Shame in the Supervisory Hour: Do Supervisors Sense What is Hidden?

Melanie R. Harkins

Follow this and additional works at: https://aura.antioch.edu/etds

Part of the Clinical Psychology Commons
Shame in the Supervisory Hour: Do Supervisors Sense What is Hidden?

by

Melanie Rose Harkins

B.S. Bates College, 2010
M.S. Antioch University New England, 2016

DISSERTATION

Submitted in partial fulfillment for the degree of
Doctor of Psychology in the Department of Clinical Psychology
At Antioch University New England, 2020

Keene, New Hampshire
The undersigned have examined the dissertation entitled:

**SHAME IN THE SUPERVISORY HOUR: DO SUPERVISORS SENSE WHAT IS HIDDEN?**

presented on July 27, 2020

by

**Melanie Rose Harkins**

Candidate for the degree of Doctor of Psychology and hereby certify that it is accepted*.

Dissertation Committee Chairperson: Roger L. Peterson, PhD, ABPP

Dissertation Committee members: Lorraine Mangione, PhD Barb Belcher-Timme, PsyD

Accepted by the Department of Clinical Psychology Co-Chairpersons

Vincent Pignatiello, PsyD on **7/27/2020**

* Signatures are on file with the Registrar's Office at Antioch University New England.
Dedication

This dissertation is dedicated to my supervisors, current supervisors, and future supervisors-to-be.

To my supervisors, thank you for your guidance, support, clinical knowledge, and feedback (positive and not-so-positive, yet always constructive). You have taught me about the process of meaningful change. You have helped me learn how to build relationships with others, how to show up and be present, that it’s okay to be my most genuine self, and helped me be okay with and learn from my own mistakes/weaknesses. Thank you for laughing with me, crying with me, and teaching me about change. My graduate training has changed the person who I am and the psychologist that I am. Thank you for guidance during this professional journey—yes, there’s much more to come—and allowing me to grow into my personal and professional self.

To our future psychologists and future supervisors. May you listen to your doubt, but not let it guide you. May you listen to your “imposter syndrome,” and let it motivate you to grow. May you listen to frustration and anger, and let it spark curiosity and self-exploration. May you listen to shame and insecurities, yet embrace vulnerability and show up anyway. May you make “mistakes” and embrace the lessons you can learn from them. May you find ways to show-up for supervisees.
Acknowledgements

I would like to acknowledge all those who assisted with this project directly and indirectly. This dissertation would not have been completed without a number of people who gave their time, support, guidance, knowledge and confidence in my own abilities.

I want to thank the participants who took their time to share their stories and experiences.

My advisor Roger Peterson, PhD who helped me through the daunting process of coming up with a research topic and believing in my abilities to see it through. Your feedback was always appreciated and your belief in me as a psychologist is even more appreciated.

The Antiochians who were part of my dissertation seminar shared their own personal supervision stories with me, acted as a sounding board for my ideas, and sparked my curiosity in this topic. Thank you for being vulnerable and sharing your stories with me.

Kate Mayhew, PsyD and Susan George, PhD helped code interviews increasing the rigor of my dissertation! Thank you for your willingness to help, your feedback, and insight.

My parents, Gail and Chris, provided unconditional support and willingness to listen to my complaining kept me sane during this process. Your support, listening ears, and pep-talks kept me going. Although my Uncle and Papa who will never get to read this or “see me” graduate; your love and faith in me will be felt forever. My enrollment in this program would not have been possible without you.

My Antioch carpool crew: Kate, Leah, and Katie. Your support, laughter, guidance, and small celebrations for my small victories made a big difference. You are fabulous friends, colleagues, and psychologists!
# Table of Contents

Dedication ................................................................................................................................. iii

Acknowledgements ................................................................................................................... iv

Abstract ......................................................................................................................................1

Shame in Supervision: Do Supervisors Sense What is Hidden? ...................................................2

   The Project’s Aim ...................................................................................................................4

Literature Review ........................................................................................................................4

   An Overview of Shame ..........................................................................................................5

   Supervisees are Vulnerable to Shame .................................................................................14

   Shame Leads to Nondisclosure .............................................................................................16

   Supervisees Hide Important Clinical Information ..............................................................20

   What is Supervision? ............................................................................................................21

   The Supervisory Relationship is a Protective Factor ............................................................29

   Supervision is an Important Vehicle for Exploring Supervisee Shame .............................31

   This Study .............................................................................................................................33

Method .....................................................................................................................................34

   Research Design: A Qualitative Analysis .........................................................................34

   Theoretical Underpinnings and Rationale for Method .........................................................35

   Participants ..........................................................................................................................41

   Informed Consent and Confidentiality ..................................................................................43

   Interview Schedule ..............................................................................................................45

   Procedures ............................................................................................................................45

   Data Analysis .......................................................................................................................46
Abstract

Shame inevitably arises for psychologists in training, as they are required to expose potential mistakes or oversights in their personal and professional selves (Hahn, 2001). However, studies show that shame impedes supervisee’s willingness to disclose information to the supervisor, especially regarding clinical difficulties (Ladany et al., 1996; Yourman, 2003) or concerns with professional competence (Ladany & Lehrman-Waterman, 1999). The presence of shame in supervision threatens the assumption of most supervision models: supervisees will willingly disclose pertinent information (Falender & Shafranske, 2004). Fortunately, strong supervisory relationships can buffer negative emotions and supervisors can encourage disclosures (Hess et al., 2008). Utilizing qualitative research methods, this study used Interpretive Phenomenological Analysis (IPA) to examine the interviews of 8 psychologists who have experience supervising clinical and counseling psychology graduate students. The results provide common experiences that supervisors face when dealing with shame within supervision, how they recognize shame, how one might intervene, and what they did to help manage their own uncomfortable feelings. Seven superordinate themes emerged from the analysis: (a) learning how to supervise and manage shame, (b) the supervisory relationship is a protective factor, (c) factors that lead to shame in and out of the supervision room, (d) recognizing shame through nonverbal and verbal cues, (e) “We need to talk about it,” (f) shame can help and hinder growth, (g) feeling stuck. The author applies participants’ reactions to shame to Nathanson’s (1992) “Compass of Shame” theory and implications for supervisory practice are discussed.

This dissertation is available in open access at AURA, http://aura.antioch.edu/ and Ohio Link ETD Center, https://etd.ohiolink.edu/.

Keywords: supervision; supervisee shame; supervisory relationship; professional development
Shame in Supervision: Do Supervisors Sense What is Hidden?

Shame is a powerful human emotion that often enters the supervisory relationship. Given the evaluative nature of supervision and the use of one’s self as a tool in psychotherapy (e.g., countertransference), one can imagine that shame is a normal emotion within the supervisory relationship. However, shame can also impede the supervisory relationship, supervisee learning, and client care (Falender & Shafranske, 2004; Talbot, 1995). Shame-inducing experiences can result in missed opportunities for the supervisee to explore their influence on treatment and leads to nondisclosure of clinical interactions (Yourman & Farber, 1996). When supervisees withhold information from supervisors, evaluation methods are compromised, opportunities for therapist development are missed, client welfare may be jeopardized, and the supervisor’s license is at risk (Yourman & Farber, 1996).

Supervisees are constantly in an environment where they are required to expose themselves and their work to critical feedback and evaluation, which may result in shameful feelings (Farber, 2006; Hahn, 2001; Ladany et al., 1996; Yourman, 2003). Supervisors often rely on the ability of trainees to discuss cases in a detailed, complex, and sophisticated manner, which is often through self-report methods (O’Donovan et al., 2011). However, to defend against scrutiny and feelings of shame, trainees who are concerned about being negatively evaluated may choose to select only portions of their clinical work that they feel more comfortable with (Farber, 2006; Ladany et al., 1996). Therefore, the ability of supervisees to provide unbiased clinical information can be colored by feelings of shame. Ethically, this poses a concern: If supervisees do not disclose clinical mistakes, supervisors are unable to address supervisee incompetence, and act according to their ethical obligation of protecting the client from harm (American Psychological Association, 2015).
Supervisees are less likely to disclose their mistakes when the supervisory relationship is weak and may be less willing to follow through on supervisors’ recommendations (Ladany et al., 1996; Yourman & Farber, 1996). Negative interactions and ruptures in supervision create an environment in which supervisees’ may feel unsafe and unsupported, lose confidence in themselves, feel uncomfortable trying out new skills, become guarded or defensive, hide their clinical mistakes, and in some extreme cases, reduce career commitment (Ellis, 2017; Ladany et al., 1996; Nelson & Friedlander, 2001). When supervisees are unwilling to expose their mistakes, ask questions, and feel the need to hide clinical information, supervisors are unable to provide effective evaluation and feedback. Moreover, supervisors may be unable to meet ethical standards and accurately perform their function as gatekeepers to the profession, as they may lack full knowledge of their supervisees’ abilities and mistakes. Fortunately, there are supervisors who have strong bonds with their supervisees, where ruptures and negative emotions can be worked through, leading to an even stronger relationship (Nelson et al., 2008; Sarnat, 2016).

