Much of this book has focused on shame experienced by the client. However, what happens when the therapist experiences shame? Many authors, including many who wrote for this volume, have noted that therapist shame can significantly influence the process and outcome of psychotherapy (Covert, Tangney, Maddux, & Heleno, 2003; Leith & Baumeister, 1998; Pope, Sonne, & Greene, 2006). For example, Pope et al. (2006) argued that embarrassing and shameful moments reveal unacknowledged, uncomfortable feelings of which the therapist is unaware that will likely have unknown effects on clients. Clearly, identifying therapist shame, and then working through the therapist's experience, can be critical given its potential influence on the therapist's ability to function effectively in clinical contexts. To that end, the purpose of this chapter is to define therapist shame, offer examples of types of therapist shame along with examples of therapist and client responses to therapist shame, and provide a case example of how therapist shame can be worked through in supervision. We propose the critical events model of supervision.

The second and third authors contributed equally to this chapter, and their names are included alphabetically.
(CES) as a potential framework for working through therapist shame experiences within the context of supervision. Although this model was not developed specifically for addressing shame, it provides a useful context for identifying, addressing, and resolving shame that is experienced by therapists in the course of their clinical encounters.

DEFINING THERAPIST SHAME

Summarizing and expanding upon the literature (e.g., Gilbert, 1997; M. Lewis, 1993; Sorotskin, 1985), we define therapist shame as an intense and enduring reaction to a threat to the therapist’s sense of identity that consists of an exposure of the therapist’s physical, emotional, or intellectual defects that occurs in the context of psychotherapy. For example, a therapist may experience shame if he or she fell asleep during a session. It would be particularly shameful if the therapist believed it reflected on his or her competence and if the emotional experience haunted him or her long past the time at which the event occurred.

It is important to distinguish between therapist shame and related, yet distinct, constructs of therapist embarrassment, humiliation, and guilt (Leith & Baumeister, 1998; H. Lewis, 1971; Tangney, Miller, Flicker, & Barlow, 1996; Tracy & Robins, 2004):

- Therapist embarrassment is most closely linked to shame and can be thought of as an experience on the other end of the shame-embarrassment continuum. Embarrassment, unlike shame, tends to be short lived and acute and is experienced mildly rather than intensely. In the previous example, rather than the therapist falling asleep, the therapist may have been distracted by something and recognized the distraction as an infrequent yet common and normal occurrence in therapy.
- Humiliation arises from the actions of others, and there is a minimal sense of disruption to identity. If, for example, a therapist trainee was distracted momentarily in a session, and later, in a classroom of peers, a supervisor angrily told the trainee that it was a stupid mistake, the therapist would likely feel humiliated but could attribute the experience to the supervisor’s inappropriate behavior.
- Guilt results from a specific action that results in harm to others, in this instance specifically to the client (Leith & Baumeister, 1998; H. Lewis, 1971; Tangney et al., 1996; Tracy & Robins, 2004). In the running example, if the client abruptly terminated
shortly after the therapist fell asleep during session, the therapist may feel guilt for having fallen asleep.

In summary, shame distinguishes itself from other constructs in the following manner: It is more intense and extreme than embarrassment; it arises from the self more than from others as in humiliation; and the focus of attention pertains to the self, in contrast to guilt’s focus on behavior.

EXAMPLES OF SHAMEFUL EVENTS AND THERAPIST AND CLIENT RESPONSES

Research on therapist shame appears to be almost nonexistent. Recently, Kulp, Klinger, and Ladany (2007) offered avenues for understanding therapist shame in the preliminary analyses of their studies on therapist and supervisor embarrassment and shame (more than 90 experienced therapists or supervisors in each sample). Although they combined embarrassment and shame events in their categorization (because they were deemed to be on a continuum and were difficult to distinguish in many ways, such as in cases of high-embarrassment or low-shame events), their results offer insight into the potential types of therapist shame events. The researchers examined shameful events identified by practicing therapists—specifically, the content of the event, the therapist’s reactions to the event, and the client’s reactions to the event.

