.

Research Questions and Hypotheses

1. To what extent are women more shame-prone than men, based on responses on the TOSCA-3?

   Previous research has found that women are generally more shame-prone than men, and that this difference has been consistently found in research on shame-proneness (Tangney & Dearing, 2002; Brown, 2004, 2006; Meulman & McHugh, 2017). This study included the TOSCA-3 and examined gender differences in reported rates of shame and guilt-proneness, as well as on externalizing behaviors (blame).

2. What is the rate of shame experiences in supervision?

   While shame in supervision is theorized to be pervasive, self-reported rates of shame in supervision has been low (Hemlick, 1997; Hahn, 2001). While the low rates may be due to limited shame exposure in supervision, this could also be reflective of the difficulty with identifying and measuring shame experiences. This study asked participants to think of their most negative shame experience prior to completing the SISI in order to better understand the rate of shame in negative supervision experiences.

3. To what extent do women experience shame in the context of supervision, as compared with men?

   While men and women are proposed to experience different rates of shame, how does this relate to their vulnerability to shame in supervision. Overall, gender differences in the shame in supervision research has not been reported, and

this study aimed to better understand the gendered experience of shame as it relates to supervision.

4. How does one's self-reported level of social support impact one's vulnerability to experiencing shame in supervision?

    Brown (2004, 2006, 2009) emphasizes the importance of social support as the cure to shame, as it provides an opportunity for expression of their shame that is met with empathy and understanding. Without social support, shame thrives with silence and interpersonal distance. This study explores the role of social support in the shame experience. It is hypothesized that individuals that are highly shame-prone will report less shame in supervision if they have a strong social support network.

5. How does self-reported rates of self-compassion impact one's experience of shame in supervision?

    Shame is the painful emotion that occurs when one makes a global, negative self-evaluation based on a negative event. In contrast, self-compassion is the act of self-kindness, and a reduced tendency to negatively judge oneself. Because of the overwhelmingly negative experience of shame, shame-prone individuals have been found to have reduced self and other-oriented empathy, as they are overwhelmed by their own experience (Covert et al., 2003). This study explored the relationship between self-compassion and shame and it is hypothesized that those with higher levels of self-compassion will be less shame-prone, and will report less shame within the context of supervision.

CHAPTER V

METHODS

Participants

This sample consisted of graduate-level clinical and counseling psychology students, as well as interns and post-doctoral students who are continuing to receive supervision. Only participants who have experienced supervision within the last year were eligible to participate in the study.

Procedure

Participants were recruited to participate in the study through the communication with clinical training directors. The training directors were contacted via email and were asked to disperse the study information to their graduate students. All contact emails were obtained via university websites (see Appendix B for a sample email). A link was included in the email that directed participants to the survey and created an anonymous user identification for each participant to protect their identity. In addition to contacting program training directors, graduate students in clinical training programs were recruited at the Indiana University of Pennsylvania (IUP.

All participants were first prompted to think of a negative supervision experience and then completed a series of questionnaires. The study includes a demographic questionnaire, the Test of Self-Conscious Affect, Version 3 (TOSCA-3), the Shame in Supervision Instrument (SISI), a question on investment in supervision, the Self-Compassion Scale (SCS), and the Multidimensional Scale of Social Support (MDSSS). Finally, the participants were asked a series of open-ended questions to further describe and explore their negative supervision experience.

Measures

All available measures can be found in the appendix.

Demographic Questionnaire

Participants were asked to complete a demographic questionnaire (see Appendix C) that identified their gender, race, and ethnicity. The participants were also asked about the type of program they are in (counseling or clinical; master's or doctorate), the total number of supervisors they have been assigned to for supervision, and their identified theoretical orientation. Participants were then prompted to think of their most negative supervision experience and then provided additional information about the supervisor (i.e., gender of the supervisor, perceived theoretical orientation of the supervisor, and perceived theoretical style of supervision).

Test of Self-Conscious Affect, Version 3 (TOSCA-3)

The Test of Self-Conscious Affect, Version 3 (TOSCA-3) assesses for shame and guilt proneness through a series of vignettes based on written accounts from college and non-college adults (Tangney, Dearing, Wagner & Gramzow, 2000; Tangney & Dearing, 2002). See Appendix D for the TOSCA-3. The participants' responses were assessed for guilt, blame (externalization of responsibility) and shame on a Likert scale ranging from 1 (not likely) to 5 (very likely). The TOSCA-3 includes the same scenarios previously used in the TOSCA-2 but the maladaptive guilt scale was removed due to poor discriminant validity (Tangney, Dearing, Wagner & Gramzow, 2000; Tangney & Dearing, 2002).

Tangney and Dearing (2002) outline several strengths of the TOSCA-3, including its clear differentiation between shame and guilt, as well as the use of behavioral

descriptors, rather than relying on participants to accurately describe their experience as shaming or guilt-inducing. Furthermore, the TOSCA-3 independently measures shame and guilt, thus allowing for the same participant to have high scores (or low scores) on both the shame and guilt measure, providing a greater understanding of their emotional affect and experience in relation to scenarios. The TOSCA-3 has displayed moderate reliability in research (.85 for shame, .74 for guilt) and due to the trait-like experience of shame and guilt-proneness, the TOSCA-3 has been shown to have strong test-retest reliability (Tangney & Dearing, 2002).

Shame in Supervision Instrument (SISI)

The SISI consists of 49 items on a Likert scale ranging from 1 (not at all true of me) to 7 (very true of me) (Hemlick, 1997). After receiving a prompt to think of their most recent supervision experience, participants responded to indirect questions about shame based on behavioral and cognitive indicators of shame, as well as phenomenological descriptors (See Appendix E). A factor analysis yielded five factors of shame (see Appendix K): inadequacy as a counselor, negative reaction during supervision, concealing from supervisor, supervisor investment, and inadequacy as a person (Hemlick, 1997). The factors related to feelings of inadequacy as a counselor and person were conceptualized to be most significantly related to shame-proneness but the effects were modest. The SISI appears have strong construct validity, as it encompasses the different dimensions of the shame construct, and strong internal reliability ($\alpha = .92$) (Hemlick, 1997).

Hemlick (1997) based the SISI on four foundational dimensions to the experience of shame in supervision including a (1) failure to live up to an ideal, (2) exposure of self-

deficiencies, (3) exposure of self to supervisor, and (4) a fear of abandonment and rejection. The failure to live up to an ideal is based in dynamic and cognitive theories of shame and describes the professional and personal ideals trainees have for themselves, as well as their related fear of not meeting these expectations. Shame-proneness was found to be the largest predictor of this dimension and accounted for 22% of the variance in responding (Hemlick, 1997). Exposure of self is based on the phenomenological experience of shame and is related to the critique of one's therapeutic work within the context of supervision. The self-deficient dimension of supervisee shame assesses the trainee's global self-perception of inadequacy in the development of therapeutic skill and knowledge. Trainees with less experience were found to be at an increased risk of shame in supervision, as trainees are likely to experience greater struggle in their professional identity and self-efficacy earlier in their training. Finally, the fear of abandonment and rejection dimension is based on their fear of devaluation, which is central to the experience of shame. This includes the supervisee's perception of the loss of the supervisor's investment and attention in supervision because of the supervisee's deficiency in psychotherapy (Hemlick, 1997).

Hemlick (1997) found lower rates of shame in supervision than had been hypothesized, and theorized that the lower rates could be due to instrument error, lack of knowledge about shame, or the avoidant nature of shame reactions. Despite the low shame findings, the SISI successfully differentiated shame in supervision from general shame-proneness. Furthermore, the SISI accounted for the role of shame-proneness in the increased likelihood of experiencing shame in supervision (Hemlick, 1997). Due to the low levels of self-reported shame, this study prompted participants to think of their most

negative supervision experience, as opposed to their most recent experience, in order to better understand the role and frequency of shame in negative supervision experiences.

Investment in Supervision

In her study of shame in supervision, Hemlick (1997) asked about trainees' level of investment in supervision outside of concern about a grade on a 7-point Likert scale ranging from 1 (minimally invested) to 7 (extremely invested) (See Appendix F). Hemlick (1997) hypothesized that higher levels of investment in shame would be associated with higher self-reports of shame in supervision. However, this hypothesis was not supported, as increased shame was related with lower reports of trainee investment in supervision. Due to the withdrawal and avoidant nature of shame reactions, it appears that lower self-reports of investment in supervision may instead be indicative of the experience of shame in supervision (Hemlick, 1997). Thus, the reduced investment in supervision may be a protective reaction from the trainee with the goal of reducing the risk of future shame. This study also examined trainee's level of investment to better understand the impact of shame on investment in supervision.

Self-Compassion Scale (SCS)

The self-compassion scale is a 26-item self-report measure assessing statements on a 5-point Likert scale ranging from 1 (almost never) to 5 (almost always) (Neff, 2003). The self-compassion scale consists of six subtests based on three principle components including kindness (being kind v. judgement), mindfulness (holding painful emotions v. over-identifying) and common humanity (suffering is a part of humanity v. isolating because of imperfection) (See Appendix G). The self-compassion scale has discriminant validity from self-esteem, as self-compassion does not require the feeling of superiority

that is associated with higher levels of self-esteem. Furthermore, Neff (2003) asserts that based on the validation studies, the scale is psychometrically sound and a theoretically valid measure of self-compassion (α = .93).This study included a measure of self-compassion, as increased self-compassion is theorized to be inversely correlated with shame-proneness and protective against the experience of shame in supervision (Brown, 2007, 2009). Thus, it is expected that those who report high self-compassion will have low self-reported shame-proneness and lower rates of shame experiences in supervision. Furthermore, self-compassion has been associated with mastery-based goals, as opposed to performance goals, thus further reducing one's proneness to shame (Neff, 2003).

Multidimensional Scale of Perceived Social Support (MSPSS)

The Multidimensional Scale of Perceived Social Support (MSPSS) consists of 12 items, with responses ranging on a Likert scale from 1 (very strongly disagree) to 7 (very strongly agree) (Zimet, Dahlem, Zimet & Farley, 1988). The MSPSS includes three subscales representing different sources of support, including family, friends and significant other (See Appendix H). The MSPSS is a widely used assessment and has been used in thousands of research projects with strong internal reliability (α = .91) (Dahlem, Zimet & Walker, 1991). Furthermore, it represents moderate construct validity, as high levels of social support have been found to be inversely associated with anxiety and depression symptoms (Zimet et al., 1988). Brown (2004, 2006, 2007, 2008, 2009) asserts that "speaking shame" and receiving empathy is the antidote to shame. This study included the MSPSS as a measure of social support to better understand the relationship between social support, shame proneness and potential experiences of shame in supervision.

Open-Ended Shame in Supervision Questions

Although Hemlick (1997) found lower rates of shame in supervision than initially hypothesized, she suggested that future research include questions related to the experience and potential triggers of shame in supervision. This study included open-ended questions to help provide context to the experience of shame, as well as to allow participants to describe their experiences of in their own words (See Appendix I). Furthermore, the open-ended questions were included to better understand the frequency and intensity of experiences of shame in supervision. Participants were prompted to answer four open-ended questions: (1) describe a time you felt incompetent/inadequate in supervision, (2) describe a time you feel you disappointed your supervisor, (3) describe a time you felt shame, and (4) describe a time you felt shame in supervision.

CHAPTER VI

RESULTS

Treatment of Missing Data

The following approach was used to manage missing data across all analyses. If a respondent was missing more than two responses per questionnaire, their responses were excluded from analysis. With response to the sample, 101 participants opened or started the survey and 72 completed the quantitative portion. 2 respondents completed the demographic questions and the TOSCA, but failed to complete the SISI, SS, SCS, or open-ended questions. Of the completed questionnaires, 8 participants did not complete the open-ended questions (64 total responses).

Description of Sample

Participants for this study included 74 students from graduate programs in clinical or counseling psychology. Participants were recruited through email correspondence on list-servs and distribution of surveys to various counseling and clinical graduate psychology programs. Table 1 illustrates the demographic information for the sample.

Demographics

The sample was predominantly female, including 58 women (75.3%) and 15 men (19.5%). One participant did not disclose their gender. The sample was predominantly Caucasian (59 respondents, 79.7%) with other participants identifying as African American/Black (3 respondents, 3.9%), Latina/Hispanic (3 respondents, 3.9%), Asian/Pacific Islander (7 respondents, 9.1%) and Biracial/Multiracial (2 respondents, 2.6%).