The secretive nature of shame poses an additional challenge for supervisors, as it likes to hide and transform. Although supervisors are equipped with a variety of therapeutic skills, their supervisees are not their clients. Furthermore, not all supervisors received supervision of supervision and may not be aware of the impact shame may have or how it can present. Historically, supervision was largely based on the assumption that therapeutic skills and theory will transfer to the supervisory role (Falender & Shafranske, 2012), which can pose an ethical concern when a supervisor overlooks the complexities of their role. This concern is supported by evidence that psychologists are providing inadequate and harmful supervision (Ellis et al., 2014). However, the practice of supervision is now widely acknowledged as a “distinct activity” and is
now a core competency domain for psychologists (American Psychological Association, 2015). Despite the presence of evidence-based supervision models (Falender & Shafranske, 2004) and theories of shame and shame reactions (e.g., Alonso & Rutan, 1988; Brown, 2006; Nathanson, 1992), it is hard to know what happens in practice.

**The Project’s Aim**

There is a gap in the existing literature regarding how we understand the subjective experience of practicing clinical supervisors. Given the tendency for shame to be hidden, little is known about how supervisors identify or experience the effects of shameful feelings of their supervisee. To address this gap, this research helps us understand what it is like to be a supervisor and to explore how supervisors experience supervisee shame in supervision, as well as how shame presents in this specific context. Understanding how supervisors manage supervisee shame may inform training for graduate students—who may one day be supervisors—by shedding light on the lived experience of practicing supervisors and how they manage this hidden, and at times, destructive emotion. Furthermore, exploring how supervisors manage shame with their supervisees may provide techniques to work through shameful feelings and strengthen supervisory bonds. By interviewing current supervisors, this study may also highlight common experiences of practicing supervisors that have been overlooked in the current research.

**Literature Review**

This portion of the literature review will provide a phenomenology of shame based on a literature review of psychological theory and research. The first section offers a definition of shame and its membership as a self-conscious emotion. The next section highlights psychological theories and how shame has evolved over time. Common reactions to shame, or
coping styles, are discussed in the following section. Specifically, Nathanson’s (1992) “the compass of shame” offers a means through which to understand reactions to shame and behaviors that may manifest in supervision. To better understand shame in the context of supervision, Alonso’s (1988) conceptualization of how shame can enter clinical supervision follows, as well as how shame impacts disclosing mistakes. Lastly, the value of working through shame in supervision is addressed.

An Overview of Shame

Shame is commonly written about as a response to a moment of exposure, which uncovers aspects of the self that are sensitive, intimate, and vulnerable. Consequently, the feeling of shame can be painful, debilitating and lead one to withdraw or hide. Kaufman (1993) explains, “like a wound made from the inside by an unseen hand, shame disrupts the natural functioning of the self” (p. 5). Externally, shame is a response to the self being seen as bad or inadequate. Internal shame is the experience of internally evaluating the self in comparison to others with the fear of exposure. Both can lead to self-criticism and self-persecution (Gilbert, 2007). In addition to the unpleasant feeling shame creates, shame also has negative impacts on interpersonal behavior and creates problems in relationships, whether parent–child, teacher–student, therapist–client, or supervisor–supervisee (Morrison, 1996).

Shame can be considered a trait or a state. The state of shame is a momentary, yet painful feeling that passes. Shame is comprised of both negative self-evaluations (e.g., thinking one is an awful person; feeling badly about oneself) and avoidance behaviors or intentions (e.g., leaving the situation; hiding). Over time, frequent shameful states can lead to a disposition called shame-proneness (Tangney & Dearing, 2011), which is considered to be a stable trait across

**Shame is a Self-Conscious and Moral Emotion**

Shame is considered a self-conscious emotion along with guilt, embarrassment, and pride. This “family” of emotions are grouped together due to their self-evaluative process (Tracy & Robins, 2004) where the self, evaluates the self. Self-conscious emotions are evoked in situations where a person’s behavior or traits are considered inconsistent from social or moral standards. They are distinguished from “basic” emotions due to their need for appraisal of how a situation relates to the self and are thought to play a basic role in self-regulation of moral behavior (Tangney & Dearing, 2011).

Self-conscious emotions are also considered moral emotions. Self-conscious emotions are thought to help us act morally and avoid wrong-doing; or repair any wrongdoing that may have occurred (Tangney et al., 1995). Shame along with embarrassment, guilt, and pride, guide our behaviors or actions based on others’ reactions. These emotions are distinguished by the type of appraisal that is made. For instance, shame occurs after an accidental breach of moral code versus the feeling of embarrassment that occurs after an accidental breach of social convention (Tangney et al., 1995). Furthermore, guilt is more likely to occur in response to thinking about the effect of an action on others, as opposed to shame, which is felt in response to feeling concerned about others’ evaluation on the self. Although guilt and shame tend to be used interchangeably, they are quite different; the negative evaluation of the whole self that accompanies the feeling of shame differentiates the emotion from guilt, a negative evaluation of a behavior or action. The phenomenological experience of shame is an intense concern with the self, especially regarding how negative events have, or might, impact the self.
Sources of shame can be both interpersonal and intrapsychic processes, whereby there is a sense of exposure for others to scrutinize. Taylor (1985) argues that the feeling of being publicly exposed or judged by the other is a part of shame, but the perspective of “other” can easily be taken on by the self; there does not need to be a physical other to feel shame. Similarly, Williams (1993) argued that shame is an internalized ethical other made up of values and attitudes within a social context. The actual presence of another person is not needed for one to feel scrutinized, unworthy, and ashamed.

Applying this to the context of supervision, shameful feelings may arise for supervisees when there is a discrepancy between their performance and internally held standards. Talbot (1995) describes this process as the painful realization that there is a disparity between our actual self and our ideal self. It makes sense that shame may be a common emotional response when working with supervisors, whose role is to evaluate. Shame may occur in response to ruptures (Mehr et al., 2010; Yourman, 2003), perceived microaggressions (Constantine, 2008; Constantine & Sue, 2007), or a supervisor’s response to clinical work (Ellis et al., 2014). When supervisees feel scrutinized by their supervisors, it is common for shame to arise along with feeling incapable, helpless, and powerless, which may continue outside of the supervision.

**Shame versus Guilt**

Clinical psychologist Helen Block Lewis (1971) merged her extensive background in psychoanalytic theory and ego psychology to deepen the conceptualization of shame and identify key differences between shame and guilt. She argued that shame is typically more painful than guilt because a behavior is the focus of guilt (e.g., “I did that horrible thing”), while the self is the focus of shame (e.g., “I did that horrible thing”). When feeling guilt, attention is directed
outward at what they have done, ideally leading to accepting and taking responsibility. Shame attracts attention inward at the self, leaving one feeling powerless and deficient.

Tangney et al. (2007) considers guilt to be more adaptive than shame. Guilt leads to corrective behavior, whereas shame hinders thought process and problem solving leading to withdrawal strategies (Tangney et al., 2007). Tangney et al. (2007) further explain, “Painful feelings of shame are difficult to resolve. Shame offers little chance of redemption. It is a daunting challenge to transform a self that is defective at its core” (p. 353). In focusing on bad behavior (i.e., guilt), versus the bad self (i.e., shame), it is easier to recognize the effects of that behavior on others and make a repair. When feeling ashamed, we become self-focused and have difficulty empathizing with others (Tangney, 1995), and instead, we hide our “bad” selves.

However, shame may not be all bad. Rodogno (2008) theorized that shame can be adaptive in certain contexts and when healthy people feel short episodes of shame, they recover quickly. He notes that shame in small instances (versus chronic shame states) may help to motivate and create change. Blum (2008) notes that shame does not have to be destructive and has a socializing power. Shame in itself is not a problematic or bad emotion, it’s the ineffective coping of shame that seems to be the problem. Lickel et al. (2014) found that for college students, shame over guilt predicted stronger feelings of motivation to change the self for the future. Similarly, Izard (1977) argued that: “The effort to repair and strengthen the self after experiencing intense shame often continues for several days or weeks … the processes can lead to a sense of adequacy and enhance self-identity” (p. 404). For 136 college undergraduate students, shame was found to elicit approach-related motivations, particularly when actions could improve upon a past failure to restore a positive self-image and prevent further damage to the self (de Hooge et al., 2010). Although there are discrepancies between how destructive
shame can be, Dearing and Tangney (2011) notes that there are “good ways and bad ways to feel bad” (p. 711). In trying to understand more about shame and how one might manage this emotion, we need to better understand common patterns of coping.