Most notably, some of the more typical types of shameful events included the therapist falling asleep in session, chronic difficulties with time management, referring to a client by another client’s name, forgetting significant client information such as a death in the family, bodily function difficulties, internal recognition that an intervention was failing miserably, and sexual behaviors by the client. In all of these instances, the therapists indicated that to various extents, the therapeutic relationship was affected, client outcomes may have been compromised, and their own self-efficacy was altered.

Therapist reactions to the shameful events included reactions at the moment of the event, such as changes in the therapist’s body (e.g., tensing); reactions in the session subsequent to the event, such as apologizing to the client, using humor, processing the event with the client, or ignoring the event; and reactions that lingered past the event, such as persistent feelings of shame and recurring thoughts about the event. Therapists also identified client reactions to the events that included negative reactions (e.g., hostility, withdrawal, termination) and positive reactions (e.g., forgiveness, humor). As could be seen, at times the therapist shame event was used therapeutically and may actually have been beneficial to the therapeutic work, and at other times the event led to significant therapeutic problems.
Experiencing shameful events is likely a normal therapy experience. As such, it seems important to consider what therapists should do once they've experienced a shameful event. In the case of embarrassing events and perhaps mildly shameful events, therapists may be able to put the event in context personally or share the event with a trusted colleague. However, psychotherapy trainees and master therapists alike would do well to work through moderately to significantly shameful events in supervision (Jennings & Skovholt, 1999). This section reviews a model of supervision suited for working through an event that caused a therapist shame—the critical events model of supervision (Ladany, Friedlander, & Nelson, 2005).

The CES was based on an extension of task analysis models developed to understand change in therapy (e.g., Greenberg, 1984, 1986; Safran, Crocker, McMain, & Murray, 1990) but expanded to recognize and integrate the unique differences and interpersonal dynamics that distinguish supervision from psychotherapy (e.g., evaluation, educational aspects). Moreover, five assumptions form the basis of the model. First, the CES was created to be pantheoretical such that it is applicable to multiple theoretical approaches to psychotherapy. Second, the model recognizes the interpersonal nature of supervision, thereby including the contributions of both the trainee and supervisor. Third, supervision is intended to facilitate supervisee growth as opposed to focusing on case management or being primarily administrative. Fourth, the process of supervision can be divided into a series of events, each having a beginning, middle, and end, and all of which can occur within a single session or across multiple supervisory sessions. Fifth, the events themselves are linked with specific supervision outcomes.

A number of common critical events have been identified and include remediating skill difficulties and deficits, heightening multicultural awareness, negotiating role conflicts, working through countertransference, managing sexual attraction, repairing gender-related misunderstandings, addressing problematic supervisee emotions and behaviors, facilitating supervisee insight, and facilitating a supervisee corrective relational experience. For the purposes of this chapter, we add an additional critical event: working through supervisee shame. According to Ladany et al. (2005), any event can be broken down into four components: (a) the supervisory working alliance, (b) the marker, (c) the task environment, and (d) the resolution.

Supervisory Working Alliance

The supervisory working alliance has been one of the most studied constructs of supervision, has been found to be related to a variety of supervision
process and outcome variables, and has been considered to be the foundation on which effective supervision is based (Ladany & Inman, in press). The CES expands on Bordin’s (1983) model of the supervisory working alliance and, like Bordin, deems the alliance to consist of three components: (a) mutual agreement between the supervisee and supervisor on the goals of supervision (e.g., increase therapy skills, enhance self-awareness), (b) mutual agreement between the supervisee and supervisor on the tasks of supervision (e.g., manner and type of feedback), and (c) an emotional bond between the supervisee and supervisor consisting of respect, caring, liking, and trusting. As a salient part of the CES model, the supervisory alliance acts as a figure-ground concept, whereby it rises to the figure early in the supervision relationship or following a rupture and recedes to the ground when adequate strength is reached.