Education Status

Participants were primarily pursuing degrees in Clinical Psychology graduate programs (59 respondents, 76.6%) with 15 participants in Counseling Psychology graduate programs (19.5%). Participants were predominantly pursuing doctoral degrees with 30 (39.0%) participants receiving a Doctor of Philosophy (Ph.D.) and 40 (51.9%) receiving a Doctor of Psychology (Psy.D.) upon completion. Three participants (3.9) were pursuing a Master's of Arts (M.A.) and 1 participant identified receiving a Master's of Science (M.S.) upon completion of their program.

Table 1
Demographics

Characteristics	**n**	**%**
Gender		
Female	58	75.3
Male	15	19.5
Missing	1	0.01
Total	73	98.65
Race		
African American/Black	3	3.9
European American/Caucasian	59	79.7
Latina/Hispanic	3	3.9
Asian/Pacific Islander	7	9.1
Biracial/Multiracial	2	2.6
Total	74	100
Characteristics	**n**	**%**
Program Type		
Counseling Psychology	15	19.5
Clinical Psychology	59	76.6
Total	74	100
Degree Upon Completion		
Master's of Arts (M.A.)	3	3.9
Master's of Science (M.S.)	1	1.3
Doctor of Philosophy (Ph.D.)	30	39.0
Doctor of Psychology (Psy.D.)	40	51.9
Total	74	100

Theoretical Orientation

Participants wrote in their theoretical orientation and of the 73 total participants in the sample, 22 theoretical orientations were identified. This researcher categorized the self-identified theoretical orientations into one of four categories: insight-oriented, symptom-reduction, unknown and other. The insight-oriented theoretical orientations included dynamic, interpersonal, humanistic and emotion-focused therapies and accounted for 41.9 percent of the sample (31 total participants indicated an insight-oriented theoretical orientation). Twenty-eight participants (37.8 percent) described their theoretical orientation as more focused on symptom reduction including cognitive-behavioral (CBT), dialectical behavior (DBT), and acceptance and commitment (ACT) therapies. Nine participants reported not currently knowing their theoretical orientation, accounting for 12.2 percent of the sample. Five participants (6.8 percent) identified theoretical orientation that did not fit in the three prior categories, including integrative (undisclosed), eclectic, and biopsychosocial therapies.

Test of Self-Conscious Affect, Version 3 (TOSCA-3)

The TOSCA-3 assesses for proneness of guilt, shame and externalizing behaviors based on vignette scenarios (Tangney, Dearing, Wagner & Gramzow, 2000). Previous research has found that women are generally more shame-prone than men (Tangney & Dearing, 2002; Brown, 2004, 2006; Meulman & McHugh, 2017). The TOSCA-3 has displayed moderate reliability in research (.85 for shame, .74 for guilt) and the current study yielded a similarly strong reliability score for the shame-proneness scale (Cronbach's alpha = .810) and a poor reliability score for the guilt-proneness scale (Cronbach's alpha = .5.07) (Tangney & Dearing, 2002). Table 2 displays the descriptive

statistics (mean, median, mode, standard deviation) for the TOSCA-3 blame, guilt and shame subscales by gender. In comparison to the normative data reported by Tangney and colleagues (Tangney, et.al., 2000), the current sample yielded average scores for men and women across all three subscales. This suggests that the current sample of graduate students in clinical and counseling psychology programs is consistent with the previously established general adult normative sample (Tangney, Dearing, Wagner & Gramzow, 2000). However, the results from this sample are inconsistent with previous research that found a significant difference in scores between men and women in relation to shame-proneness and blame (Tangney, Dearing, Wagner & Gramzow, 2000; Meulman & McHugh, 2017).

Table 2
TOSCA-3: Blame, Guilt and Shame-Proneness by Gender

Gender	TOSCA: Blame	TOSCA: Guilt	TOSCA: Shame
Women	Mean: 23.035 Median: 22.000 Mode: 23.000 SD: 5.909	Mean: 46.741 Median: 47.000 Mode: 46.000 SD: 3.927	Mean: 34.258 Median: 35.000 Mode: 23.000 SD: 7.564
Men	Mean: 25.667 Median: 25.000 Mode: 20.000 SD: 5.912	Mean: 44.6000 Median: 45.000 Mode: 47.000 SD: 4.306	Mean: 31.800 Median: 34.000 Mode: 34.000 SD: 7.012

TOSCA-3: Gender Analysis

A one-way 3x2 between-subjects multivariate analysis of variance (MANOVA) was conducted to evaluate the potential gender differences between scores on the TOSCA-3 subscales (proneness for shame, guilt and blame). The dependent variables were the total scores for the shame, guilt and externalizing subscales. The between-

subject factor was gender with two levels (men, women). There were no extreme scores or outlies in this dataset. There were no noted statistical assumption violations and the Box's M Test of Equality of Covariance Matrices was nonsignificant (p=.394), suggesting that the MANOVA is interpretable. The Levene's Test of Equality of Error Variances also revealed nonsignificant results (TOSCA-3 Shame: p=.976, TOSCA-3 Guilt: p=.971, TOSCA-3 Blame: p=.511), suggesting that the assumption of equality of variance was not violated for the TOSCA-3 subscales. The Wilks' Lambda test was used to assess for gender differences across the TOSCA-3 subscales and was nonsignificant (p=.098) suggesting that no significant difference existed between men and women on self-reported rates of shame, guilt and blame proneness (Tabachnick & Fidell, 2007). Overall, the women in the current sample reported less shame-proneness as compared to previous samples examining the relationship between gender and shame (Meulman & McHugh, 2017). These results are not consistent with prior findings, as women have been found to be more shame and guilt-prone as compared to men, and men are more prone to externalizing behaviors as compared to women (Tangney & Dearing, 2002; Brown, 2004, 2006; Meulman & McHugh, 2017).

Investment in Supervision

Participants were asked to rate their overall level of investment during their most negative supervision experience on a 7-point Likert scale. Previous research found significant differences in self-reported investment between men and women, with women reporting significant greater investment as compared to men (Hemlick, 1997). Overall, levels of investment in supervision was high (N=72, M= 5.04, SD=1.551). Gender differences were assessed using an independent samples t-test and revealed

nonsignificant results. Women (M=5.09) reported nonsignificantly higher rates of investment than men (M=4.87), t(72) = .487, p = .628.

Self-Compassion Scale (SCS)

The Self-Compassion Scale (Neff, 2003) assesses for six aspects of self-compassion including self-kindness, self-judgment, common humanity, isolation, mindfulness and over-identification. These six subscales consist of positive self-compassion (self-kindness, common humanity, and mindfulness) and negative barriers to self-compassion (self-judgment, isolation, and over-identification). Subscale scores were created by calculating the mean score of the subscale items. The total self-compassion score was calculated by reverse-scoring the negative subscales and then computing a grand mean based on the six subscale means. Table 3 displays the descriptive statistics for each of the SCS subscales and total grand mean.

Table 3
Self-Compassion Scale: Mean, Median, Mode & Standard Deviation

SCS Scale Score	Mean	Median	Mode	Standard Deviation
Self-Judgment (Reverse Scored)	2.8083	2.600	2.40	.890
Isolation (Reverse Scored)	2.740	2.750	2.75	.914
Over-Identification (Reverse Scored)	2.892	2.750	3.25	.791
Self-Kindness	2.958	3.000	3.60	.936
Common Humanity	3.118	3.250	3.75	.846
Mindfulness	3.365	3.500	4.00	.713
Self-Compassion Total Score	2.980	3.067	3.39	.611

SCS: Gender Analysis

A one-way independent samples t-test was used to assess for gender differences on the subscales of the SCS (see Table 4). The Levene's Test for Equality of Variance was used to assess for the interpretability of the results and was nonsignificant for each of

the subtests, suggesting that the assumption of equality of variance was not violated. The results revealed that men and women did not significantly differ in their ratings of total self-compassion, self-judgment, over-identification, self-kindness, common humanity and mindfulness. Women reported significantly greater isolation as compared to men, suggesting greater feelings of self-reported isolation or disconnection at times of reduced self-compassion (Neff, 2016).

Table 4
Self-Compassion Scale: Mean Differences by Gender

SCS Scale Score	Women	Men	t	Significance Value (p)
Self-Judgment (Reverse Scored)	2.832	2.600	.916	.363
Isolation (Reverse Scored)	2.844	2.250	2.334	.023*
Over-Identification (Reverse Scored)	2.942	2.667	1.197	.236
Self-Kindness	2.989	2.773	.793	.430
Common Humanity	3.156	2.933	.902	.370
Mindfulness	3.214	3.450	-.624	.534
Self-Compassion Total Score	3.014	2.779	1.356	.179

Multidimensional Scale of Perceived Social Support (MSPSS)

The Multidimensional Scale of Perceived Social Support (MSPSS) was used to assess for perceived degree of social support among clinical and counseling psychology graduate students. While the MSPSS includes three subscales representing different sources of support (support stemming from family, friends, and a significant other), a total social support calculation was used. Items were rated on a Likert scale from 1 (very strongly disagree) to 7 (very strongly agree). The mean social support scale for the overall sample is 5.611 (women: 5.755, men: 5.011). An independent samples t-test was used to assess for gender differences, but the Levene's Test of Equality of Error Variance

revealed significant results (F=6.916, p=.011) suggesting that the assumption of error variance was violated and further analyses are not interpretable.

Exploratory Factor Analysis: Shame in Supervision Instrument (SISI)

An exploratory factor analysis was completed in order to assess the way in which the items in the Shame in Supervision Instrument (SISI) group together based on conceptual understanding of the experience of shame in supervision (Hemlick, 1997). This researcher also assessed if changing the instructions such that participants answered the items while thinking of their most negative supervisor, as opposed to their most recent supervisor, impacted the loadings of the items onto the factors. A Principal Component Analysis (PCA) was completed using SPSS version 25 with principal axis factoring as the extraction method (Beavers et al., 2013). The factorability of the measure was assessed using Bartlett's Test of Sphericity (Bartlett, 1954) and the Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy (Kaiser 1970, 1974). In order to determine if a factor analysis is appropriate, the Bartlett's Test of Sphericity should be significant and the KMO index should be .6 or higher with a maximum rating of 1 (Tabachnick & Fidell, 2007; Beavers et al., 2013). The correlation matrix was determined to be factorable due to a KMO of .832 and a significant finding of the Bartlett's Test of Sphericity (chi square = 1823.788, df=496, p=.000).

The principal components analysis was completed through an exploratory process in which this researcher ran multiple exploratory analyses until the fewest factors were identified that accounted for the most possible variance. The researcher used Kaiser's criterion when determining if an item should be included in the factor and excluded all items that did not have an eigenvalue greater than .300. This research used the pattern

matrix with a promax rotation to determine how items loaded on factors. In keeping with Tabachnick & Fidell's (2007) recommendation, items that cross loaded onto two factors were further examined to determine if the item accounted for unique variance for each factor. When items were loaded onto two factors, the item was kept if the absolute difference in the correlation was greater than .2, suggesting that there were unique contributions for both factors from the item. If the absolute difference in the correlation coefficient was less than .2, the item was eliminated as the contribution to the factor did not meet the threshold for unique contributions (Tabachnick & Fidell, 2007).

This researcher completed three exploratory factor analyses to determine the fewest possible factors that explained the greatest variance, while also assessing the theoretical explanation for how the items were similarly correlated. The initial extraction included all 49 items in the SISI and resulted in 11 total factors with 77.92% of the variance explained (see Table 5). This researcher examined the item correlations and removed five items that were similarly loaded on at least one factor (item 18, 23, 25, 28, 49). After the removal of those items, a second extraction was completed resulting in 10 total factors with 76.92% of the variance explained. After further evaluation of the factors, an additional 17 items were removed from the factor analysis due to similar loadings on multiple factors (items 1, 4, 5, 6, 8, 9, 10, 13, 16, 22, 24, 29, 30, 31, 32, 33, 35).

Table 5
Eigenvalues and Percent of Variance Explained by Initial Extraction of the Principal Components Analysis (PCA) of the SISI That Yielded an 11-Factor Solution

Factor	Eigenvalue	Percent of Total Variance Explained	Cumulative Percent of Total Variance Explained
1	18.62	37.99	37.99
2	3.87	7.89	45.88
3	2.94	6.00	51.89
4	2.31	4.71	56.60
5	2.23	4.55	61.15
6	1.79	3.65	64.80
7	1.53	3.13	67.92
8	1.44	2.93	70.85
9	1.28	2.60	73.46
10	1.17	2.39	75.85
11	1.01	2.07	77.92

The third Principal Components Analysis (PCA) revealed the presence of six factors with eigenvalues greater than 1, which explained 42.69%, 9.79%, 6.03%, 4.73%, 3.83% and 3.45% respectively with the total cumulative variance explained as 70.53% (see Table 6). A fourth extraction was completed in order to assess if removing items with overlapping loadings resulted in a more parsimonious model, but the model produced a six-factor model with items that were less interpretable. It was determined that the third extraction produced the most parsimonious and interpretable factor model.