**Shame Reactions**

Although shame can be difficult to recognize, there are common reactions or methods of coping. Using clinical observations, Nathanson (1992), an avid shame researcher, conceptualized how people react to shame and developed the *Compass of Shame Theory*. According to this model, effective shame management occurs when a person attends to the source of shame and addresses it. Nathanson includes four shame coping styles (i.e., poles) people typically engage in to diminish, ignore, or magnify shame. The four poles are viewed on a spectrum of mild to severe reactions: (a) withdrawal, (b) attack-self, (c) avoidance, and (d) attack-others.

The action associated with the withdrawal pole is to escape or hide, limiting the feelings of shame. Although shame is recognized and accepted as valid, it is too painful and the individual attempts to escape. The attack-self pole also requires acknowledging and accepting the shameful feeling, but the shame is internalized and amplifies the feeling. The response is often harsh criticism, contempt, and anger directed toward the self. Self-deprecation is also used in order to accept the shame and to elicit reassurance from others. An important difference between the withdrawal and attack poles is that the individual who withdraws may sacrifice relationships, whereas those who attack self will endure shame to maintain relationships (Elison, et al., 2006). In both poles, the self is experienced as flawed and defective.

Both attack-others and avoidance poles involve the limited awareness of shame. At the attack pole, shame may not be recognized, likely is not accepted, and to alleviate discomfort, attempts are made to make someone else feel worse (Nathanson, 1992). To defend against
feelings of worthlessness and rejection, anger is directed at the source of shame; the shame is projected onto another (Elison et al., 2006). The avoidance pole also involves a failure to recognize or nonacceptance of shame. Attempts are made to distract, dissociate, or disconnect the self from shame. The purpose of the avoidance behaviors is to minimize the awareness of shame or to prevent the conscious experience shame (Elison et al., 2006).

The four strategies identified in the Compass of Shame model are not used independently and an individual might utilize features of multiple poles simultaneously (Nathanson, 1992). However, a common characteristic of these strategies is that they fail to promote successful processing of emotion. Some individuals are able to cope with shame effectively, which can strengthen relationships with others and the self. To capture this coping style, Elison et al. (2006) added onto Nathanson’s model by adding a fifth pole of adaptive coping, which occurs when a person acknowledges shame and is motivated to apologize and/or make amends.

**Cultural Implications**

Culture impacts responses to shame, as well as the perceived effectiveness of how one copes with shame. Although Ellsworth (1994) argued that all humans have emotions that are hardwired for action, different cultures have varying beliefs about what defines something dangerous to run from. Ellsworth explains that “although basic emotions are universal, cultures differ in their beliefs about the meaning of these emotions and about the appropriateness or inappropriateness of emotional expressions and emotional behaviors in different social contexts” (p. 29). For example, *chemyeon* is a Korean term meaning, “face without shame,” which implies that one’s behavior has complied with others’ expectations. Choi and Kim (2004), suggest that given the cultural importance of chemyeon, Koreans are highly aware of shameful feelings that arise during moments when they feel incompetent. Given the social context of shame, different
cultures impact when and where someone might feel ashamed. Although some individuals may be vulnerable to shame, the manner in which shame feels or motivates behavior may be different.

The purpose and function of shame may differ between cultures. Every cultural group uses shame differently in parenting, instilling values and morals, setting social norms, and in punishment techniques. Cultures use shame as a means of making-meaning, furthering social control, and a socializing tool (Ellsworth, 1994). The different ways in which shame is used to socialize will have an effect on how shame is experienced by people in various cultural contexts. Some cultures place less importance on the individual who feels shame, while others focus on bringing shame (dishonor) to their families and communities (Gilbert, 2007). Given the cultural implications on how shame is experienced, it is important to acknowledge the influence of the Western culture on this current study and remember that we all interpret shame through our own personal and cultural lens.

**Theoretical Frameworks of Shame**

**Affect Theory.** Silvan Tomkins (1987) used psychological theory and biology to enhance our understanding of shame as an affect. Tomkins posits that affects are sets of muscular, glandular, and skin receptor responses located in the face (and distributed throughout the body) that generate sensory feedback to a system that finds them either acceptable or unacceptable. Within this theory, affect is the primary innate biological motivating mechanism.

Tomkins (1987) hypothesized that shame is one of nine inherent affects that form the core system of human motivation. Positive affect includes interest, enjoyment, and surprise. Negative affects include distress, fear, anger, shame, and disgust. Affects can override “hardwired” drives (e.g., hunger, sex drive), as they turn a person’s conscious attention to matters requiring action (Tomkins, 1987). However, shame is unique in that it “interrupts
positive affect whether it be through non-responsiveness of another person or the realization by an individual that he or she is not as smart, beautiful or creative as he or she had previously thought” (Nathanson, 1992, p. 143). In addition, shame is powerful in that it limits intimacy and empathy by interrupting affective communication and blocking further positive affect.

**Psychodynamic Influences.** Psychoanalytic approaches to shame focus on the internal dynamics of self-evaluation. These approaches rest on the basic assumption that shame originates in the unconscious (Morrison, 1996). In Freud’s work he briefly mentioned shame as a defense against sexual impulses. However, the main focus of his work was on guilt, which he theorized arose in response to moments when the id (i.e., impulse) or ego (i.e., mediator between id and superego) impulses clash with the moral standards of the superego (Morrison, 1996).

Following Freud’s work, a number of neo-Freudian psychologists attempted to distinguish between the emotions of guilt and shame. Adler (1927), an early associate of Freud, coined the terms “inferiority feelings” and the “inferiority complex,” which highlights the role of shame or shame-related phenomenon in personality development. Similarly, Karen Horney’s hypothesis was that shame and humiliation result in response to a violation of pride (Nathanson, 1992).

Piers and Singer (1953) argued that shame occurs when the ego and ego-ideal (i.e., ideal behaviors developed from social/parental standards) are in conflict. The ego-ideal is an idealized moral self that includes components of “narcissistic omnipotence, positive identifications with parental imagines, positive identifications with other social relationships and instincts” (Piers & Singer, 1953, p. 84). When a goal (of the ego-ideal) is not reached, it indicates a failure or shortcoming and leads to abandonment and hiding (Piers & Singer, 1953). Lewis (1971) shared a similar conceptualization to shame and theorized shame to be an emotion arising from the
evaluation of the whole self and that “identification with the beloved or admired ego-ideal stirs pride and triumphant feeling; failure to live up to this internalized admired imago stirs shame” (p. 23). Shame continued to gain popularity when Erik Erikson (1950) directly named shame as an essential component in development. In his theory, shame is the second of eight stages that span the life cycle, and results in autonomy or shame and doubt. Shame is conceptualized as a global self-doubt and feeling inadequate contrast to feeling self-confident and secure in the outside world.

**Attachment Theory.** Bowlby (1973) proposed that powerful emotions, both negative and positive, are products of attachment relationships. Bowlby theorized that a “good enough” caretaker-child relationship is a secure base where the child develops a positive internal working model for relationships with which they can navigate the relational world in a safe way. The development of this internal model is a process that happens through stable and consistent affective regulation with cycles of attunement, rupture, and repair. However, when there is a rupture in the attachment between a caregiver and infant, shame can occur. Bowlby described that when a child is rejected by his parents “he is likely not only to feel unwanted by his parents but to believe that he is essentially unwanted, namely unwanted by anyone” (p. 238).

The need to belong and to form attachments extends to other social relationships and is a fundamental human motivation. Schore (1998) used Bowlby’s psychoanalytic theory of attachment as a landscape to create a neuro-regulatory view of attachment and shame. He states that shame is “the reaction to an important other’s unexpected refusal to co-create an attachment bond that allows for the dyadic regulation of emotion” (p. 65). Physiologically, he explains that shame is the inhibition of excitement from the sympathetic autonomic nervous system and engagement of the parasympathetic nervous system, creating a shift from an energy mobilizing
to conserving state; this shift is associated with negative affect, shame behaviors (e.g., hiding), and distress. If a caregiver is attuned to the child, they respond to the distress with empathy and attempt to repair the bond. Cozolino and Santos (2014) notes that repeated experiences of a rapid return from shame can create an expectation that challenging social interactions will have a positive outcome. Conversely, repeated negative experiences lead to deep rooted shame, instilling the belief that “I am bad.”

In supervision, responding to affective material is essential for effective supervision. Schore and Schore (2008) argue that for emotional growth that goes beyond words; in psychotherapy, there needs to be “right brain to right brain” communication between patient and psychotherapist. Within the supervisory relationship, when supervisors create a calm and receptive atmosphere, the supervisee can more easily settle into their own emotions and think more deeply (Sarnat, 2016).