The Marker

The marker occurs at the beginning of a critical event and signals that an event is about to take place. Markers are usually statements or a series of statements made by the supervisee asking for help. These statements may be simple, such as “I had this shameful experience with my client that I need to talk about.” Alternatively, markers can take on a more subtle character, such as when a supervisee avoids talking about a particular client, forgets the client’s name, or becomes uncharacteristically defensive when the supervisor brings up a client. At other times the supervisor, in the case of therapists in training, may observe the shameful event when watching a video recording of the therapy session. The marker, then, brings to the fore the next phase of the critical event, the task environment.

The Task Environment

The task environment is where much of the action takes place in a critical event. In the task environment, the supervisor engages in a series of interaction sequences, the 12 most common of which include (a) focusing on the supervisory working alliance (e.g., using empathy, reflections, and negotiations), (b) focusing on the therapeutic process (e.g., the interactions that transpired in therapy), (c) exploring supervisee feelings, (d) focusing on countertransference (e.g., biases that may be affecting the therapeutic work), (e) attending to parallel process (e.g., considering how therapy and supervision may be mimicking one another), (f) focusing on supervisee self-efficacy, (g) normalizing the experience, (h) focusing on therapy skills, (i) assessing knowledge (e.g., determining whether the event involved a skills or knowledge deficit), (j) focusing on multicultural awareness (e.g., gender, racial, sexual orientation identity), (k) focusing on evaluation, and (l) case review. The task environment typically
consists of three to six interaction sequences of the 12 identified. For the purposes of demonstration, the interaction sequences are described in an order; however, the order, as well as the notion that the specific sequence occurs within a single session, is done for heuristic value.

In the context of working through a therapist shame event, we identified five likely interaction sequences that constitute the task environment: (a) focusing on the supervisory alliance, (b) exploring feelings, (c) focusing on countertransference, (d) focusing on self-efficacy, and (e) normalizing the experience (see Figure 13.1). Because feelings of shame are what characterize a shame event, it is critical that the supervisor empathize with the supervisee. Even with experienced clinicians in the role of supervisee, it is critical that an alliance is developed via empathy and understanding of the event and the supervisee’s experience. The supervisor should also be collaborative in terms of negotiating the manner in which things will be discussed and the goal of these discussions. The effectiveness of the rest of the supervisory work is contingent upon the adequacy with which the alliance is strengthened.

For the shame experience to be fully understood, it is critical that the supervisor facilitate the exploration of the supervisee’s feelings about the shame event. This exploration may involve deepening the supervisee’s understanding of his or her reactions to the shame event by, for example, exploring possible links to previous shame events in the supervisee’s life, as well as the similarities of the reaction to these previous experiences. Hence, exploration of feelings will likely lead to a focus on the countertransference or, simply put, the general internal struggles and biases that the therapist experiences in reaction to the client’s presenting material. Next, because shame events, by definition, affect the therapist’s sense of professional self, attention to the supervisee’s self-efficacy is warranted, with perhaps statements that reinforce or rebuild the self-efficacy that was lost. Finally, the supervisor would do well to normalize the supervisee’s experience. The recognition that therapists are human and that mistakes, even significant ones, are bound to happen can be quite validating to the supervisee and ultimately help him or her rebound effectively from the experience.

The Resolution

The end or outcome of a particular event is called the resolution. Resolution can occur in varying degrees (from totally unresolved to totally resolved) along four dimensions: self-awareness, knowledge, skills, and the supervisory working alliance. Self-awareness, the type most linked to a shame event, refers to changes in supervisees’ understanding about how their feelings, beliefs, and behaviors are considered in the context of their psychotherapy work. So for a shame event, the therapist may have an enhanced understanding of how and
why the shame event occurred and of the impact of the event on the client. Moreover, the therapist’s self-efficacy may have been restored. All of these are positive resolutions. In the case of negative resolutions, the therapist may not have acknowledged feeling shamed by the experience and thus may not have gained in self-awareness. Knowledge about therapy would be increased if the supervisee gained an appreciation for how therapists can experience shame and learned ways to buffer himself or herself against the occurrence of such experiences in the future (i.e., change in approach or skills in relation to the therapeutic work). Finally, through all the work that is done during the event, the supervisory working alliance can become altered, preferably for the better, thereby serving as a foundation for future work. The following case example illustrates a process model for a successfully resolved supervisee/therapist shame event. Our example includes an intern in the role of the supervisee; however, we believe that similar processes would take place with more experienced psychotherapists.