Table 6
Eigenvalues and Percent of Variance Explained by Initial Extraction of the Principal Components Analysis (PCA) of the SISI That Yielded the Maximum Solution of the SISI With 6 Factors

Factor	Eigenvalue	Percent of Total Variance Explained	Cumulative Percent of Total Variance Explained
1	13.66	42.69	42.69
2	3.13	9.79	52.48
3	1.93	6.03	58.51
4	1.52	4.73	63.24
5	1.23	3.83	67.07
6	1.11	3.45	70.53

The third iteration of the rotated pattern matrix produced six factors, and items with loadings of 3.0 and greater were used in interpreting the factor (Beavers et al., 2013). Table 7 presents the six factors with the associated loaded items. Factor 1 accounted for 42.69 percent of the total variance. In the current study, Factor 1 had strong internal consistency with a Cronbach's alpha coefficient of .940. The nine items that were interpretable for Factor 1 appeared related to a sense of inadequacy and incompetency as a therapist, as well as a sense of not being at one's expected clinical level. Factor 1 loaded on the same nine items as Hemlick's (1997) original factor analysis, however her analysis also included three other items ("During supervision I felt incompetent;" "It was hard not to take feedback about specific behaviors as an evaluation of my overall potential as a counselor;" "Comparing myself to my supervisor made me feel worse about myself as a counselor/therapist") on that factor (See Hemlick's (1997) factor analysis model in Appendix K). Based on the items loading into the factor and Hemlick's (1997) original factor analysis, this factor was labeled as "Therapist Shame."

Table 7
Final Extraction Factors: SISI Items and Associated Factor Loadings

Item Number	SISI Item Text	Factor Loading
	Factor 1: Therapist Shame	
2	As a counselor, I felt flawed.	.565
3	I sometimes felt that I was really falling short of where I should be.	.869
7	I felt totally inadequate as a counselor.	.761
11	I feared that my supervisor would discover I was really incompetent.	.855
12	It felt like there was a big gap between where I was and where I thought I should be in my development as a counselor.	1.059
15	I felt that I had serious weaknesses as a counselor.	.832
19	I sometimes felt like I was lacking essential qualities that other counseling students have.	.618
45	In supervision, I felt like I was never as good as I should be.	.685
47	I found it hard to accept that I wasn't where I thought I should be with my skills.	.822
	Factor 2: Exposure of Self (Inadequacy of Person)	
14	During supervision, I came to feel there was something deeply wrong with me.	.824
21	I felt inadequate as a person during supervision.	.572
27	Sometimes after supervision I wished that I could go away and hide.	.824
31	I felt exposed in supervision.	.414
32	Sometimes during supervision I felt like sinking into the floor	.968
34	Sometimes after supervision I felt like I didn't want to face anyone.	.509
40	I felt that my supervisor was disappointed in me when I made mistakes.	.400
	Factor 3: Healthy Alliance	
20	(Reverse Scored) After supervision sessions, I felt better about myself as a counselor.	.916
30	(Reverse Scored) I looked forward to reviewing my audio/video tapes with my supervisor	.796
37	(Reverse Scored) I felt at ease having my supervisor scrutinize my work.	.731

Item Number	SISI Item Text	Factor Loading
43	(Reverse Scored) In supervision, I felt I could make "foolish" mistakes and still be a good counselor/therapist.	.796
	Factor 4: Inadequacy as a Counselor	
17	It was devastating when I felt like I failed.	.376
26	It was hard not to take feedback about specific behaviors as an evaluation of my overall potential as a counselor.	.554
31	I felt exposed in supervision	.642
38	I was concerned that if I didn't measure up, my supervisor might be less committed to working with me.	.398
39	Sometimes it was hard for me to look my supervisor in the eye.	.317
	Factor 5: Self-Disclosure	
29	I was torn between wanting to share my work with my supervisor and wanting to protect myself.	.651
36	I sometimes wished I could take back something I shared with my supervisor about myself or my work.	.542
41	(Reverse Scored) I felt that I didn't have to share any more than I wanted to about myself or my work with my supervisor.	.598
	Factor 6: Perceived Supervisor Commitment	
38	I was concerned that if I didn't measure up, my supervisor might be less committed to working with me.	.652
42	I felt like my supervisor thought I wasn't worthy of her/his time.	.649
46	I was careful not to say things that might cause my supervisor to withdraw from me.	.767

Factor 2 accounted for 9.79 percent of the total variance and had strong internal consistency with a Cronbach's alpha coefficient of .920. The seven items included in Factor 2 described a sense of exposure, inadequacy and negative self-appraisal and was labeled "Exposure of Self (Inadequacy of Person)." This factor did not fit with previous factors found in Hemlick's (1997) factor analysis, and instead constituted a mix of items

from two of her identified factors (Negative Reaction During Supervision and Inadequacy as a Person).

Factor 3 consisted of four items and accounted for 6.03 percent of the total variance. Factor 3 displayed good internal consistency with a Cronbach's alpha coefficient of .854. This factor consisted of four reverse-scored items and described aspects of a healthy supervisory alliance. The items described feelings of support, confidence and opportunities for learning within the supervisory relationship and was labeled "Healthy Alliance." This factor did not fit with any previous factors obtained in Hemlick's (1997) factor analysis.

The fourth identified factor consisted of five items and accounted for 4.73 percent of the total variance. Factor 4 displayed good internal consistency with a Cronbach's alpha coefficient of .849. This factor did not match previous factors identified by Hemlick, but appeared to describe feelings of "Inadequacy as a Counselor" (Hemlick, 1997). The items described feelings of failure, exposure and a global negative evaluation in the supervisory relationship. Hemlick (1997) also identified an "Inadequacy as a Counselor" factor with items describing feelings of exposure, falling short of expectations and feelings of incompetency (see Appendix K).

Factor 5 consisted of three items and accounted for 3.83 percent of the total variance. Factor 5 displayed very poor internal consistency with a Cronbach's alpha coefficient of .181. The items in this factor exemplified reduced supervisee disclosure about client information or personal information in order to preserve one's image to the supervisor. While Hemlick (1997) also identified a factor regarding reduced disclosure, the current factor analysis resulted in one similarly loaded item ("I was torn between

wanting to share my work with my supervisor and wanting to protect myself"). This factor was named "Self-Disclosure."

The final factor, Factor 6, consists of three items and accounted for 3.45 percent of the total variance. The internal consistency for this factor was good with a Cronbach's alpha coefficient of .702. This factor is labeled "Perceived Supervisor Commitment" and the items reflect the supervisee's fear of doing something wrong such that the supervisor loses interest in their training. This factor has one overlapping item ("I felt like my supervisor thought I wasn't worthy of her/his time") with Hemlick's (1997) factor analysis which resulted in a factor she labeled as Supervisor Investment.

Shame in Supervision Instrument (SISI): Descriptive Analyses

In keeping with Hemlick's (1997) findings, the individual factor scores are used to assess supervisee's experience of shame in supervision, as opposed to calculating a total SISI score. Mean scores for each of the factors were calculated, with all factors suggesting a moderate occurrence of shame in supervision (average ratings above 3 out of total Likert scale of 7). Table 8 presents the mean, median and modal scores for each of the factors. These mean findings are higher than previously reported factor score means, as Hemlick (1997) found that participants reported overall low levels of shame in supervision. Previous research found that 60% of participants reported scoring in the lower third range of scores, suggesting low levels of overall shame in supervision (Hemlick, 1997). This sample reported moderate levels of shame in supervision, with an average score for the experience of therapist shame as 3.889.

Table 8
SISI Factors: Mean, Median, Mode, & Standard Deviations

Factor	Factor Name	Mean	Median	Mode	SD
1	Therapist Shame	3.889	3.778	2.00	1.700
2	Exposure of Self (Inadequacy of Person)	3.585	3.929	1.29	1.971
3	Healthy Alliance	3.403	3.500	3.50	1.597
4	Inadequacy as a Counselor	3.544	3.400	1.80	1.606
5	Self-Disclosure	3.801	4.000	4.67	1.619
6	Perceived Supervisor Commitment	3.032	2.667	2.33	1.603

Multiple Regression

Pearson product-moment correlation coefficients were used to assess the relationship between total shame-proneness, social support, self-compassion and the identified SISI factors. Preliminary analyses yielded no violations to the assumptions of linearity, normality and homoscedasticity associated with this test. Significant positive correlations were found between total self-compassion, social support and a healthy therapeutic alliance (see Table 9). A significant negative correlation was found between self-compassion and shame-proneness and the experience of shame in supervision. Overall, the correlations are in the anticipated directions. The identified factor scores that describe negative supervision experiences were found to be positively correlated with one another and negatively correlated with a healthy alliance. These correlations are consistent with current theoretical understanding regarding the relationship between shame-proneness, social support, self-compassion and the SISI factor scores.

For social support, significant negative correlations were found with shame-proneness, therapist shame, feeling exposed in supervision, feelings of inadequacy as a therapist and perceived supervisor commitment. Shame-proneness was found to be

significantly negatively correlated with self-compassion and social support, supporting Brown's (2004, 2006, 2007) conceptualization of building shame resilience through reaching out and speaking shame. Shame-proneness is also significantly positively correlated with therapist shame, exposure of self, feelings of inadequacy as a counselor and supervisor commitment. The first SISI factor, "Therapist Shame," was significantly negatively correlated with social support and self-compassion, and was found to be significantly positively correlated with shame-proneness and SISI factors of therapist shame, exposure of self, inadequacy as a counselor, self-disclosure in supervision and perceived supervisor commitment.

Table 9
Correlation Matrix Among Self-Compassion, Social Support, Shame Proneness and SISI Factors

	Self Compassion	Social Support	Shame Proneness	SISI 1	SISI 2	SISI 3	SISI 4	SISI 5	SISI 6
Self Compassion	r = 1	r = .404** p <.001	r =-.433** p<.001	r= -.240* p=.043	r = -.191 p=.108	r=.244* p=.039	r = -.080 p=.503	r = -.119 p=.321	r = -.117 p=.326
Social Supp-ort	r= .404** p<.001	r = 1	r=-.344** p=.003	r= -.270* p=.022	r=-.328** p=.005	r =-.026 p=.829	r = -.297* p=.011	r = -.098 p=.415	r = -.287* p=.014
Shame Prone-ness	r= -.433** p<.001	r= -.344** p=.003	r = 1	r=.428** p<.001	r=.435** p<.001	r=.048 p=.686	r=.435** p<.001	r= .213 p=.072	r= .302** p=.010
SISI 1	r= -.240* p=.043	r= -.270* p=.022	r=.428** p<.001	r = 1	r= .740** p<.01	r= -.098 p = .411	r= .708** p<.001	r= .442** p<.001	r=.524** p<.001

		Self Compassion	Social Support	Shame Proneness	SISI 1	SISI 2	SISI 3	SISI 4	SISI 5
SISI 2	r= -.191 p= .108	r=-.328** p=.005	r=.435** p<.001	r=.740** p<.001	r = 1	r= -.161 p=.176	r=.798** p<.001	r=.560** p<.001	r=.557** p<.001
SISI 3	r=.244* p=.039	r= -.026 p=.829	r=.048 p=.686	r= -.098 p=.411	r= -.161 p=.176	r = 1	r= -.158 p=.184	r= -.256* p=.030	r= -.072 p=.549
SISI 4	r= -.080 p=.503	r= -.297* p=.011	r=.435** p<.001	r=.708** p<.001	r=.798** p<.001	r= -.158 p=.184	r = 1	r=.622** p<.001	r=.527** p<.001
SISI 5	r= -.119 p=.321	r= -.098 p=.415	r=.213 p=.072	r=.442** p<.001	r=.560** p<.001	r= -.256* p=.030	r=.622** p<.001	r = 1	r=.233* p=.048
SISI 6	r= -.117 p=.326	r= -.287* p=.014	r=.302** p=.010	r=.524** p<.001	r=.557** p<.001	r= -.072 p=.549	r=.527** p<.001	r=.233* p=.048	r = 1

The second SISI factor, "Exposure of Self," was found to be significantly negatively associated with social support and significantly positively correlated with shame-proneness and several factor scores from the SISI (therapist shame, inadequacy as a counselor, self-disclosure and supervisor commitment). This finding fits with previous research regarding the impact of exposure on the shame experience, including increased feelings of inadequacy and reduced self-disclosure and perceived supervisor commitment. Furthermore, the feeling of being exposed is consistent with the experience of shame, as this is a commonly described occurrence. The third SISI factor, "Healthy

Alliance," was found to be positively correlated with self-compassion, suggesting that a positive supervisory relationship is associated with reduced negative self-talk and is associated with greater supervisee disclosure in supervision.