**Supervisees are Vulnerable to Shame**

Novice therapists entering the field face the challenge of examining, understanding, and improving the complex lives of humans, which is magnified by frequent evaluation. Hahn (2001) suggests that shame is an inevitable consequence of the demands of exposure during supervision; supervisees are being evaluated and scrutinized by people whose opinion deeply matters to them. The power dynamics that arise when being evaluated is supported by Ladany, Ellis, and colleagues (1999), who found that evaluation may moderate the relationship between working alliance and supervision outcome. For example, a trainee may not self-disclose relevant personal information out of the fear that they may adversely affect his or her evaluation. Doehrman (1976) highlights this tension, “supervisors are not only admired teachers, but feared judges who have real power” (p. 11). The paradoxical nature of supervision creates an additional complexity to
how evaluation occurs and how evaluation impacts supervisees. However, within the context of a strong supervisory bond, sharing challenging cases and exposing clinical work is a welcomed method for many (Ladany, Ellis et al., 1999). Heckman-Stone (2003) found that clinical and counseling psychology graduate students desired positive and negative feedback from supervisors that was frequent, immediate, clear, and specific. Results also highlighted the challenges of balancing feedback, as a deficit of positive feedback and a lack of immediate or frequent feedback were identified as common problems.

The social-evaluative nature of supervision can be particularly shame inducing (Kemeny & Shestyuk, 2008). It is well known that shame is often experienced in regard to one’s areas of vulnerabilities, which supervisees are required to share and expose in supervision. Kemeny and Shestyuk further explain that social evaluative threat occurs in conditions in which one may be negatively judged, contexts that require performance of valued skills (e.g., intelligence), when group membership is at risk, and when uncontrollable aspects of one’s identity are salient to others. These conditions are common experiences in graduate training, as evaluation and feedback from supervisors, instructors, and peers are expected components of supervision and classroom interactions. Supervisees are part of multiple environments that are fertile grounds for shameful feelings. Over time, supervisees may perceive negative social evaluation by professors and/or supervisors, which transforms into negative self-evaluation.

The inherent power differential and evaluative component of supervision places the supervisee in a vulnerable position that can promote nondisclosure, especially in the absence of a strong working alliance (Bordin, 1983; Farber, 2006; Hess et al., 2008). When supervisors don’t bring up the power differential, this can have a negative impact on the supervisory relationship. Feelings of vulnerability and powerlessness contribute to increased guardedness around feelings,
thoughts, and experiences (Brown, 2006). Furthermore, negative experiences with past disclosures may lead supervisees to feel guarded with current or new supervisors (Hess et al., 2008). When supervisors don’t bring in negative feelings into the supervisory relationship, supervisees may withhold them. It is recommended that supervisors initiate conversations about the power differential and explore how this dynamic may impact the supervisory relationship (Sarnat, 2016).

Supervisees may feel particularly vulnerable and exposed in supervision as the self is used as a therapeutic tool. Supervisees expose sensitive parts of their personal and professional identities when they share concerns, reveal weaknesses, and ask questions (Alonso & Rutan, 1988). Self-reflection is common in training practices, and when combined with feedback about interpersonal styles from idealized supervisors, this opens up the possibility for scrutiny. Furthermore, supervisees work toward membership into the psychology field, but do not secure their place until after they complete training and licensure. As such, supervisees can experience heightened self-consciousness and discomfort due to the evaluation of interpersonal qualities, sharing challenges and mistakes, as well as personal characteristics (Bernard & Goodyear, 2018). Although vulnerability can be frightening, it allows the supervisee to learn about the self and how to distinguish the self from others. Although this can feel exposing, vulnerability can be safely contained and nurtured through a trusting, supportive, empathetic, and respectful relationship that welcomes disclosures and the development of the supervisee (Gray et al. 2001; Rousmaniere & Ellis, 2013).

**Shame Leads to Nondisclosure**

Research supports two types of nondisclosure: (a) unintentional and (b) intentional (Farber, 2006; Hess et al., 2005). Unintentional nondisclosure is the result of supervisees’
unsuccessful attempts to communicate the complexity of what is occurring in therapy or supervisees’ uncertainty about what is appropriate to share in supervision (Farber, 2006; Wallace & Alonso, 1994). Clinical work can be complex and difficult to communicate, which some argue accounts for the difference between what occurs in therapy versus what the supervisee reports in supervision (Yerushalmi, 1992). Ellis (2010), a psychologist who is immersed in training research, explains that despite having a good rapport with supervisees and trusting their abilities, supervisees often “miss or are unaware, misinterpret or inaccurately recall that which transpires in the therapy session” (p. 105). Ellis highlights the difficult position that trainees are put in when supervisors rely heavily on self-report methods.

In contrast, intentional nondisclosure (i.e., intentionally withholding of information) is the result of supervisees’ conscious decisions to not disclose or to distort significant information (Farber, 2006; Ladany et al., 1996). Hess et al. (2008) refer to this behavior as “willful withholding” (p. 400). Empirical evidence confirms a pattern of intentional omission by supervisees with varying levels of training and experience (Ladany et al., 1996; Webb & Wheeler, 1998; Yourman, 2003; Yourman & Farber, 1996). Although there are challenges with assessing the prevalence of unintentional disclosures, research illuminates the prevalence of intentional disclosures of supervisees. For example, in a sample of 108 clinical and counseling psychology doctoral students, Ladany et al. (1996) found that 97.2% of participants reported withholding information from their supervisors, with an average of 8.06 instances of withholding information over the course of supervision. Participants rated the withheld information as moderately important to their clinical training. In addition, Mehr et al. (2010) interviewed 204 trainees about their most recent supervision session and found that 84.3% of those trainees failed to disclose information during that session. On average, participants reported 2.68 nondisclosures
Supervisees intentionally hide information from their supervisors. Learning more about how shame impacts the decision to share or withhold information is worth further exploration.

**Supervisee Shame Affects Intentional Nondisclosure**

Shame is a common emotion felt by supervisees that leads to hiding, omitting, and/or distorting information relevant to supervision (Alonso & Rutan, 1998; Farber, 2006; Yourman, 2003; Yourman & Farber, 1996). Ladany et al. (1996) interviewed 108 therapists-in-training and found that the most typical nondisclosure involved negative reactions to the supervisor (e.g., deference to the supervisor, impression management, fear of political suicide). Similarly, Hess and colleagues (2008) interviewed 14 counseling predoctoral interns (i.e., PhD and PsyD) and found two common reasons for non-disclosing: (a) concern about poor evaluation affecting their future; and (b) not disclosing due to negative feelings (e.g., insecure, unsettled, vulnerable, self-doubt, embarrassed). For example, one participant’s response illustrated how negative feelings interfere with her comfort in supervision, “I felt insecure because I felt I should know more than I did…I felt vulnerable and had self-doubts” (Hess et al., 2008, p. 404). Another participant shared their fear of evaluation, “I did not want the confusion I felt to interfere with my supervisor’s evaluation of me…Disclosure threatened to endanger my supervisor’s favorable opinion of me” (Hess et al., 2008, p. 404). In both of these studies, supervisees attempted to avoid negative reactions from their supervisors, as well as avoid feeling embarrassed or ashamed about their own competence.

Shame-proneness is linked to nondisclosure. In an attempt to better understand the relationship between shame-proneness and disclosure, DeLong and Kahn (2014) provided measures to 312 U.S. college students, and those who were shame-prone were more likely to
keep secrets hidden from a hypothetical counselor due to fearing the risks of their self-disclosure. In general, those who were rated as higher in shame-proneness expected that disclosing their secret would be associated with greater risk than those who were less shame-prone. Additionally, shame regarding a specific event or secret was negatively related to disclosing; they tended to keep their secrets hidden. In general, shame-proneness seems to heighten people’s concerns about what negative outcomes might occur from disclosing.

Similarly, a longitudinal study was conducted to assess the influence of trainee shame-proneness on the supervisory process (Bilodeau et al., 2012). In this study, 47 male and female first-year masters counseling students underwent a 5-session supervision process, and were given a series of questionnaires, one of which measures internalized shame (i.e., The Internalized Shame Scale). Results suggested that trainees who were higher in shame-proneness first reported a higher strength of supervisory working alliance; however, the strength of the alliance and rapport (i.e., trainee’s perception of supervisor support) declined over time. The authors suggest that supervisees who are shame-prone may be more likely to use defense mechanisms as emotional protection. Particularly high shame-prone supervisees may avoid emotionally engaging with their supervisors to avoid exposure to the humiliation associated with shame, impacting the supervisory alliance and the quality of the learning for the supervisee.

For beginning therapists receiving supervision, it is likely that there are some supervisees who are shame-prone and may have a heightened concern for what negative outcomes may arise in supervision, regardless of the supervisor’s presentation, response, or personality. Furthermore, they may be aware of the potential benefit of sharing these secrets or clinical challenges, yet their fear of being shamed may ultimately result in non-disclosure. In general, trainees are in an
environment where they are being evaluated frequently and in different domains (e.g., clinical practicum, academic classes), which may make this group more vulnerable to feel shame.