CASE EXAMPLE

The supervisory dyad consisted of Nel, a 45-year-old supervisor who had 18 years of clinical experience and 10 years of supervisor experience, and Eva, a 31-year-old predoctoral intern. The setting was a university counseling center. Nel and Eva had met for seven supervisory sessions, and their alliance to date had been relatively strong. Eva had been open to discussing her personal issues and how they affected her work with clients. She was also aware of and insightful concerning her development as a psychotherapist.

The marker began when Eva reported being challenged by a new client, Silas, during their second session. Eva described to Nel how after engaging Silas in a breathing exercise to cope with his anxiety, Silas stated, “Well, that didn’t work. Are you sure you know what you’re doing?”

Eva: I need to talk about something that happened with a new client I’m seeing.

Supervisor: OK; tell me about it.

Eva: Well, I got stuck when my client told me the intervention didn’t work and challenged my ability.

At this point, the supervisor was unsure of what Eva needed and suggested they listen to the tape of the session.

Supervisor: Wow, it sounds like he really challenged you there.

Eva: Yes! I didn’t know what to do! I felt so incompetent and embarrassed and . . .
Supervisor: Sounds like it was difficult for you.

Eva: Yeah, it really was. I guess I felt a lot of shame, like I failed.

The supervisor clearly saw the marker as Eva’s reported feelings of shame due to a client challenge and recognized that the shameful feelings needed to be worked through. Because Eva’s feelings had the potential to influence her therapeutic alliance with the client and the quality of treatment, the supervisor decided to address these feelings of shame. The supervisor recognized Eva’s discomfort in disclosing her feelings of shame and therefore began the discussion with a focus on the supervisory alliance before moving into processing her feelings:

Supervisor: I can imagine feeling that way, too.

Eva: Yeah.

Supervisor: This seems like a difficult topic for you. How does it feel telling me about this?

Eva: Well, I feel comfortable talking to you about most topics, but I guess this is different because I feel like I failed and I want you to think I’m a good therapist.

Supervisor: That makes sense. I appreciate you bringing this up, and I understand that you may question if I’m judging you.

Eva: I don’t know if I feel judged, but I know I don’t want you to think negatively of me.

Supervisor: That’s understandable. I think the most important thing to remember is that we are working through these issues together, and I think we’ve done well with that so far.

Eva: I do, too.

Supervisor: What’s most pressing for you to address with this client in relation to what happened?

Eva: I think I would like to feel at ease with him and figure out what’s preventing me from being able to work effectively with him.

Here the supervisor brought the focus back to Eva’s work with the client. She also addressed the supervisory alliance by collaborating with Eva concerning the goals for the session. The supervisor was able to assess that the supervisory alliance has not been ruptured, as indicated by Eva’s honest self-disclosure of her discomfort. By emphasizing the importance of the agreement of goals and Eva’s contribution to the focus of the supervisory sessions, the supervisor strengthened the alliance.
Supervisor: I know you haven’t disclosed feeling this way with other clients. Beyond his statement, is there anything else about your interactions with him that contributed to your difficulties working with him?

Eva: Well, there is something about him that makes me uncomfortable and reduces my confidence.

Supervisor: Tell me more about what he does or says that creates this experience for you.

Eva: I guess he pushes me for a solution, yet everything I offer him seems wrong. And this time, he really made a point of making me feel like an idiot!

Supervisor: So it sounds like you feel pressured to give him an answer, but your efforts get rejected.