The fourth SISI factor, entitled "Inadequacy as a Counselor" was significantly negatively correlated with social support and significantly positively correlated with shame-proneness and SISI factor scales of therapist shame, exposure of self, self-disclosure and supervisor commitment. This fits with previous literature, as feelings of inadequacy and failure are common occurrences within the shame experience (Hahn, 2001; Brown, 2004, 2006; Tangney & Dearing, 2002). The fifth factor, "Self-Disclosure," was significantly positively correlated with SISI factors of therapist shame, exposure of self, inadequacy as a counselor and supervisor commitment. Self-Disclosure was also significantly negatively correlated with a healthy alliance. These findings are consistent with Yourman's (2003) findings regarding the impact of shame on disclosure in the supervisory relationship, as supervisees who are experiencing shame are less likely to disclose issues in their clinical work or issues related to supervision. The final SISI factor, "Supervisor Commitment" was significantly positively correlated with shame proneness, therapist shame, exposure of self, inadequacy as a counselor and self-disclosure suggesting that perceived low supervisor commitment was associated with increased shame and feelings of exposure and inadequacy. It was significantly negatively correlated with social support.

A multiple regression analysis was calculated in order to assess for the predictive relationship among the variables of shame-proneness (as measured by the TOSCA), gender, race, theoretical orientation, self-compassion, and social support in relation to

Therapist Shame (Factor 1, SISI). A Breusch-Pagan test for Heteroskedasticity was calculated to assess for the assumption of homoscedasticity, which requires a linear relationship between the independent and dependent variables. The test was found to be significant (Chi Square = 7.252, df = 1, p=.007) suggesting that the relationship is not truly linear. Cubic and quadratic models were calculated but did not impact the heteroskedasticity of the model, thus the linear model with robust standard errors is presented (Tabachnick & Fidell, 2007). Figure 1 shows the theoretical regression and mediation model.

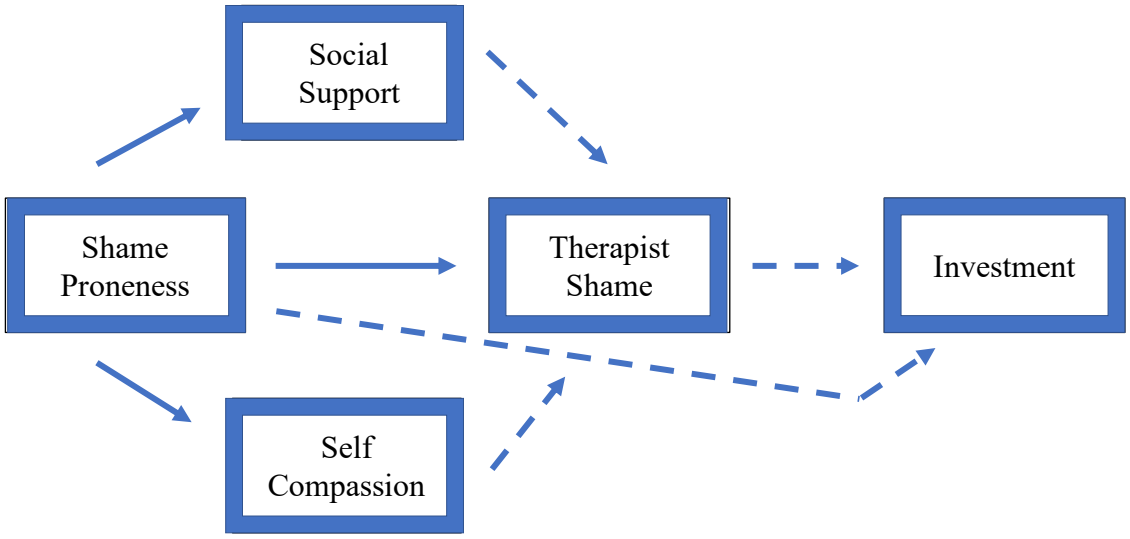

Figure 1. Theoretical model for predictors of shame in supervision.

A significant regression equation was found (F(9, 60) = 2.949, p=.006) and accounted for 30.7% of the variance in Therapist Shame scores (R^2=.307). Shame-proneness was found to be a unique predictor of therapist shame in supervision (p=.005) with an effect size of .119. Table 10 shows the predictive value of each of the independent variables along with the associated significance and effect size estimates.

Table 10
Parameter Estimates With Robust Standard Errors Predicting Therapist Shame

Parameter	B	t	Significance	Effect Size
Shame-Proneness	.076	2.196	.005*	.119
Self-Compassion	-.122	-.342	.734	.002
Gender	-.500	-.1242	.219	.024
Theoretical Orientation (Symptom-Based to Insight)	.625	1.500	.139	.034
Race/Ethnicity	-.327	-.548	.586	.005

Participants self-reported theoretical orientations were coded into four categories: insight-based, symptom-based, other or unknown/undecided. Hemlick (1997) found significantly higher rates of shame in supervision among participants identifying as psychodynamic as compared to cognitive-behavioral. This research found non-significant differences between theoretical orientation, suggesting that orientation did not significantly account for variance in the experience of shame in supervision. While those identifying as insight-oriented reported greater shame than symptom-based treatment providers, the difference was not significant. A gender analysis was also completed in the regression to assess for gender differences in the experience of shame in supervision. Nonsignificant results were found suggesting that for this sample, men and women did not report significantly different shame experiences.

Hemlick (1997) found a significant positive correlation between investment and the experience of shame in supervision, suggesting that greater levels of investment were associated with increased feelings of shame. This research found contrasting results, as investment did not have a significant impact on the reporting of shame in supervision.

Self-reported investment was not significantly impacted by the experience of shame in supervision (i.e., Therapist Shame) or shame-proneness.

A mediation analysis was conducted to assess for the predictive relationship between therapist shame on the experience of shame in supervision (therapist shame) and to explore the differential impact of social support and self-compassion on the predictive relationship between shame proneness and therapist shame. Table 11 displays the results of the mediation analysis. Shame-proneness significantly predicts social support (CR=-3.408, p=.002), self-compassion (CR=-3.992, p<.001) and the experience of shame in supervision (CR=2.974, p=.0003). Self-compassion and social support did not significantly mediate the relationship between shame-proneness and therapist shame.

Table 11
Mediation Analysis: Variables, Estimate, Standard Error, Critical Ratio and Significance

Predictive Variables	Estimate	SE	CR	Significance
Shame Proneness → Social Support	-.058	.019	-3.408	.002
Shame Proneness → Self-Compassion	-.034	.009	-3.992	.000
Shame Proneness → Therapist Shame	.082	.028	2.974	.003
Shame Proneness → Investment	.032	.026	1.226	.220
Social Support → Therapist Shame	-.173	.148	-1.169	.242
Self-Compassion → Therapist Shame	-.070	.327	-.215	.830
Therapist Shame → Investment	-.030	.119	-.257	.797

Qualitative Analyses

Participants completed four open-ended questions to provide additional context and understanding to the experience of shame in supervision. First, participants were asked to describe times in which they felt incompetent in supervision (see Figure 2). Participants identified feedback as the primary reason for feelings of incompetency in supervision. Other identified causes for feelings of incompetency in supervision included difficulty articulating a conceptualization, feeling unprepared with a new skill/intervention, and disagreement with a supervisor.

Theme	Examples	N (%)
Difficulty articulating conceptualization	"At times, I missed an important piece of a conceptualization." "I was told my interventions did not have any theoretical backing and that I needed to be more intentional as to why I was using the intervention."	5 (7.576)
Critical feedback about emotionality and/or clinical skills.	"Early in my training, I mishandled a suicide risk assessment and my supervisor critiqued me for being "too emotional" about my patient's suicidal ideation." "My supervisor told me in her opinion and when compared to other interns at our site, I was not competent at basic counseling skills while other interns were working on advanced skills."	30 (47.619)
Disagreement with supervisor	"I felt I had arrived at an incredible insight regarding a client's problems and my supervisor did not agree in the slightest."	4 (6.349)
Made a mistake	"After leaving identifiable information for a client with a treatment alias in an area viewable by other staff"	2 (3.175)

Theme	Examples	N (%)
Feeling unprepared with new skill	"A previous supervisor asked me to work in a style that is not natural to me and to make interventions that I did not feel comfortable with. I still tried these interventions because I felt I had to and they fell flat, likely because I was not doing it well, but also because it seemed to me that was not what the client needed. It made me feel incompetent because I was failing both my supervisor and my client." "I was trying to learn how to conduct CBT and had asked for assistance from my supervisor who laughed at me for spending effort trying to learn it and subsequently told me to "just act like you're stupid and that you don't understand what they're saying so that they repeat themselves and work it out on their own." I felt very frustrated and incompetent because she laughed at me for trying to learn and apply something."	19 (30.159)
Other (different priorities, roleplay, over-instruction from supervisor)	"Showing up for supervision and my supervisor didn't welcome me into his office. I waited and the door, he didn't look up from his computer, and dismissed me abruptly." "I felt incompetent when a supervisor I had gave me no space to make my own decisions about my work with my clients. She gave me step by step and sometimes sentence by sentence it felt degrading."	4 (6.349)
None/No Experience	"I don't think I ever really have; my supervisors have always been great about making criticisms productive and constructive rather than demeaning."	2 (3.175)

Figure 2. Describe a time you felt incompetent in supervision. Total Responses: 63

Participants were asked to describe a time in which they felt they had disappointed their supervisor and identified critical feedback and unclear expectations as the primary cause (26.563% of responses). Participants also identified difficulty

implementing feedback and a poor supervisory alliance as other themes for times in which they identified feeling they had disappointed their supervisor. Figure 3 provides a codebook for the themes identified from the participant answers, as well as relevant examples and percentages of responses.

Theme	Examples	N (%)
Broke chain of commanded, Avoided talking with supervisor	"I had a client disclose child abuse and my supervisor told me not to report it. Because I am a mandated reporter, I decided to call Childline anyway and reported it. I had to tell her after I reported it and even though she shrugged it off, it still felt like she thought I was stupid for doing it."	3 (4.688)
Critical feedback, Unclear expectations	"I told my supervisor about a personal hurt that shaped my experience as a clinician and he told me that I talk about it too much and to get over it." "My supervisor was not clear with her expectations and my efforts to clarify were not successful. They were consistently changing and it was difficult to know where I stood. She was often late to supervision times and I felt as though I was bothering her. In addition, her expectations of me were much higher than her own standards for herself…"	17 (26.563)
Mistake, Failure to live up to ideal	"I once lost a client's file, (I'm pretty sure it was accidentally put in the shredder). I felt bad about it, and while my supervisor was very kind, she seemed disappointed as well."	7 (10.938)
Other	"I began to cry in supervision about a client's experience with racism and police brutality and my supervisor started to laugh at me."	5(7.813)

Theme	Examples	N (%)
Poor Supervisory Alliance; Supervisor appears late, distracted, uninvested	“On my last day at prac[ticum] he did not show up at all, did not tell me he would not be there, and did not thank me for any of my time or efforts during the year.”	12(18.750)
Difficulty with implementing feedback, new skill, timeliness	“My supervisor explained how he used the antecedents, beliefs, and consequences in therapy multiple times over the course of a year, but I rarely found it helpful when I worked with patients. This persisted over the course of a year. I could not figure out why it was so difficult for me to use this intervention when my supervisor described it as a "go-to" intervention with all his patients.”	9(14.063)
None		11 (17.189)

Figure 3. Describe a time you felt incompetent in supervision. Total Responses: 64

Participants were asked to complete an open-ended question in which they described a time that they have felt shame. This researcher identified themes of interpersonal relationships, work/school situations, and feelings of exposure as triggers for shame (see Figure 4). Work and school related experiences were the most commonly reported with 36.923% (N=24) of the sample identifying shaming experiences in the context of work/school.