**Supervisees Hide Important Clinical Information**

A number of research studies have examined the content of what supervisees choose to withhold. Existing studies have consistently highlighted supervisees’ non-disclosure or partial concealment of potentially salient information (Hess et al., 2008; Ladany et al., 1996; Mehr et al., 2010; Webb & Wheeler, 1998; Yourman & Farber, 1996). Although there is a range of subject content, the most common reported content areas include: clinical mistakes (Mehr et al., 2010; Walsh et al., 2003), issues related to the supervisory relationship (Hess et al., 2008; Ladany et al., 1996; Mehr et al., 2010; Skjerve et al., 2009), personal/countertransference reactions to clients (Hess et al., 2008), and personal/non-client related issues (Ladany et al., 1996; Mehr et al., 2010). The meaningful content of non-disclosures has important implications for supervision being able to effectively fulfill its intended purpose. Most importantly, nondisclosure of relevant clinical information limits the supervisor’s ability to evaluate and guide the trainee’s work with clients (Bernard & Goodyear, 2018). In extreme cases, the supervisor may be unaware of a serious ethical violation on the trainee’s part or some other threat to a client’s welfare.

Yourman and Farber (1996) found that trainees reported they do not always inform their supervisors of interactions with patients when they believe that supervisors will disapprove. In addition, trainees often found themselves telling their supervisor what they believe he or she has wanted to hear, and omitting clinical errors. This phenomenon is supported by the idea that conflicts in the supervisory hour can develop from the supervisor being unreceptive to supervisee’s point of view, and the desire for the supervisee to see things his or her way (Nelson
Similarly, Ladany and colleagues (1996) surveyed psychology graduate students (N=108) and found that 44% of supervisees did not disclose (perceived) clinical mistakes in order to “maintain a positive appearance to the supervisor” (p. 19). Although it is understandable that supervisees may be reluctant to voice a negative perception of the supervisor or a supervision process, when a trainee refrains from disclosing these feelings (Ellis et al., 2014; Nelson & Friedlander, 2001), the supervisor does not have the opportunity to become more responsive to their needs.

**What is Supervision?**

Some would say that the supervisory relationship is a primary vehicle by which supervisors enhance the development of their trainees and the quality of treatment. Over time, the definition of supervision has shifted, as it is now recognized as a distinct professional competence and core competence. Falender and Shafranske (2004) provide a competency-based framework for supervision and state that “supervision is the experiential foundation for the psychologist’s knowledge, skills, and values to be consolidate and applied” (p. 3). In this approach, supervision is viewed as a distinct professional practice that has specific competencies that can be learned in order to foster the growth of supervisee’s clinical competence and application of ethical values, knowledge, skills, and attitudes (Falender & Shafraske, 2004). Falender and Shafraske (2004) define supervision as:

Supervision is a distinct professional activity in which education and training aimed at developing science-informed practice are facilitated through a collaborative interpersonal process. It involved observation, evaluation, feedback, the facilitation of supervisee self-assessment, and the acquisition of knowledge and skills by instruction, modeling, and mutual problem solving. In addition, by building on the recognition of the strengths
and talents of the supervisee, supervision encourages self-efficacy. Supervision ensures that clinical consultation is conducted in a competent manner in which ethical standards, legal prescriptions, and professional practices are used to promote and protect the welfare of the client, the profession, and society at large. (p. 3)

Inherent in this model, as well as most other models of supervision, is the expectation that supervisees will disclose to their supervisors about themselves, their clients, and the therapeutic and supervisory relationships to facilitate the supervision process and therapist development. For instance, in order to engage in mutual problem solving, the supervisee must first disclose problems and then be willing to engage in the back-and-forth sharing of ideas and observations in order to finding a possible solution. Through act of self-disclosing, supervisors are better able to understand the needs of their supervisees, care for the well-being and treatment of patients, and support the development of supervisee needs (Ladany et al., 1996; Yourman, 2003). When supervisees withhold important information from supervisors, opportunities for therapist development are missed and client welfare may be jeopardized (Ladany et al., 1996; Yourman & Farber, 1996).

The sum of one’s experiences in supervision influences the development of attitudes and skills that will support meaningful self-assessment, competence, and counseling self-efficacy (Falender & Shafranske, 2004). However, if practicing supervisors have not received adequate training about the practice of supervision and/or are unaware of this dynamic in supervision, how do we know what is being practiced or if the psychologist is a competent supervisor? Although clinical supervision has been recognized as a distinct practice in the literature for many years it has not always been valued as a core competency (Bernard & Goodyear, 2018). For years, many supervisors continued to practice without education, or training in supervision (Bernard &
Goodyear, 2018; Falender, 2018; Scott et al., 2000). Without such training, supervisors rely on implicit methods of supervision based on past experiences as a supervisee or skills learned from clinical training as a therapist (Falender & Shafranske, 2004). Sarnat (2016) describes the importance of working with feelings in supervision and modeling interpersonal processing with supervisees (e.g., identifying transference) versus learning from a didactic method. The assumption that the skills of an effective psychotherapist leads to an effective supervisor minimizes the intricacies of supervision and poses concern for ethical issues regarding client welfare (Falender, 2018). This is particularly concerning as it is psychologists’ third most frequent professional activity, falling behind psychotherapy and assessment diagnosis (Norcross & Rogan, 2013).

Fortunately, over the last 20 years there has been a gradual recognition of supervision as a core competency, which has impacted APA-accredited counseling and clinical training programs. Currently, the APA requires doctoral programs to include a supervision and consultation course within their curriculum (APA, 2015). There are also specific guidelines for supervisors that aim to provide a framework to inform development, use as a self-assessment tool, and to promote competency-based supervision (APA, 2015; Association of State and Provincial Psychology Boards [ASPPB], 2015). In particular, APA created a domain outlining “supervisor competence” outlining how supervisors are expected to attain and maintain competence through education and training:

The formal education and training should include instruction in didactic seminars, continuing education, or supervised supervision. At a minimum, education and training in supervision should include: models and theories of supervision; modalities; relationship formation, maintenance, rupture and repair; diversity and multiculturalism; feedback, evaluation;
management of supervisee’s emotional reactivity and interpersonal behavior; reflective practice; application of ethical and legal standards; decision making regarding gatekeeping; and considerations of developmental level of the trainee. (p. 15)

Organizations that inform education and training for clinical psychologists like APA and the ASPPB, recognize the importance of training, which has shifted the pedagogy of supervision toward using theory and evidence to inform practice (APA, 2015). Though researchers, psychologists, and the APA have done their best to increase our knowledge of supervision and to operationalize competency in supervision, there are still difficulties that arise in supervision.

Falender and Shafranske (2012) explain that without foundational experiences in a competency-driven supervision, professionals will not have the necessary tools to develop the complex roles of a supervisor. This may be the case for practicing supervisors, as research shows the presence of inadequate (Ellis, 2017), culturally-insensitive (Constantine & Sue, 2007), and harmful supervision (Ellis, 2010; Ellis et al., 2014). It is recommended that supervisees and supervisors discuss their sources of discomfort or conflict. Addressing conflicts or negative events in supervision can be healing, and even improve the supervisory relationship (Nelson et al., 2008). However, this poses a challenge when supervisees hesitate to share their true thoughts during supervision (Ladany et al., 1996). If supervisees are keeping conflicts hidden, supervisors may be unable to detect what is hidden.

The Supervisory Relationship

Research has long supported the importance of a strong supervisory working alliance (e.g., Bordin, 1983; Gibson et al., 2019; Ladany et al., 1999; Ladany et al., 2001), which has been linked to increased supervisory satisfaction (Ladany et al., 1999) and increased quality of the supervisory relationship (Ladany et al., 1999). Worthen and McNeill (1996) interviewed 8
intermediate level supervisees and found that “good supervision” led to an increase in confidence, refined professional identity, positive perception of the utility of supervision, and a sense of resilience when presented with challenges or “struggles” (e.g., difficult cases, self-doubt, mistakes).

To better understand the function of the supervisory relationship Bordin’s (1983) working alliance model is used as a framework. Bordin theorized that the working alliance between the therapist and client was necessary for change and growth, which he later applied to the relationship between a supervisee and supervisor. He argued that the quality of the working alliance was far more vital to positive trainee outcomes than the particular supervision model or approach. Along with creating goals and reviewing clinical work, Bordin emphasized the importance of the relationship between trainees and their supervisors, which he described as a type of attachment bond based on a foundation of mutual trust.