Eva: Yeah, exactly. I feel rejected and so embarrassed.

The supervisor now had a better understanding of Eva’s and her client’s interactions. She recognized that the client’s actions were triggering negative self-conscious emotions in Eva. Because Eva returned to her emotions by referencing feeling embarrassed, the supervisor further explored Eva’s emotional experience to help her continue to process the event:

Supervisor: What is that like for you—to feel embarrassed and rejected by this client?

Eva: Horrible! I feel so small, like I don’t know what I’m doing. I feel completely disempowered!

Supervisor: That sounds overwhelming.

Eva: Yeah, not only do I feel bad, but I started to second-guess my abilities as a therapist and feel worthless.

Here the supervisor noticed that Eva was doubting her abilities, which indicated she might be struggling with her self-efficacy. However, the supervisor decided to stay with Eva’s emotions through a here-and-now focus and return to self-efficacy later:

Supervisor: I notice you’re looking down as you’re describing this. What’s going on for you right now?

Eva: I’m just thinking about how he made me feel . . . it was like all my faults were exposed, and it was revealed that I’m not a very experienced therapist.

Supervisor: That’s a difficult place to be put as a young therapist. I can see it is still having a significant impact on you.
Eva: Yeah.

Supervisor: You mentioned before feeling a few different emotions, like embarrassment, rejection, and shame. I’m wondering if there is one emotion that stands out for you in your experiences with this client.

Because Eva disclosed feeling various emotions, the supervisor narrowed the focus of the emotions to gain clarity and work through the emotions to allow her to be more present with the client.

Eva: I hate to admit it, but I do feel a lot of shame with this client.

Supervisor: It seems like this is an emotion you move away from . . .

Eva: I guess you’re right.

Supervisor: Let’s just sit with this, then, for a moment to really take it in and stay with it.

Eva: OK.

Eva and her supervisor were silent for approximately 30 seconds to allow Eva to feel the emotion so she could begin to accept it. By having Eva sit with her feelings of shame, the supervisor was setting the stage to allow Eva to connect her experience with what the client was feeling. To deepen Eva’s experience, the supervisor moved the discussion to an exploration of countertransference:

Supervisor: How was that moment of silence for you?

Eva: It was uncomfortable at first, but I think it helped me to understand how I am feeling and recognize the feeling as shame.

Supervisor: Now that you recognize this feeling, can you think back to when you have felt this way before?

Eva: Hmm. I remember feeling this way with my dad when I was younger.

Supervisor: Does anything specific come to mind?

Eva: Yes. I brought home a report card with two Bs and was expected to get all As. My dad was really angry and told me it wasn’t good enough.

Supervisor: How did you feel when this happened?

Eva: I felt bad but didn’t know what it was. Now I realize it was shame.
Supervisor: It sounds like your father had high expectations of you, and you felt shame when you let him down, even though you were performing well.

Eva: It’s crazy how one person’s opinion can shape the way I feel, even though I know inside I am doing OK.

Supervisor: Similar to how one client can make you feel.

Eva: Oh! You mean how Silas is making me feel.

Supervisor: Exactly!

The supervisor highlighted the similarities between Eva’s experience with her father and her interactions with her client.

Eva: I never thought about it like that before, but it really does feel the same.

Supervisor: Now that you recognize this, what can we do with it?

Eva: I think being aware of it helps, but also I think I need to work through some personal issues with my dad.

Supervisor: I think both of those are important. Now how can we bring it back to your work with Silas?

Eva: I can be mindful of my feelings during the session to avoid them interfering with our work.

Supervisor: OK, good. And how about Silas’s feelings?

Eva: Oh, I bet he could be feeling shame, too, about his anxiety and not being able to manage it.

Supervisor: Right.

Eva: Wow, I can’t believe I missed that! I was so wrapped up in my own feelings.