Theme	Examples	N (%)
Work/School	"When I was told it was my fault my client wasn't getting better." "I did worse than everyone else in the class on an exam, I immediately thought that the teacher was very disappointed in me and assumed I was not a good enough student for the program. I also felt that maybe I was not a good enough student to be in the program."	24 (36.923)
Relationships & Family	"I felt shame when I lied to a romantic partner and when I was unfaithful in a relationship." "I felt shame as a child about my alcoholic father."	18 (27.692)
Feeling exposed/Fear of exposure	"The first time I came out as gay I could feel the flush of heat on my face and it was hard to make eye contact." "When going through personal difficulties and trying to keep them to myself/hide them from others."	7 (10.770)
None		4 (6.154)
Other	"When told directly that I had made a mistake and needed to correct it immediately." "Being hungover."	7 (10.769)

Figure 4. Describe a time you felt shame. Total Response: 65

Participants answered a question regarding their experiences of shame in supervision. Overall, critical feedback about clinical skills, emotionality and supervisees' personal lives accounted for 28 of the 62 responses (45.162%). This suggests that a high portion of shaming experiences are related to the feedback process. 14 participants (22.581%) reported no experiences of shame during their most negative supervision

experience. Figure 5 provides a codebook for the themes identified from the participant answers, as well as relevant examples and percentages of responses.

Theme	Examples	N (%)
Critical feedback about clinical work/skills	"…my supervisor seemed to be stockpiling mistakes in front of me, some of which I agreed with, and some of which I did not, with a motive I could only guess: to convince me he was in the right in not endorsing me? to convince me I made more mistakes than I thought? to prepare me for his negative evaluations?" "My supervisor told me that my personal counseling style was not appropriate for working with the majority of our clients and was not helpful to them."	20 (32.258)
Critical feedback about emotions/personal life	"I received feedback from a supervisor that I was coming across to the staff as slightly arrogant, even though in many ways I really was feeling inadequate. This was extremely difficult to hear, and initially made it very difficult to come into work each day. It left me again feeling worthless and hopeless, but I was eventually able to use it to help motivate some personal growth."	8 (12.903)
Made a mistake	"I made a mistake and immediately came to my supervisor about it. My supervisor recognized my mistake and made a point of correcting me for it. But also in the process and thereafter placed excess responsibility and scrutiny on me that failed to take into account my feelings and need of instruction at this level in my training. It felt like what could have been a really valuable training opportunity turned into an opportunity to punish, as well. I felt ashamed, singled-out, and unsupported. I would have been able to incorporate the feedback and grow without having had such a negative experience tied to it."	7 (11.290)

Theme	Examples	N (%)
Failure to implement feedback, feeling unsure in clinical work	"I felt shame in supervision when I failed to do something that my supervisor and I had talked about the week before. We decided something I would do during the next session and I forgot to do it. My supervisor asked me why I didn't do it and I felt very shameful for forgetting, because I felt stupid."	5 (8.064)
Disclosure/feeling exposed	"A close family member was experiencing some mental health concerns, and I was overwhelmed by the situation. I had supervision, and I began to cry in front of my supervisor. I felt shame because I did not have a close relationship with this supervisor and I did not want to share details of my personal life with that supervisor."	3 (4.839)
None/No experience		14 (22.581)
Other	"Talking about a patient who I felt had an erotic transference towards me with a male supervisor."	5 (8.064)

Figure 5. Describe a time you felt shame in supervision. Total Responses: 62

CHAPTER VII

DISCUSSION

Findings and Implications

Shame is a ubiquitous self-conscious emotion and has been described as a failure to meet one's ideals, or the exposure of the "unwanted" self to other people (Brown, 2007; Ferguson, Eyre, & Ashbaker, 2000; Teroni & Deonna, 2008). Shame can be experienced in a variety of diverse situations and the predisposition to shame has been found to be associated with poorer mental health outcomes, lower self-esteem and feelings of inferiority (Benetti-McQuoid & Bursik, 2005). Shame-proneness has also been associated with reduced quality of interpersonal relationships, reduced other-oriented empathy, and reduced ability to engage in perspective taking and conflict resolution (Tangney, 1995; Covert, Tangney, Maddux & Heleno, 2003). Ferguson & Stegge (1995) identified a predisposition to shame starting in childhood based on one's upbringing and attachment. When disciplining children's behavior, repeated, negative global statements about the child as inadequate, as opposed to the child's behaviors as a problem, has been associated with greater shame-proneness, poor self-image and negative emotions.

Shame has been increasingly studied in the context of gender, and while men and women are theorized to experience shame in a similar way, they differ in triggers based on norms, expectations and messages about masculinity and femininity (Brown, Hernandez & Villarreal, 2011). For women, Brown (2004, 2007) described the shaming experience as a layered web of expectations for who, how and what women should be. Men, in contrast, are theorized to experience shame as being confined into a small box in

which men must meet expectations of toughness, invulnerability and strength. Tangney and Dearing (2002) found that women experience greater shame-proneness across the lifespan as compared to men, and that men more typically react with externalizing behaviors (i.e., other-oriented blame, outward aggression). While gender differences have been repeatedly found in the research related to shame-proneness, the current research does not support this finding. The current research found men and women to be endorsing average levels of shame, guilt and blame-proneness based on norm data previously established by Tangney and colleagues (2000). While the current research did not find gender differences related to shame-proneness, further research should continue to explore the relationship between gender and shame.

Although shame has been theorized to occur within the supervisory relationship, it has received limited attention in research and training programs (Tangney & Dearing, 2011). Furthermore, research examining the potential for shame in the supervision relationship has found limited or unexpectedly low rates of self-reported shame in supervision (Hemlick, 1997; Yourman, 2003). Hahn (2001) describes the painful nature of the experience of shame in supervision, as the trainee wants to be liked and viewed as competent by their supervisor, and thus to admit faults, mistakes, and anxieties can be highly shame-inducing. Four contributing factors to the experience of shame in supervision include the learning regression (i.e., relearning skills to benefit therapy), the supervisor's management style, the patient population, and transference/countertransference reactions (Alonso & Rutan, 1988).

The purpose of this research was to further understand the experience of shame in the context of supervision and to better understand the frequency of negative supervision

experiences that can be characterized as shame-inducing. Brown (2007, 2009) theorized that social support and self-compassion serve as the "antidote" to shame, as shaming experiences often result in increased isolation. This researcher examined the rate of shame-proneness among trainees in clinical or counseling psychology programs, as well as self-reported self-compassion, social support and shaming experiences in the context of supervision. Through quantitative and qualitative analysis of the experience of shame in supervision, this researcher aimed to better understand the context in which shame occurs, as well as potential gender differences in the frequency and experience of shame.

Shame in Supervision: Role of Feedback

The results of this research suggest moderate rates of shame occurring in the context of supervision. Previous research studying the occurrence of shame in supervision examined trainees most recent supervision experiences and failed to find significant reports of shame in supervision (Hemlick, 1997). The current research examined trainees most negative supervision experiences and found moderate levels of shame, suggesting that negative supervision experiences are at times shame-inducing, and thus can greatly impact the supervisory relationship, supervisee disclosure, and supervisee growth. While conceptually, shame has been theorized to have a high occurrence in the context of supervision, this research found moderate rates (average of 3.8 out of 7 on a Likert scale). Qualitative data was also collected in which participants described shaming experiences in supervision. Of the 62 responses, 48 participants (77.419%) described an experience in which they felt shame during a supervision session. Common themes included critical feedback from a supervisor, making a mistake, and failure to implement provided feedback in one's clinical work. Critical feedback was the

most frequently cited example of shame in supervision (45.162% of responses), with participants describing critical feedback regarding their clinical skills or overall emotionality/personal life.

These qualitative data provide needed context for incidences in which shame has been experienced in supervision. Alonso & Rutan (1988) identified potential contributing factors to the experience of shame in supervision (including supervisor management style, countertransference/transference reactions and the learning regression associated with learning therapeutic skills), which was similarly described in the qualitative responses. The management style of a supervisor includes their ability to balance both constructive and positive feedback, as well as the balance of creating a supportive environment while also serving as a gatekeeper and evaluator. A failure of balanced feedback or an overly critical supervision environment was frequently cited as descriptions for shame in supervision experiences. The learning regression describes the process of trainees relearning cognitive and emotional processes in order to be more successful in the therapeutic relationship, and failure to implement this feedback or to relearn these processes resulted in greater feelings of disappointment, failure and shame among trainees. The qualitative data also provided information regarding countertransference reactions, as participants identified times in which they attempted to discuss a reaction with their supervisor and felt that their supervisors' responses were overly shaming and/or critical.

Little research exists regarding the impact of feedback provided in supervision on trainee confidence, growth and experience of shame. Hoffman et al. (2005) defined feedback in the context of supervision as the communication from the supervisor to the

supervisee regarding aspects of skills, behavior, attitudes and/or appearance that may have an impact on their clinical or the supervisory relationship. In a qualitative research study investigating supervisor experiences in the context of providing feedback, supervisors identified feedback about clinical work to be the easiest to provide, as it was often clear, appropriate for supervision, and situation-specific. Feedback that was identified as more difficult to provide to supervisees was feedback that felt subjective or was related to non-clinical issues (i.e., personal life, emotional reactions) and that this feedback would sometimes go unsaid due to supervisor concerns about the subjective nature of the feedback or potential supervisee reactions. Additionally, supervisors identified supervisee non-openness to be a barrier to providing feedback, as well as a perceived poor supervisory relationship (Hoffman et al., 2005). While this research increases important contextual understanding of barriers for supervisors providing feedback, it did not address the importance of framing feedback in a constructive manner or address ways for supervisors to increase feelings of safety in the relationship in order to help reduce the likelihood of shame reactions.

Tangney and Dearing (2002) discussed parenting behaviors that can help to reduce shame in children after they have engaged in a maladaptive behavior and provides a useful framework for the feedback process in the supervision relationship. The authors identified six components to providing constructive feedback that emphasizes guilt and reparation, as opposed to feelings of shame. First, emphasis on the negative behavior, rather than a negative judgement about the person is important. Second, the consequences of the behavior are emphasized in order to increase understanding and enhance other-oriented empathy. Third, an emphasis on reparative action can help to empower

correction of the behavior, as opposed to increased self-judgment and vulnerability related to the wrong-doing. Fourth, avoidance of public humiliation, as this can result in increased susceptibility for a shame reaction. Fifth, avoid teasing or sarcastic humor, as this can also increase potential for shame. The final recommendation is that discipline should occur within a caring and warm context, with a mix of positive and constructive feedback (Tangney & Dearing, 2002). These recommendations are useful in the context of supervision, as it provides supervisees with increased understanding of the behavior, emotion, or attitude that is problematic, as well as emphasizes how they can repair with their clients and prevent future occurrences of the same incident. Furthermore, the emphasis on a warm and safe environment is needed in supervision so that supervisees feel more comfortable expressing and processing their shame reactions.

Shame in Supervision: Factor Scores

This analysis examined the Shame in Supervision Instrument (SISI; Hemlick, 1997) and based on participants responses regarding their most negative supervision experience, this researcher identified six factor scores including therapist shame, exposure of self, healthy alliance, inadequacy as a counselor, self-disclosure and perceived supervisor commitment. These factors have similar elements to factors identified by Hemlick (1997) including significant overlap on the first factor, labeled as therapist shame in the current research (previously identified as inadequacy as a counselor by Hemlick, 1997). The healthy alliance factor was not identified in Hemlick's (1997) research and provides useful framework for times in which supervisees have felt safe to identify growth areas in a non-shaming and non-critical environment. Despite the differences among the factors, the current research yields results that fit with the current

understanding of shame, including the increased feelings of exposure and inadequacy in one's clinical work and personal life, as well as increased concealment from the supervisor and perceptions of reduced supervisor commitment and investment when shame is experienced.

Shame in Supervision: Personal Experience

During my training experience, I had a negative supervisory relationship in which I frequently felt feelings of shame, inadequacy and frustration. My experience fits within the factors identified in the current study, as I experienced feelings of therapist shame, in which I felt incompetent, lacking in skills, and believed that I was behind developmentally when compared to my peers. During this training year, I often felt unsure about what to share in the supervision hour, as I wanted to protect myself from further feelings of inadequacy while also wanting to grow and receive feedback on how to improve my clinical skills. Furthermore, I often felt exposed and questioned my reactions to clients, as well as my ability to navigate difficult client dynamics in the therapy room. After supervision, I would often go into my office and shut the door, as I would need time to process the feedback I was given, as well as to protect myself when I was feeling exposed and vulnerable. Due to my own high standards and self-criticism, and the general nature of the feedback that was provided, I had difficulty limiting the feedback to specific behaviors and instead often felt as though I was being negatively evaluated in my overall abilities as a counselor.