Bordin’s (1983) model is useful, as he defines the relationship or alliance, indicates how the relationship is strengthened and weakened, and links the relationship to potential outcomes. This model consists of three components: (a) a mutual understanding and agreement between the supervisor and supervisee on the goals of supervision (e.g., improving technical skills, enhance conceptualization, increase awareness of countertransference); (b) an agreement between supervisor and supervisee on the tasks of supervision; (c) developing a strong emotional connection or bond between supervisor and supervisee. To establish an emotional bond in the alliance, there must be trust, mutual caring, and liking. Like most interpersonal relationships, the supervisory alliance is susceptible to conflict, disagreement, and negative emotions. Bordin suggested that the degree to which change and growth can occur within the supervisor relationship depended upon the ability to build a relationship, navigate conflicts, and repair.
A Framework for Shame in the Supervisory Relationship

The supervisory relationship is susceptible to frequent shameful experiences. Alonso and Rutan (1988) provide a psychodynamic framework that is useful to understand how shame can enter the supervisory relationship and how the supervisee can intervene. They identified four main contributing factors that generate shame in supervision: (a) the learning regression, (b) the patient population, (c) the supervisor’s management of the supervisory hour, and (d) transference and countertransference in supervision. Although supervision is a common space for shame to occur, it is also a space for healing.

Learning to be a psychotherapist differs from learning in other professions because the thoughts, feelings, personality, and behavior of the therapist plays a major role in the daily tasks of the profession. Supervisees experience a learning regression, in which the demands of a developing new professional ego generate intellectual and emotional stressors that contribute to a generally uneasy state. Naturally, the supervisory process elicits a learning regression as students are expected to be vulnerable with their supervisors by exposing their work and parts of their internal emotional world (Alonso & Rutan, 1988).

Trainees enter supervision with admiration for their supervisors, who are seen as respected “primary professional objects” (Alonso & Rutan, 1988, p. 577). Alonso and Rutan (1988) theorize that trainees worry about losing admiration from their supervisors and about receiving negative reactions from supervisors. The trainee is faced with a dilemma: in order to become an expert, work must be exposed, and personal flaws will likely be illuminated in front of admired supervisors. At the same time, this exposure leaves the trainee sensitive to the gap between professional ego ideal (in the form of the supervisor), and his or her own self-image as a professional. Ego ideals often inspire growth, learning, and desire for mastery; however, the gap
between the ego ideal and the perception of actual self and actual performance can lead to feelings of failure and humiliation (Alonso, 1983). Thus, students study hard and work hard to avoid embarrassment, and sometimes distort facts (Ladany et al., 1996; Talbot, 1995). Other times, individuals live in fearful anticipation of embarrassment, experience shame and anxiety, or develop a perfectionistic style to avoid shameful feelings (Alonso & Rutan, 1988). Despite painful feelings, Alonso and Rutan argue that the supervisory hour is an optimal place to experience this regression if the supervisor is aware of the value of this process and if the learner can ultimately integrate the feedback and learning.

Supervisees may feel shame that is projected onto them by clients through the defense mechanism of projective identification. A supervisee who is new to clinical work may have a particular difficulty identifying this defense and accept the feeling as their own. Shame may present in a few ways: (a) supervisees feel ashamed and believe they are “bad,” (b) supervisees feel anger toward the patient, or (c) supervisees distance themselves in order to relieve the discomfort (Hahn, 2001). Transference and countertransference can also lead to shameful feelings for the supervisee. Through a parallel process, the supervisee unconsciously enacts conflicts with their supervisor that are occurring during sessions with their clients, and it’s common for the patient, the clinician, and the supervisor to be caught in the same transference–countertransference pattern. Worst case, the supervisor joins with the patient in criticizing and blaming the clinician, with little awareness of the defense mechanisms and parallel processes at play (Hahn, 2001). Consequently, the student is prone to feeling shame about his or her capacities or lack thereof, and guilty for potential harm being done to the patient.

Boundary issues can also lead to shameful feelings and potentially harmful supervision experiences (Falender, 2016). Alonso and Rutan (1988) describe how challenging it can be
managing the many roles of a supervisor. They note that the supervisor may struggle to manage the roles of teacher, mentor, and therapist in supervision. For instance, supervisors may feel conflicted with being an evaluator and a listener of clinical struggles. Alonso and Rutan use a metaphor of a tightrope to describe the balancing act of managing multiple roles: “The supervisor’s agility in walking this tightrope can be difficult to maintain, and he or she may easily tip too much toward one side or the other, thereby causing inadvertent shame to the trainee in the supervisory process” (p. 579). The supervisee also must develop their own boundaries as they are “learning to work in and with affect, but not necessarily to explore or bear all his or her own affect at the same time” (p. 579).

The multiple relationships in supervision are not always harmful, yet can lead to boundary issues (Ellis, 2017; Falender & Shafranske, 2004). Positive boundary crossings, such as socializing and self-disclosing, can enhance supervisory relationships (Kozlowski et al., 2014). However, inappropriate boundaries and abuse of power can lead to harm and role confusion (Ellis, 2017). Due to the possible ethical violations (e.g., loss of objectivity, confidentiality) that can arise with multiple roles, Falender and Shafranske (2004) state that boundaries in supervision need to be clearly defined, with a focus on how problems or issues may impact the supervisory relationship or relationships with clients.

The actions of supervisors can elicit shame in supervisees. Ellis (2017) interviewed 11 clinical supervisees regarding their experience with harmful supervision, where feelings of embarrassment, shame, and fear are discussed. For instance, one supervisee reported wanting approval from their supervisor, who ultimately made negative judgments toward their clinical interventions (e.g., “That was a weird thing to say” and “I have no idea what you were doing”), made racist remarks calling them a “mutt,” and treated this supervisee differently from the other
students in training (e.g., skipping over this supervisee when congratulating all students in training). In response, this supervisee questioned their competence, and was unable to explore the relational dynamics with their supervisor due to this supervisor’s resistance.

In a less extreme case, another supervisee described the experience of receiving negative feedback from a supervisor, which led to shame and humiliation. This supervisee received negative feedback for the first time from her supervisor during a quarterly evaluation. She reported feeling humiliated and as if this were a “brutal attack” on the person she was, as he stated that her “introversion was pathological…and she should not be in the field of psychology” (Ellis, 2017, p. 51). Although supervision in itself requires supervisees to be vulnerable and opens them up to possible feelings of shame, the actions of supervisors also can induce shame, and in extreme cases, humiliate their supervisees, ultimately creating harm.

**The Supervisory Relationship is a Protective Factor**

Strong supervisory relationships help with navigating (implicit or explicit) disagreements, intense emotions (Ellis, 2017), and managing critical events (Ellis, 2006; Ladany & Friendlander, 1995). Ladany and Friedlander found that supervisory pairs with strong bonds can work through and resolve conflicts more readily. However, in the context of a weak supervisory relationship, a challenge may be seen as harsh or insulting.

The supervisory relationship has been found to have a significant influence on supervisee disclosure (Gibson et al., 2019; Gray et al., 2001; Ladany et al., 1996). For instance, a positive relationship has been found between rapport in the supervisory relationship and disclosure of clinical and supervision-related issues (Webb & Wheeler, 1998). In a group of 257 trainees, Gibson and colleagues found that nondisclosure was most frequent when supervisor working alliance was perceived as poor and when the supervisor did not utilize a collaborative or
relational approach (e.g., process supervisees’ feelings). Similarly, in a study that examined trainee willingness to disclose clinical mistakes among pastoral counseling students, a supportive supervisory relationship (e.g., feelings of mutuality in the relationship; supervisor interest in trainee achievements) was the most influential determinant of trainee willingness to disclose (Walsh et al., 2003). Similarly, Hess and colleagues (2008) discovered that predoctoral interns in “good” supervisory relationships were provided safety (e.g., open, nonjudgmental, respectful, and non-intimidating environment), and these interns felt comfortable disclosing both personal and professional issues with their supervisors.

Ladany and colleagues (2001) suggest that supervisory self-disclosure directly influences the emotional bond within the supervisory alliance by communicating trust. When Hess and colleagues (2008) asked predoctoral interns what would have facilitated disclosure about a clinical mistake, typically they reported that supervisor self-disclosure about a similar event would have facilitated more frequent disclosures. Similarly, Sweeney and Creaner (2014) interviewed graduate students regarding specific past nondisclosures and found that incorporating interpersonal processing into the supervisory relationship and allowing space for processing of personal issues were other ways in which supervisees thought their supervisors could have been more helpful. Relational models of supervision emphasize the importance of this type of emotional processing, which can involve personal issues in supervision, as reflecting on personal and professional issues can lead to a more complex understanding (Sarnat, 2016). For instance, Mangione et al. (2011) interviewed 8 supervision dyads and found that supervisees and supervisors identified sharing personal experiences, along with role-playing, sharing mistakes, expressing genuine affect, and revealing reactions to the workplace, as part of the learning process and moments of emotional closeness. Supervisees feel less exposed and less
threatened if supervisors are open to appropriately disclosing their own challenges in the work, thus normalizing the trainees experience and strengthening their bond (Hess et al., 2008; Mehr et al., 2010).