Through exploring Eva’s countertransference related to feelings of shame with her father, she was able to clarify her own emotional experience and that of her client. The supervisor recognized that this process was difficult for Eva, who was continuing to doubt her abilities as a counselor. Therefore, the supervisor transitioned the discussion to Eva’s perception of herself as a competent therapist (i.e., self-efficacy):

Supervisor: You mentioned before feeling incompetent working with this client, and I want to check in with you about that.

Eva: Yeah. That is an issue, but I feel like this discussion has helped me to see more clearly what’s going on with me and the client. I think I may be able to better relate to him now.
Supervisor: I think you’re right. How do you think you can better relate to him?

Eva: Maybe by going back to exploring his feelings about his anxiety and not focusing so much on solving it.

Supervisor: Like what we have been doing in here.

Eva: Yeah, like that.

Supervisor: How do you feel about this plan?

Eva: I feel more prepared going into our next session, like I know what I am doing now.

To further attend to Eva’s needs, the supervisor returned to her original concern of feeling incompetent. Through devising a plan for working with this client, Eva’s confidence in her ability improved. At this point, the supervisor validated her concerns with this client and assured Eva that she was going through a normal developmental process (i.e., normalized the experience):

Supervisor: Good. Supervision is often a difficult process, but it sounds like we both have done good work today and learned something new.

Eva: Yeah, I knew I needed to discuss this today, but it is always hard to come in here when I feel like I haven’t performed to the best of my ability.

Supervisor: The way we improve our abilities so that we can perform our best is by being honest about our mistakes and working through our countertransference. And this is something that we all have to go through to become effective therapists.

Eva: I know that’s the case, but it is still comforting to hear it, especially after this session, because I never expected to feel so much shame with a client.

Supervisor: It sounds like it was unexpected for you, and that’s also something that is common for therapists to go through. We are often surprised when strong emotions come up for us in session. And the goal is to process these emotions so that we minimize the impact on the client.

Eva: It’s nice to hear that this is normal and all a part of my learning process.

The supervisor normalized Eva’s struggle by validating her concerns and her feelings of shame. She also educated Eva about the process of becoming an effective therapist and emphasized the difficulty of this process. Moving into the resolution phase, the supervisor and Eva summarized their discussion by
tying together Eva’s insights about her feelings of shame and her process of working through it:

**Supervisor:** Eva, we covered a lot of emotional material today, and I want to check in with you about how you are doing.

**Eva:** It was hard to accept that my feelings of shame interfered with the session, but I learned a lot about what I should be aware of with my clients.

**Supervisor:** All right; let’s review what kinds of things you should be aware of.

**Eva:** I should be aware of my feelings of shame and how they could be affecting my work with clients. If I recognize they are interfering, I need to check in with myself and work to resolve them. And then I could use my own experience to relate better to the client.

**Supervisor:** It sounds like you did a lot of good work today and have a good handle on how to manage your feelings of shame with your clients. Maybe next week we can check in about your next session with Silas.

**Eva:** Sounds good.

Eva was able to successfully work through her shame by exploring her interactions with her client and her own experiences with shame. Eva also made connections between her feelings of shame and her client’s experience. The next step was for Eva to translate her work in supervision to her therapeutic work with her client.

**CONCLUSION**

The case example illustrates what can happen in relation to working through a therapist shame event. We recognize that the steps in real life may not be as orderly, sequential, and easily accomplished. However, we hope that the model offers therapists and supervisors a sense of what can occur when a therapist has experienced a shame event and perhaps provides avenues for discussion not considered previously. Clearly, more research on the model in relation to working through therapist shame events is needed to determine the utility of this approach. In addition, highlighting therapist shame experiences brings to the fore other issues in relation to shame, such as supervisee or supervisor shame that takes place in the context of supervision (Bernard & Goodyear, 2009; Kulp et al., 2007; Yourman, 2003). Therapist shame appears to be a prodigious and salient phenomenon that can have significant implica-
tions for therapy and supervision, and it therefore deserves continued recognition and study in the literature.

REFERENCES