During this relationship, I would limit what I would share with my supervisor. Most notably, I would avoid discussion of our relationship or my reactions to the feedback, as that felt particularly unsafe. I would often wonder about my supervisor's

investment in the relationship and was fearful that she would eventually withdraw or give up on helping me to improve my clinical skills. In this supervision relationship, I did not experience the attributes associated with a healthy alliance, as I often left supervision feeling worse about myself as a counselor and I would often dread attending supervision. After reflecting on this experience, I realized that much of the time, my shame would be heightened during evaluations or times in which I was provided with feedback, as it was often generalized and not specific, and it was often feedback that contradicted feedback I had previously been given. I would often leave supervision feeling confused and vulnerable and unsure of how to ask for more specific feedback or how to repair my relationship with my supervisor. For me, sharing my experience with my advisor, peers in my program and other supervisors has helped me to label this experience as shame-inducing and thus has helped to reduce the intensity of my shame reaction. It has also helped me to separate myself from my shame reaction and thus, I'm able to take a more objective perspective on my experience and the feedback I was given. Looking back, my experience is consistent with much of the shame literature in the context of supervision, and similarly to Brown's (2004, 2007, 2008) theory, receiving social support in relation to the shame experience was the most helpful way to reduce the power of my reaction.

Previous Research: Significant Findings

Gender differences have been found to impact the ways in which people are susceptible to and experience shame (Brown, 2008; Tangney & Dearing, 2002). Previous research has found women to have greater proneness to shame and guilt as compared to men, who have been found to engage in more other-oriented externalizing behaviors following negative experiences (Efthim, Kenny & Mahalik, 2001; Benetti-McQuoid &

Bursik, 2005; Brown, 2007). This finding was not supported in the current research, which found no gender differences related to shame-proneness or the experience of shame in supervision. In the regression model, gender did not significantly account for variability in overall therapist shame. This finding may in part be due to the small overall sample size, as well as the predominantly female participation in the research. Overall, men and women in the sample reported average rates of shame-proneness, as measured by the TOSCA, and moderate levels of shame in supervision. Although gender was not found to significantly impact the experience of shame in this research, future research should continue to investigate potential gender differences in the experience of shame as well as in the reactions to shame.

Hemlick (1997) found supervisee investment to be significantly correlated with the experience of shame in supervision, such that supervisees who reported shame also reported increased rates of investment, as compared to those who did not experience shame. Furthermore, Hemlick (1997) identified gender differences related to self-reported investment, with women reporting significantly greater investment as compared to men. The current research did not find investment to significantly impact the experience of shame in supervision and overall reported investment was high. Furthermore, no gender differences were found in relation to self-reported investment. While gender was not found to impact investment, the overall sample size and the predominantly female participation in the sample may have some impact on these findings, and thus future research should continue to explore potential gender differences in supervision investment and shame.

Another identified factor that impacted previous research was supervisee theoretical orientation, with more insight-based orientations having greater association with shame experiences (Hemlick, 1997). The current research did not find significant differences in shame in supervision among those who identified in insight-oriented or symptom-based orientations. Because participants were asked to self-describe their theoretical orientation that was later coded by this researcher into four categories (symptom-based, insight-oriented, not disclosed/unknown, or other), this may have reduced ability to capture the link previously found to be associated with increased shame. Furthermore, the limited sample size may have also impacted the power needed to capture this potential relationship between theoretical orientation and shame.

Theoretical Understanding of Shame

This research is based on Brown's (2004, 2006, 2008) conceptual model regarding the gendered experience of shame, as well as her theorized discussion of ways to reduce shame, including speaking shame and accessing social support, and increasing one's own self-compassion and acceptance of imperfection. A multiple regression was used to assess for the model examining the effect of shame-proneness on the experience of shame in supervision, as well as the potential mediators of social support and self-compassion. The findings of this research support Brown's theory regarding the impact of shame-proneness on social support and self-compassion, as higher rates of shame-proneness were significantly associated with reduced social support and reduced self-compassion. This supports Brown's conceptualization of shame, as shame can serve to isolate people from one another and make it very difficult to find compassion for ourselves, or to look for compassion and support from others (Brown, 2006, 2008).

The regression also yielded a significant relationship between shame-proneness and the experience of shame in supervision, supporting Brown's theory (2006, 2008) that shame-proneness results in increased susceptibility and actual experience of shame. While shame-proneness has been previously found to be associated with poorer mental health outcomes and lower self-esteem (Benetti-McQuoid & Bursik, 2005), this finding suggests that shame-proneness is also associated with increased risk of actual shame experiences. However, the current research yielded nonsignificant mediation effects, such that social support and self-compassion did not significantly impact the relationship between shame-proneness and the experience of shame in supervision. This research is not consistent with current understanding about building shame resilience, as increased social support and self-compassion did not affect the relationship between shame-proneness and shame in supervision. Brown (2004, 2006, 2008) conceptualized the sharing of shaming experiences to reduce the overall impact of shame and this would benefit from further exploration in order to explore the impact of shame discussions on overall intensity shame experiences, as well as to determine if building shame resilience reduces the frequency of shame reactions.

Implications for Training

This current research suggests that shame in supervision is occurring for the majority of graduate student clinicians pursuing degrees in clinical or counseling psychology, which fits with previous theories regarding the prevalence of shame in supervision. Due to the difficulty with recognizing shame reactions (Brown, 2007; Morrison, 2011; Herman, 2011) and the frequent avoidance of shame by supervisees and supervisors (Tangney & Dearing, 2002; Yourman, 2003), shame reactions often go

undiscussed and unprocessed. Furthermore, shame responses in supervision, as identified by Hahn (2001), may include withdrawal, active avoidance of topics perceived as dangerous, attack of others (appearing dismissive or challenging of feedback), and attack of self (the supervisee appears overly critical and focuses on mistakes and negative feedback), which supervisors may mistakenly interpret as resistance or supervision-stopping behaviors.

Alonso and Rutan (1988) recommended supervision to occur in small groups, as group therapy was previously conceptualized to adequately address shame experiences. However, in the parenting literature, Tangney and Dearing (2002) recommend avoiding potential public humiliation when providing feedback, as it can increase the child's potential for shame. While group supervision may provide additional social support for a trainee to process their shaming experience, providing feedback in a public setting, such as in group supervision, may increase the potential for a shame experience. Supervisors should be considerate when providing feedback within a group supervision setting and be aware of the potential for increased shame. It is recommended that supervisors provide potential negative feedback to a supervisee privately, or provide the feedback generally, such that other trainees can benefit from the feedback.

Due to the power dynamic in supervision, supervisors must be knowledgeable regarding potential shame reactions in supervision and create a safe, empathic and open environment in which supervisees can speak shame. Additionally, supervisors must be skilled at identifying signs of shame reactions in order to help supervisees voice and label their experience as shame, as shame can be difficult to identify alone. Because supervisees are prone to experiencing shame in supervision, the supervisor must work

towards creating a nonjudgmental environment in which the supervisee feels increased comfort processing their shame. Hahn (2001) also recommended supervisor disclosure of previous mistakes and learning experiences in order to reduce supervisees feelings of isolation with their shame reaction. Furthermore, frequent positive feedback, as well as an active role in case management and conceptualization can help supervisees to have clearer understanding of supervisors' perception of them and can help to increase feelings of safety and connection in the supervisory relationship.

Limitations

A limitation of the current research is the limited sample size, which fell below the recommended sample for a factor analysis (Tabachnick & Fidell, 2007). Furthermore, a gender analysis was completed in order to better understand the previously found differences in gender experience and expression. However, due to the limited number of male participants, inadequate gender analysis was completed and the power was not sufficient to detect potential significant differences between men and women. The reduced sample size also limited analysis of the impact of theoretical orientation on potential shame, as the categories of theoretical orientations were insufficiently filled. Because graduate students in clinical and counseling psychology training programs are a unique population, future research should have greater sample size in order to better understand the experience of shame in supervision. Furthermore, due to the focus of this research on a population with unique skills and training requirements, the results are not generalizable to other populations.

While qualitative data were collected in order to better understand participants perceptions of their shaming experiences, as well as to obtain additional context and

sources of shame, the information provided by participants varied in terms of detail, context, and perceived severity of the event. While most participants identified an experience in supervision as shaming, this research does not capture the full extent of the shame process, as the potential impact of these shaming experiences on trainee growth, disclosure, and the supervisory alliance were not obtained.

Future Considerations

Below is a review of possible directions for future research, including further examination of the association between shame and perfectionism, as well as further understanding regarding the process of experiencing shame in the context of supervision.

Shame & Perfectionism

The current research explored the impact of shame-proneness on investment and experience of shame in supervision. Potential variables that impact shame-proneness and shame experiences that were explored included gender, theoretical orientation, social support and self-compassion. Future research in the field of shame in supervision would benefit from increased exploration of the role of perfection in the experience and susceptibility to shame. Perfection has been found to be associated with shame-proneness, fear of rejection or negative evaluation, and fear of failure (Elison & Partridge, 2012; Tangney, 2002). Brown (2010) discussed the relationship between perfectionism and shame, suggesting that perfection fuels shame, as it requires the perception of meeting unattainable standards. Perfectionism emphasizes the many expectations that society dictates for men and women, thus creating further opportunity to fall short and experience shame. Additionally, because perfection is based upon how one is perceived by others, Brown (2010) argues that perfection results in increased silence

related to shame experiences, creating greater interpersonal distance and feelings of isolation associated with shame.

Dayal, Weaver and Domene (2015) explored the experience of shame among counselor trainees with disordered eating patterns and identified perfection and the fear of negative evaluation as barriers to talking about their relationship with food and from asking for help from supervisors. The participants identified perfection as a method of maintaining secrecy related to their shame, as well as preserving the positive image they strived for in supervision. The "invalidation of perfection," in which participants identified the role of perfection in protecting their shame, was a central process in helping trainees to feel more authentic and shame resilient (Dayal, Weaver & Domene, 2015). Further understanding of the relationship between self-compassion and social support in relation to shame-proneness and shame experiences would help to further increase understanding about the complicated and dynamic shame process in supervision.

Understanding the Shame Process

This research examined the impact of shame-proneness on the experience of shame in supervision. Participants described times in which they experienced shame, feelings of inadequacy, and disappointment in the context of supervision, which provided increased context for the experience of shame. Future research would benefit from continued use of qualitative methods to better understand the dynamic process of shame in supervision. Qualitative interviews in which participants discuss previous shame experiences in supervision, including the trigger, resulting actions and feelings towards self and the supervisor, and the impact of the shame experience on the course and quality of the supervision relationship would provide useful information regarding the frequency,

intensity and impact of shame in the supervisory relationship. Future research should also examine the short and long-term impact of shame in supervision, as well as the impact of repeated shame experiences with the same supervisor, or across supervisors. Furthermore, research on the supervisor's understanding and experience of trainee shame would help to elicit potential barriers to the discussion of shame in supervision, as well as provide needed recommendations to increase shame identification and processing in supervision. Future research should also examine the potential for shame in both group and individual supervision experiences in order to better understand the impact of feedback shared publicly in the shame experience. The current study, along with previous research, argue for the inclusion of material and training associated with shame and shame-proneness in supervision courses. Additionally, licensed therapists, especially those providing supervision, would benefit from this training as research suggests that discussions related to shame go undiscussed in therapy and supervision (Hahn, 2001).

Building Shame Resilience

Two models of shame resilience are reviewed here as potential models for training.

Model 1

Brown (2009) developed a "Connections Curriculum," which aims to teach people about shame to assist in the development of shame resilience (Brown, Hernandez & Villarreal, 2011). The curriculum involves 12 sessions, with the first three focused on building connections within the group, psychoeducation about shame and guilt, and building a conceptual and gendered framework to understanding shame (Brown, 2009; Brown, Hernandez & Villarreal, 2011). Sessions four and five in the Connections

Curriculum are focused on defining shame resilience, defining empathy, and differentiating empathy from sympathy. During these sessions, participants discuss barriers to empathic responding, while also making connections from their own experiences to others' shaming experiences to increase insight in both shame and shame resilience. Session six further helps participants to recognize shame through the exploration and identification of physical symptoms involved in shaming reactions. The participants discuss the physical sensations as shaming cues that can help a person to recognize they are experiencing shame, and that shame involves a whole-body experience.