Errors and difficulties in clinical work need to be welcomed in supervision (Alonso & Rutan, 1988; Nelson et al., 2008). Nelson and colleagues (2008) asked 12 highly competent clinical supervisors about their experience and management of conflict within the supervisory relationship and found that the supervisors were open to conflict and interpersonal processing, willing to acknowledge shortcomings, developmentally oriented, and willing to learn from mistakes. Moreover, supervisors believed in creating strong supervisory alliance, discussing evaluation early on, modeling openness to conflict, and providing timely feedback. When supervisees have a “person-to-person” relationship with their supervisors, they feel listened to, encouraged, have fewer shameful feelings, felt their opinions were listened to, and were encouraged (Nelson et al., 2008). Although shameful feelings are a common occurrence, establishing a good supervisory alliance with trust and communication can reduce shameful concealment of clinical material (Ellis, 2010; Falender & Shafranske, 2004).

**Supervision is an Important Vehicle for Exploring Supervisee Shame**

Although theoretical frameworks use different language to conceptualize shame, there is a clear pattern: shame can be a painful emotion that can stunt growth and compromise exploration. Exploration of trainee shame can be therapeutically necessary when supervisees are feeling “confused, stymied, or ineffective” in the therapist role (Dearing & Tangney, 2011, p. 397). However, shame can be difficult to identify. Talbot (1995) speaks to the “hidden manifestations” of shame: (a) nondisclosure, (b) intellectualization, (c) avoidance of cases, and
(d) distant or vague descriptions of clinical interaction. If not addressed, shame often disguises itself in the supervisory relationship and potentially leads to rupture.

To better understand how shame can impact the openness of training students, Chorinsky (2003) interviewed 12 pre- and post-doctoral trainees. All participants reported feeling shame in supervision, of which half identified their supervisor as helpful and supportive in dealing with the shameful experience. Three variables were identified as contributing to supervisors being unhelpful during shaming experiences: (a) perception of “not wanting to deal,” (b) negative relationship factors (e.g., supervisee didn’t feel safe), and (c) the supervisor being the cause of the shaming feeling (e.g., supervisor was dismissive, having a flat or blunt affect, unempathetic). Supervisors can be unhelpful in managing shame, which can further increase shameful feelings. Although we know less about what supervisors specifically do that is helpful, it is clear that all supervisees experience shame at some point in their training and the supervisory alliance likely plays a part in the ability to manage emotions effectively.

With the presence of a strong working alliance, the supervisory relationship provides a safe place to share vulnerabilities and work through shame. Moreover, working through shame can facilitate growth and development, including increased self-awareness and self-efficacy, curiosity, and self-compassion (Brown, 2006). Hahn (2001) argued that there are a few ways supervisees benefit from addressing shame in supervision. First, supervisees will gain self-awareness, particularly around how their own experiences show up in therapy. Second, supervisees will have an improved sense of self-efficacy within their professional roles. Third, addressing shame increases supervisees’ knowledge of the nature and process of therapy and being vulnerable. Lastly, the supervisory working alliance is ideally strengthened by the process of working through shame. The supervisor can help to demystify shame through normalizing
feelings of insecurity and inadequacy, disclosing professional errors and struggles, and contextualizing the supervisee’s experience within the process of graduate training.

In the context of psychoanalytic supervision, Doehrman (1976) found that through parallel process supervisees unconsciously enacted difficulties they had with their patients with their supervisors. In order for change to occur, the supervisee needs to work through these difficulties with their supervisor. If the supervisor can effectively address these dynamics in supervision, then the supervisee affectively experiences this clinical intervention and can learn from the process (Sarnat, 2016). Some clinical interventions cannot be simply taught or instructed, but are better understood if they are felt and experienced.

Addressing conflicts or negative events in supervision can be healing, and even improve the supervisory relationship (Nelson et al., 2008). However, this poses a challenge when supervisees hesitate to share their true thoughts during supervision (Ladany et al., 1996). If supervisees are keeping conflicts hidden, supervisors may be unable to detect what is hidden. By exploring the experience of practicing supervisors, this study sought to contribute to understanding the impact of shame on the supervisor hour, and identify if or how supervisors can identify and manage supervisee shame.

This Study

Supervisors should be sensitive to and educated about the phenomena of shame within the supervisor relationship (Graff, 2008). As discussed, shame leads supervisees to keep information from their supervisors, some of which is clinically related to patient care. Moreover, shame is a painful emotion that often hides and takes the form of other behaviors (e.g., avoidance, projection, withdrawal) and feelings (e.g., anger), making it difficult to notice and address in supervision. This poses a challenge as supervisors often rely on supervisees to share
clinical information during supervision. Although there are models and frameworks outlining how shame can present, supervisors must have this knowledge in order to respond accordingly. In a subjective sense, it also may feel differently to experience shame firsthand, as noticing the emotion and then responding have proven to be quite challenging. Understanding the specific ways shame presents in supervision and how supervisors manage the presence and effects of this emotion is important to the supervisory process.

There is a gap in the research as it pertains to how supervisee shame is handled in the supervisory relationship. Given the tendency for shame to hide, little is known about how supervisors identify or experience supervisees who have shameful feelings. Although there is research that explores how supervisees experience shame and how shame impacts their decision to disclose information to their supervisors, the research examining how practicing supervisors experience and manage supervisee shame is scarce. Thus, this study explores how shame is experienced by the supervisor. Exploring shame from the perspective of the supervisor may inform how supervisee shame is addressed in training, how supervisors can identify supervisee shame, or how to manage difficult emotions that arise for supervisees.

Method

Research Design: A Qualitative Analysis

This study utilized Interpretative Phenomenological Analysis (IPA; Smith et al., 2009) to explore the subjective experience of how supervisors manage supervisee shame in the supervisory relationship. IPA is a qualitative research approach that examines how people make sense of their life experiences. I chose to use IPA to learn about this hidden experience that many, dare I say all, supervisors encounter. Supervisors of psychology doctoral students participated in this study. Through the use of semi-structured interviews, the supervisors shared
their experience of being a supervisor, how they notice shame in their supervisees, and spoke about a specific encounter with a supervisee who may have felt ashamed. The analytic process involved a process of (a) examining each unique narrative (i.e., case), (b) identifying emergent patterns (i.e., themes), and (c) developing larger frameworks to highlight important relationships between themes.

In this section, I present a rationale for using IPA and discuss its philosophical underpinnings, which informs my rationale, as well as the lens I used as the researcher. Then, I outline the criteria for participants in this study, as well as the methodology I followed. Included is the semi-structured interview used and reasoning for types of questions asked. Within IPA research, there is a set of common processes, principles, and strategies that are applied flexibly (Smith et al., 2009). However, because I am a novice of IPA, the methods outlined in Smith et al. were followed closely. I outline the specific steps and techniques used in this study. However, the reading and re-reading of interviews and notes happened organically guided by my own curiosity, reflections, and desire to make sense of each participant.

**Theoretical Underpinnings and Rationale for Method**

IPA is a qualitative research design that aims to capture and explore lived experience (Smith et al., 2009). This type of qualitative analysis is concerned with understanding lived experiences by exploring their “relatedness to, or involvement in, a particular event or process (phenomenon)” (Smith et al., 2009, p. 40). Oftentimes, life moves so quickly that we miss opportunities to slow down and reflect on important experiences of our lives; a few examples could be returning home after deployment, the experience of losing a parent, or even graduating from a doctoral program. From a phenomenological lens, ‘an experience’ occurs when we slow down, reflect, and become aware of what is happening around us or within us. To better
understand a phenomenon, IPA uses an *idiographic approach* in its attention to the inner experience of an individual and how they make meaning of their world. Through the use of interviews, the IPA researcher aims to better understand how an individual makes sense of important experiences, and in turn, their world. The analysis and method of IPA pulls from the theory of *hermeneutics*, as participants are asked to make meaning or interpret their life experiences (e.g., thoughts, feelings, interactions), which are then interpreted by the researcher in the stages of analysis.

The basis of the analytic process is both iterative and inductive (Smith et al., 2009). Through the process of analysis, I often repeated and returned to past steps (e.g., reading and re-reading data, and my notes) with the intention of better understanding the experience of each supervisor. However, Warnock (as cited in Smith et al., 2009) points out that the particular and the general are not so different and as we dig deeper into a particular experience, we may better understand how others may experience this situation. Hence, inductive analysis brings us closer to the particular, and in turn, we learn more about how others might experience a similar situation, bringing hidden universal meaning making to the surface.

According to Smith et al. (2009), IPA is informed by three philosophies of knowledge: (a) phenomenology, (b) hermeneutics, and (c) idiography. Although these approaches and theories are introduced above, I highlight a few foundational ideas relevant to this study.