In the Connections Curriculum, session seven involves the exploration and identification of shaming triggers and vulnerabilities. This session emphasizes the identification of one's unwanted and ideal identities, and the subsequent feeling of shame when the unwanted identity is exposed and at risk of judgment by others. Session eight focuses on the identification of "shame screens," which is the reaction that people use to hide their shame from others, thus prompting introspection about their own methods of shame avoidance (Brown, 2009; Brown, Hernandez & Villarreal, 2011). The identification of a shame screen helps participants to identify their shame avoidance reactions, and then compare these methods to those of reaching out for connection and empathy. Session nine involves the practice of critical awareness, with a focus of reality checking, stepping back to understand the full picture, and examining the socio-cultural expectations that fuel shame. The final three sessions focus on empowering participants to reach out to others outside of the group, to speak their shame, and to practice empathy when met with shaming situations. Finally, this curriculum emphasizes the importance of

being authentic when faced with shame, as shame often results in the exposure of an unwanted identity. The practice of authenticity empowers people to accept themselves as they are, which is a powerful and integral aspect of building shame resilience (Brown, 2009; Brown, Hernandez & Villarreal, 2011). This curriculum would greatly benefit trainings associated with the provision of supervision, as it illustrates a process to aid supervisors and supervisees in their efforts to identify, express and process shame experiences.

Model 2

Van Vliet (2008) conducted qualitative interviews regarding participants shame experiences and shame resilience and identified shame as an assault on one's self-concept, one's interpersonal functioning and connection, and resulting avoidance/withdrawal behaviors. Shame resilience was theorized as a "rebuilding of the self" in which people empower a positive self-concept, increase connections and increase feelings of power and control. This rebuilding occurs through a five-step process including connecting, refocusing, accepting, understanding and resisting. Van Vliet (2008) defines connection as finding allies to discuss shame, as well as finding ways to feel more connected generally to a larger community in order to increase self-understanding and to distract from shame. Connection also included repairing relationships as needed and increasing connection to a higher power. Refocusing was defined as a shift of focus towards empowerment and nonjudgment through the identification of values, positive behaviors and goals that can increase one's feeling of self-worth (Van Vliet, 2008). Acceptance was defined as moving away from avoidance in order to face the shaming experience through the process of identifying and expressing

resulting emotions (Van Vliet, 2008). Understanding is the process of rebuilding through making sense of the shame experience and separating oneself from the shame in order to increase insight and make meaning of the event. Finally, resisting is the process of identifying attitudes and behaviors that can reduce vulnerability to future shaming experiences. The process of resisting occurs through assertion and challenging of others. Van Vliet (2008) argues that this process allows for people to reduce their distress in relation to shame, and to increase feelings of understanding and shame resilience.

Building Shame Resilience in Supervision

In supervision, supervisors can aid in the process of building shame resilience by helping supervisees to identify, understand and voice their shame (Brown, Hernandez & Villarreal, 2011; Van Vliet, 2008). Furthermore, supervisors must create a warm and supportive environment such that supervisees feel an increased sense of safety when exploring triggers for shame. Due to the moderate levels of shame identified in supervision in the current research, trainees would likely benefit from increased shame protection and resilience through the processing of their shame. The ability to understand their ideal identity as a therapist can help to increase clarity when supervisees feel inadequate or exposed, and thus at increased risk for shame. Supervisors must also be aware of potential signs of shame, as well as ways to increase feelings of shame resiliency among supervisees in order to empower them to voice and process their shame. Future research should continue to explore the shame in supervision process, as well as to include further study of the impact of shame resilience on current and future shame experiences. Furthermore, shame resilience should be studied in order to find the most effective methods to increase resilience among graduate student clinicians, as well as to

provide supervisors with increased tools to aid in the identification and processing of shame.

This research has found moderate levels of shame occurring in the context of supervision. Furthermore, shame-proneness has been found to significantly predict one's self-compassion and perception of social support, as well as one's actual experience of shame. This suggests that repeated shame experiences can impact one's ability to rely on others for emotional support, as well as reduces one's feelings of understanding and care towards oneself. The identification of an experience as shaming and speaking shame has been theorized to be the antidote to shame, as it reduces shame's isolating power (Brown, 2004, 2006, 2010). During my experience, identifying people that I believed were safe to hear my story helped me to better understand my reaction, as well as help me to feel less isolated and inadequate. In the process of building shame resilience in the context of supervision, it is important for supervisors to take an active role, as they hold power in the supervisory relationship. Creating a supportive environment in which the trainee feels safe to be vulnerable and discuss potential mistakes is highly important in order to provide best client care, as well as to help trainees to identify potential shame reactions. For me, if I had not had the support of close friends and colleagues, as well as increased knowledge about shame, I do not know if I would have been able to label my experience as shame. The act of labeling shame can help to reduce the power of the shaming event and thus provide increased feelings of confidence and self-efficacy regarding finding next steps (Brown, 2004, 2006). Had I been unable to identify my experience as shaming, I may have failed to examine the feedback within context, reach out for additional support and feedback from trusted supervisors, and identify ways to move forward.

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Appendix A

Informed Consent Form

You are invited to participate in this research study. This information is provided to help you make an informed decision about whether to take part in this study. You are asked to participate in the current study because you are a graduate student in a clinical or counseling psychology program, and have received supervision within the last year. To participate, you must be at least 18 years of age. The current study will utilize Qualtrix surveys to distribute the study materials to eligible participants.

The purpose of this study is to learn more about negative supervision experiences. Specifically, this research will examine the differences in how men and women react to negative supervision, as well as explore specific examples of negative supervision experiences.

The research is being conducted by this researcher, who is a psychology graduate student attending Indiana University of Pennsylvania. The information obtained from the surveys will be used for my dissertation and may be presented at professional and educational conferences and meetings. The information presented will be completely anonymous, therefore, you will not be asked to provide identifying information (e.g., your name).

In the decision to participate, you are free to leave the study at any time prior to submitting the survey if you feel uncomfortable about the content of the material. Once the survey is submitted, you will not be able to withdraw due to the anonymity of the collected data. Demographic information will be requested in the survey with questions regarding gender, year in program, theoretical orientation, and supervisor's theoretical orientation. You will be asked to read vignettes, and report responses that are most likely true for you. Additionally, you will be asked to rate responses to vignettes regarding the likelihood that you would engage in the behavior. You will also be asked about the degree to which you feel stress in different situations.

Voluntariness and Confidentiality

Your participation in this study is **voluntary**. You are free to decide whether you wish to take part in the current study. If you decide to participate, you can change your mind later and exit the study at any time prior to submitting the survey. If you decide to leave the study before submitting the survey, your answers will be deleted. If you choose to participate, all the information and recorded answers on the surveys will be confidential. Your name will not be listed or computed at any time on the surveys, to ensure anonymity. Once I finish looking at the surveys and all the data is properly collected, I will report percentages and other statistics that demonstrate what most people did.

Risks/ Benefits and Compensation:
This research is of minimal risk to you. Individuals who participate in the study may receive some personal benefits from their participation, as the questions posed may get them to think about their personal reactions to hypothetical life events. If considering the vignettes brings up feelings of distress, here are resources in the area:

IUP Counseling Center	724-357-2621
Armstrong/Indiana Crisis Hotline	724-465-2605

This research is being done by Melissa Meulman under the direction of Dr. Maureen McHugh. Please contact us if you have any questions about the study.

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This project has been approved by the Indiana University of Pennsylvania Institutional Review Board for the Protection of Human Subjects (Phone: 724-357-7730).

If you agree to participate in this study, please press continue to begin the study. Please understand that your responses are completely anonymous and that you have the right to withdraw from the study at any time. An unsigned copy of this informed consent form will also be available for you to keep.

Appendix B

Sample Email

Dear XXXX,

My name is Melissa Meulman and I am a graduate student studying clinical psychology at the Indiana University of Pennsylvania (IUP). As part of my doctoral dissertation, I am interested in learning about negative supervision experiences. I'm looking for graduate students who would be interested in participating in this survey, and who would volunteer their time to complete an online questionnaire that lasts approximately 30-60 minutes. I would greatly appreciate if you could pass this information along to clinical graduate students who have received supervision within the last year. Results from this study may help to better understand negative supervision experiences, and explore ways to instill and increase resilience among graduate students. Below you will find the link to the survey, as well as more information about the study. Thank you for your consideration. Please feel free to contact me with any questions about the study.

Link to study

All the best,

Melissa Meulman, M.A.
Doctoral Candidate
Indiana University of Pennsylvania

Dr. Maureen McHugh, Ph.D.
Professor of Psychology
Indiana University of Pennsylvania

Appendix C

Demographic Questionnaire

1. What is your gender? _____

2. What is your race/ethnicity?
    a. African American/Black
    b. European American/White
    c. Latina/Hispanic
    d. Native American/Alaska Native
    e. Asian/Pacific Islander
    f. Biracial/Multi-racial (please specify) _____
    g. Other (please specify) _____

3. Type of program attended?
    a. Counselling Psychology
    b. Clinical Psychology

4. Final degree upon completion of program?
    a. Master's
    b. Doctorate

5. Number of supervisors assigned for supervision? _____

6. How would you describe your theoretical orientation? _____

7. Think of a negative supervision experience.
    a. What was the gender of your supervisor? _____

    b. What was the theoretical orientation of your supervisor? _____

    c. To the best of your knowledge, what was the identified theoretical orientation used in supervision? _____

Appendix D

Test of Self-Conscious Affect, Version 3 (TOSCA-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 in different ways at different times.

For Example:

<u>You wake up early one Saturday morning. It is cold and rainy outside.</u>

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

a) You would think: "I'm inconsiderate." 1 --- 2 --- 3 --- 4 --- 5 Not Likely Very Likely

b) You'd think you should make it up to your friend as soon as possible. 1 --- 2 --- 3 --- 4 --- 5 Not Likely Very Likely

c) You would think: "My boss distracted me just before lunch." 1 --- 2 --- 3 --- 4 --- 5 Not Likely Very Likely

2. You break something at work and then hide it.

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 Not Likely Very Likely

b) You would think about quitting. 1 --- 2 --- 3 --- 4 --- 5 Not Likely Very Likely

c) You would think: "A lot of things aren't made very well these days." 1 --- 2 --- 3 --- 4 --- 5 Not Likely Very Likely

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

a) You would feel incompetent. 1 --- 2 --- 3 --- 4 --- 5 Not Likely Very Likely

b) You would think: "There are never enough hours in the day." 1 --- 2 --- 3 --- 4 --- 5 Not Likely Very Likely

c) You would feel: "I deserve to be reprimanded for mismanaging the project." 1 --- 2 --- 3 --- 4 --- 5 Not Likely Very Likely

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

a) You would think the company did not like the coworker. 1 --- 2 --- 3 --- 4 --- 5 Not Likely Very Likely

b) You would keep quiet and avoid the co-worker. 1 --- 2 --- 3 --- 4 --- 5 Not Likely Very Likely

c) You would feel unhappy and eager to correct the situation. 1 --- 2 --- 3 --- 4 --- 5 Not Likely Very Likely

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

a) You would feel inadequate that you can't even throw a ball. 1 --- 2 --- 3 --- 4 --- 5 Not Likely Very Likely

b) You would think maybe your friend needs more practice at catching. 1 --- 2 --- 3 --- 4 --- 5 Not Likely Very Likely

c) You would apologize and make sure your friend feels better. 1 --- 2 --- 3 --- 4 --- 5 Not Likely Very Likely

6. You are driving down the road, and you hit a small animal.

a) You would think the animal should not have been on the road. 1 --- 2 --- 3 --- 4 --- 5 Not Likely Very Likely

b) You would think: "I'm terrible." 1 --- 2 --- 3 --- 4 --- 5 Not Likely Very Likely

c) You would feel bad you hadn't been more alert driving down the road. 1 --- 2 --- 3 --- 4 --- 5 Not Likely Very Likely

7. You walk out of an exam thinking you did extremely well, and then you find out you did poorly.

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

8. While out with a group of friends, you make fun of a friend who's not here.

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

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

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

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

a) You would think: "I am irresponsible and inadequate." 1 --- 2 --- 3 --- 4 --- 5 Not Likely Very Likely

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 Not Likely Very Likely

c) You would vow to be more careful next time. 1 --- 2 --- 3 --- 4 --- 5 Not Likely Very Likely

11. 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.

a) You would stay late to help clean up the stain after the party. 1 --- 2 --- 3 --- 4 --- 5 Not Likely Very Likely

b) You would wish you were anywhere but at the party. 1 --- 2 --- 3 --- 4 --- 5 Not Likely Very Likely

c) You would wonder why your co-worker chose to serve red wine with the new light carpet. 1 --- 2 --- 3 --- 4 --- 5 Not Likely Very Likely

Appendix E

Shame in Supervision Instrument (SISI)

INSTRUCTIONS:
1. The following items describe experiences a counseling trainee may have during clinical supervision (i.e., while having his/her actual clinical work supervised). The items are designed to reflect the supervisee's personal thoughts, feelings, and perceptions during the supervision process. As such, there are no desirable or undesirable responses.

2. Please read each item and indicate the degree to which it describes your experience by circling the appropriate number on the adjacent scale.

3. **PLEASE REFER TO HOW YOU THOUGHT AND FELT DURING YOUR MOST NEGATIVE SUPERVISION EXPERIENCE WHEN RESPONDING**

	Not at all true of me						Very true of me
1. I would prefer to discuss my cases rather than show tapes of my counseling sessions if I could.	1	2	3	4	5	6	7
2. As a counselor, I felt flawed.	1	2	3	4	5	6	7
3. I sometimes felt that I was really falling short of where I should be.	1	2	3	4	5	6	7
4. I would hide certain things about myself to preserve my supervisor's good image of me.	1	2	3	4	5	6	7
5. Sometimes during a supervision session, I had the feeling my supervisor felt he/she had better things to do.	1	2	3	4	5	6	7
6. I felt confident that my supervisor's respect for me would grow as he/she came to know me better.	1	2	3	4	5	6	7
7. I felt totally inadequate as a counselor.	1	2	3	4	5	6	7
8. I felt I had to do the right thing to keep my supervisor interested.	1	2	3	4	5	6	7
9. I felt supervision required me to reveal more of myself than I really wanted to.	1	2	3	4	5	6	7

	Not at all true of me						Very true of me
10. My expectations for myself matched the level at which I felt I was performing.	1	2	3	4	5	6	7
11. I feared my supervisor would discover I was really incompetent.	1	2	3	4	5	6	7
12. It felt like there was a big gap between where I was and where I thought I should be in my development as a counselor.	1	2	3	4	5	6	7
13. I have tried to conceal aspects of my work from my supervisor.	1	2	3	4	5	6	7
14. During supervision, I came to feel there was something deeply wrong with me.	1	2	3	4	5	6	7
15. I felt that I had serious weaknesses as a counselor.	1	2	3	4	5	6	7
16. I felt that my supervisor looked forward to supervising me.	1	2	3	4	5	6	7
17. It was devastating when I felt like I failed.	1	2	3	4	5	6	7
18. I felt bad about myself when we discussed things I needed to improve upon.	1	2	3	4	5	6	7
19. I sometimes felt like I was lacking essential qualities that other counseling students have.	1	2	3	4	5	6	7
20. After supervision sessions, I felt better about myself as a counselor.	1	2	3	4	5	6	7
21. I felt inadequate as a person during supervision.	1	2	3	4	5	6	7
22. If my supervisor were late or distracted in a session, I would assume it had something to do with me.	1	2	3	4	5	6	7
23. I felt my supervisor would rather have been working with someone more talented than I.	1	2	3	4	5	6	7
24. I felt like I wasn't worthy of my supervisor's time	1	2	3	4	5	6	7

	Not at all true of me						Very true of me
25. During supervision, I felt incompetent.	1	2	3	4	5	6	7
26. It was hard not to take feedback about specific behaviors as an evaluation of my overall potential as a counselor.	1	2	3	4	5	6	7
27. Sometimes after supervision I wished that I could go away and hide.	1	2	3	4	5	6	7
28. I held back from asking for help at times because I was ashamed to think I needed it at this stage.	1	2	3	4	5	6	7
29. I was torn between wanting to share my work with my supervisor and wanting to protect myself.	1	2	3	4	5	6	7
30. I looked forward to reviewing my audio/video tapes with my supervisor.	1	2	3	4	5	6	7
31. I felt exposed in supervision.	1	2	3	4	5	6	7
32. Sometimes during supervision I felt like sinking into the floor.	1	2	3	4	5	6	7
33. I might misrepresent what happened in a counseling session to avoid looking bad to my supervisor.	1	2	3	4	5	6	7
34. Sometimes after supervision I felt like I didn't want to face anyone.	1	2	3	4	5	6	7
35. I sometimes tried to avoid supervision sessions because having my work examined made me uncomfortable.	1	2	3	4	5	6	7
36. I sometimes wished I could take back something I shared with my supervisor about myself or my work.	1	2	3	4	5	6	7
37. I felt at ease having my supervisor scrutinize my work.	1	2	3	4	5	6	7

	Not at all true of me						Very true of me
38. I was concerned that if I didn't measure up, my supervisor might be less committed to working with me.	1	2	3	4	5	6	7
39. Sometimes it was hard for me to look my supervisor in the eye.	1	2	3	4	5	6	7
40. I felt that my supervisor was disappointed in me when I made mistakes.	1	2	3	4	5	6	7
41. I felt that I didn't have to share any more than I wanted to about myself or my work with my supervisor.	1	2	3	4	5	6	7
42. I felt like my supervisor thought I wasn't worthy of her/his time.	1	2	3	4	5	6	7
43. In supervision I felt I could make "foolish" mistakes and still be a good counselor/therapist.	1	2	3	4	5	6	7
44. Comparing myself to my supervisor made me feel worse about myself as a counselor/therapist.	1	2	3	4	5	6	7
45. In supervision, I felt like I was never as good as I should be.	1	2	3	4	5	6	7
46. I was careful not to say things that might cause my supervisor to withdraw from me.	1	2	3	4	5	6	7
47. I found it hard to accept that I wasn't where I thought I should be with my skills.	1	2	3	4	5	6	7
48. I did not think much about whether I was living up to my "ideal" for myself as a counselor during supervision.	1	2	3	4	5	6	7
49. During supervision, I felt confident that I have what it takes to be a good counselor.	1	2	3	4	5	6	7

Appendix F

Investment in Supervision

Aside from being concerned about getting a good grade, how invested were you during this negative supervision experience?

1	2	3	4	5	6	7
Minimally invested						Extremely invested

Appendix G

Self-Compassion Scale (SCS)

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

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:

1	2	3	4	5
Almost Never				Almost Always

_____ 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.

1	2	3	4	5
Almost Never				Almost Always

_____ 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 H

Multidimensional Scale of Perceived Social Support (MSPSS)

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the "1" if you **Very Strongly Disagree**
Circle the "2" if you **Strongly Disagree**
Circle the "3" if you **Mildly Disagree**
Circle the "4" if you are **Neutral**
Circle the "5" if you **Mildly Agree**
Circle the "6" if you **Strongly Agree**
Circle the "7" if you **Very Strongly Agree**

	Very Strongly Disagree			Neutral			Very Strongly Agree
1. There is a special person who is around when I am in need.	1	2	3	4	5	6	7
2. There is a special person with whom I can share joys and sorrows.	1	2	3	4	5	6	7
3. My family really tries to help me.	1	2	3	4	5	6	7
4. I get the emotional help & support I need from my family.	1	2	3	4	5	6	7
5. I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7
6. My friends really try to help me.	1	2	3	4	5	6	7
7. I can count on my friends when things go wrong.	1	2	3	4	5	6	7
8. I can talk about my problems with my family.	1	2	3	4	5	6	7
9. I have friends with whom I can share my sorrows.	1	2	3	4	5	6	7
10. There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7
11. My family is willing to help me make decisions.	1	2	3	4	5	6	7
12. I can talk about my problems with my friends.	1	2	3	4	5	6	7

Appendix I

Open-Ended Shame Questions

(1) Describe a time you felt incompetent/inadequate in supervision.

(2) Describe a time you feel you disappointed your supervisor.

(3) Describe a time you felt shame.

(4) Describe a time you felt shame in supervision.

Appendix J

Debriefing Form

THIS PROJECT HAS BEEN APPROVED BY THE INDIANA UNIVERSITY OF PENNSYLVANIA INSTITUTIONAL REVIEW BOARD FOR THE PROTECTION OF HUMAN SUBJECTS (PHONE 724.357.7730)

The current study aimed to better understand how men and women react to negative supervision experiences, and the role of shame in supervision. Shame is a social emotion that results in a global negative self-evaluation, and is associated with increased rates of mental illness (Teroni & Donna, 2008). Guilt is often experienced as regret, and is situational rather than generalized to the whole self. Guilt is associated with the development of empathy, social abilities, and self-awareness (Efthim, Kenny & Mahalik, 2001).

We explore the possibility that both men and women are shamed for not adequately performing to their expected gender role, but that women experience more shame across gender role categories (Efthim, Kenny & Mahalik, 2001). Previous research indicated that women experienced a greater degree of shame and guilt proneness, whereas men expressed more of a trait guilt. Others report that women experienced shame across all domains of femininity stress; men who experienced more externalization (blaming others) during gender-role stress.

If considering the survey brings up feelings of distress, here are resources in the area:

IUP Counseling Center	724-357-2621
Armstrong/Indiana Crisis Hotline	724-465-2605

If you are interested in further information regarding the gendered experience of shame, here are recommended readings:

Brown, B. (2004). Women and shame: Reaching out, speaking truths, and building connection. Austin, TX: 3C Press.

Kilmartin, C. (2009). The masculine self (4th ed.). New York, NY: Sloan Publishing.

Appendix K

Hemlick's (1997) SISI Factor Model

Item Number	SISI Item Text	Factor Loading
	Factor 1: Inadequacy as a Counselor (12 Items)	
2	As a counselor, I felt flawed.	.65
3	I sometimes felt that I was really falling short of where I should be.	.69
7	I felt totally inadequate as a counselor.	.66
11	I feared my supervisor would discover I was really incompetent.	.60
12	It felt like there was a big gap between where I was and where I thought I should be in my development as a counselor.	.70
15	I felt that I had serious weaknesses as a counselor.	.65
19	I sometimes felt like I was lacking essential qualities that other counseling students have.	.65
25	It was hard not to take feedback about specific behaviors as an evaluation of my overall potential as a counselor.	.63
26	It was hard not to take feedback about specific behaviors as an evaluation of my overall potential as a counselor.	.47
44	Comparing myself to my supervisor made me feel worse about myself as a counselor/therapist.	.53
45	In supervision, I felt like I was never as good as I should be.	.64
47	I found it hard to accept that I wasn't where I thought I should be with my skills.	.72
	Factor 2: Negative Reaction During Supervision (9 Items)	
18	I felt bad about myself when we discussed things I needed to improve upon.	.44
25	During supervision, I felt incompetent.	.45
26	It was hard not to take feedback about specific behaviors as an evaluation of my overall potential as a counselor.	.46
27	Sometimes after supervision I wished that I could go away and hide.	.76
28	I held back from asking for help at times because I was ashamed to think I needed it at this stage.	.45
32	Sometimes during supervision I felt like sinking into the floor.	.61

Item Number	SISI Item Text	Factor Loading
34	Sometimes after supervision I felt like I didn't want to face anyone.	.59
36	I sometimes wished I could take back something I shared with my supervisor about myself or my work.	.51
40	I felt that my supervisor was disappointed in me when I made mistakes.	.46
	Factor 3: Concealing from Supervisor (5 Items)	
4	I would hide certain things about myself to preserve my supervisor's good image of me.	.59
13	I have tried to conceal aspects of my work from my supervisor.	.82
28	I held back from asking for help at times because I was ashamed to think I needed it at this stage.	.43
29	I was torn between wanting to share my work with my supervisor and wanting to protect myself.	.69
33	I might misrepresent what happened in a counseling session to avoid looking bad to my supervisor.	.76
	Factor 4: Supervisor Investment (3 Items)	
5	Sometimes during a supervision session, I had the feeling my supervisor felt he/she had better things to do.	.71
16	I felt that my supervisor looked forward to supervising me.	.61
42	I felt like my supervisor thought I wasn't worthy of her/his time.	.62
	Factor 5: Inadequacy as a Person (2 Items)	
14	During supervision, I came to feel there was something deeply wrong with me.	.57
21	I felt inadequate as a person during supervision.	.48