**Phenomenology**

Phenomenologists are interested in thinking about how humans make meaning of their lives and how they understand the world. From a phenomenological perspective, the subjective view of experience is a necessary part of any full understanding of the nature of knowledge.
(Moran, 2000). Edmund Husserl, a founder of this school of thought, argued that experience should be understood in its context, as it occurs, as opposed to fitting experiences into pre-labeled categories (Moran, 2000). To do this, Husserl employed a “phenomenological attitude” (Smith et al., 2009, p. 12), which requires one to turn attention inward to reflect on the current experience. Yet, we so often move quickly through life with our attention on the outward (e.g., tasks, objects, goals) and the conscious. Meanwhile, hidden meaning-making is occurring under the surface (i.e., underneath our consciousness). For example, you are sitting at a coffee shop and a dog walks by and you notice it. You may have various thoughts: “What type of dog is that? I wish I could pet that dog,” or later on remembering that you saw that cute dog and thinking “I wish I had a dog.” The practice of stopping and reflecting on the experience of seeing this dog, and the hopes, wishes, and thoughts you had, is phenomenological. Although seeing a dog walking past us may not be a major life experience, this process happens many times over, as we often stay in the conscious instead of reflecting on the many small, but important, experiences that make up our life.

Husserl stated that to achieve a phenomenological attitude, a major shift in viewpoint must occur through bracketing our own preconceived ideas of the world (Moran, 2000). In other words, we must set aside our own lens through which we make meaning (e.g., ideas, values, language, hopes, opinions, judgments). For IPA researchers, this means literally putting them to the side by reflecting, acknowledging, and making notes in order to focus on the essence of a different world.

**Hermeneutics**

IPA is an interpretative task and is informed by hermeneutics, the theory of interpretation. This theory states that humans are meaning-making creatures, and by listening to
stories, we will better understand how meaning is made and better understand life experiences. Hermeneutic theorists are curious about the relationship between the context of a text, methods and purposes of interpretation, and the intentions of an author (Smith et al., 2009). Martin Heidegger, a German philosopher and phenomenologist, saw a connection between hermeneutics and phenomenology (Moran, 2000). He believed that through phenomenology and inquiring about human experience, can we only understand what it means to “be” or to exist; however, “the phenomenon of existence always requires interpretation, and hermeneutics is the art of interpretation” (Moran, 2000, p. 197). Hence, phenomenology is hermeneutic in nature.

The reader, listener, and researcher always bring their worldview (e.g., assumptions, language, experiences) with them when presented with new information. Many hermeneutic theorists studied the bible and ancient texts. They were reading a (visible) story, but there were hidden stories “behind” the words and within the theorist (i.e., interpreter). For an IPA researcher, this process of interpretation is called double-hermeneutics, where the researcher is attempting to make sense of the participant who is trying to make sense of their own experience (Smith et al., 2009).

**Idiographic Approach**

To understand and examine specific details of a person’s life is particularly important in IPA (Smith et al., 2009). The idiographic approach focuses on the individual rather than making claims about a group of people. As such, IPA uses small, carefully selected samples to better understand particular phenomena (e.g., event, process, or relationship). The IPA researcher uses an inductive analysis that is iterative, in that each unique participant narrative is examined in detail (i.e., the particular), and then the researcher steps back to examine similarities and differences across participant narratives (i.e., the whole). By using this approach, IPA brings to
light both the distinct voices, as well as the patterns of meaning in a shared experience. An IPA researcher refrains from making general claims, but explores, in detail, the similarities and differences of each case.

**Rationale for IPA**

My decision to use IPA was influenced by in-person conversations with my peers and advisor, as well as reviewing findings of published research. As a student, I often heard stories from cohort members about their experiences at training sites. I was surprised by the negative experiences with supervisors that were shared, which left students feeling shut down, embarrassed, angry, not good enough, and not important. Curious about this shared experience in my program, I looked to the research and learned that students in other programs encountered negative encounters in supervision too (e.g., Constantine & Sue, 2007; Dawson & Akhurst, 2015; Gray et al., 2001; Nelson & Friedlander, 2001).

After discussing my ideas with an advisory group, I was struck by the notion that my peers who I perceived as educated, smart, and confident students, were so strongly (negatively) impacted by supervision experiences. I realized that the evaluatory environments in doctoral clinical training may evoke feelings of inadequacy, self-criticism, and perceived negative judgment from those who are valued (i.e., supervisors). These feelings may be amplified as (most) students are dedicated to being psychologists and it becomes part of their identity, which involves being vulnerable and evaluated in a variety of contexts. After many discussions, I was confident that feeling shame or being shamed by others in power had a negative impact on the students I spoke with; I wanted to learn more. As I looked to the existing research about shame in supervision, nomothetic studies attempted to assess levels of shame-proneness in supervisees (Bilodeau et al., 2012), categorize factors that led to omitting information in supervision (e.g.,
Ladany et al., 1996), and identify topics omitted in supervision (e.g., Mehr et al., 2010). I learned that feeling shame in supervision was prevalent across training programs and had potentially harmful repercussions.

Feeling a personal connection to this experience, I was pulled to hear more from graduate students, yet realized I was missing an important narrative. My viewpoint shifted after reading a phenomenological study interviewing graduate psychology students on “good” and “bad” supervision (Jacobsen & Tanggaard, 2009). They found that individual differences were profoundly important and that categorizing good and bad supervision didn’t tell the readers much, because two people may have different ideas of what good means for them, and may have varying tolerance for criticism or frustrating events. My curiosity rose as I shifted from black and white or shaming and non-shaming supervision, and I wondered if supervisors were having difficulties intervening in certain moments, as each student is unique in their skill set and emotional tolerance. Once I stepped back from my own assumptions, experiences, and personal connection, I wondered what was happening for the supervisors.

In my selection of this approach, I reflected on research findings with my own curiosity and questions in mind: I wanted to learn more about how supervisee shame showed up in supervision and how it might impact the relationship. In my search, I found more studies examining different aspects of this phenomenon from the perspective of the supervisee, compared to that of a supervisor. Supervision is an essential aspect of a training and a role that many psychologists have, yet the training has varied and the competencies in this role are relatively new compared to the rest of the field (ASPPPB Task Force on Supervision Guidelines, 2015). As a student, with supervisors of my own, I felt a particular pull to want to learn more
about the perspective of a supervisor and their world, with the hopes of also creating understanding and awareness.

IPA postulates that important understanding can be gleaned by taking the time to ask others to reflect on moments in their life, which allows the researcher to discover themes within the narratives (Smith et al., 2009). My aim was to better understand the experience of supervisors as they navigate interactions with supervisees who feel ashamed, develop relationships with supervisees who may feel more shameful, and learn more about their own meaning-making of this phenomenon. As such, participants were interviewed and encouraged to share their experience of being a supervisor and how they experience this phenomenon. Given the complexity of what occurs during the supervision hour, and the secretive nature of shame, IPA was purposefully chosen due to its exploratory nature and aim to better understand this experience.

**Participants**

**Convenience and Purposeful Sampling**

In line with the idiographic nature of IPA, a small, purposeful, and homogenous sample size of eight to ten participants is suggested as an acceptable and useful standard for IPA research (Smith et al., 2009). Although sample size in IPA studies has varied from as little as one to more than 15, a distinctive feature of this analysis is to sacrifice breadth for depth (Smith et al., 2009). The purpose of obtaining a homogeneous sample is to increase the level of significance the research questions have for each participant (Smith et al., 2009). To present a range of experiences, while also keeping the participant sample rich enough to hear the voices and lived experiences, a sample size of 8–10 participants was chosen.
Recruitment took place through online and in-person networking. For instance, I spoke with past supervisors, who graciously offered to send out recruitment emails to professional listservs (see Appendix A). I also introduced myself to psychologists with supervision experience at a conference. In addition, I contacted psychologists who I built relationships with through internship and practicum placements. These recruitment methods led to snowballing method (i.e., professional to professional introduction). Participants were sent a recruitment email by me or sent me an email of interest.

**Inclusion Criterion**

Participation was completely voluntary. Inclusion in the current study included that participants: (a) be a licensed psychologist, (b) have provided individual supervision to counseling or clinical psychology doctoral graduate students (i.e., PsyD or PhD clinical or counseling psychology students), and (c) have at least 3 years of postdoctoral individual supervision experience. When considering who might have insight into this particular phenomenon, I thought about past supervisors and looked into research about supervision. I presumed that novice supervisors may not be attuned to this phenomenon or have enough lived experience as a supervisor to answer questions in depth. Therefore, I asked that participants have at least 3 years of postdoctoral experience supervision.

**Participant Characteristics**

Participants were a national sample of 3 male and 5 female supervisors who had at least 3 years of postdoctoral individual supervision experience. All supervisors invited to participate and who expressed interest chose to do so. All participants expressed some interest in supervising and identified this role as a choice versus an obligation. The participants varied in their educational degrees, which included: PsyD, PhD in Counseling Psychology, PhD in Clinical
Psychology, and PhD in Clinical and Educational Psychology. Participants were located across the nation: 1 practicing in a southern state, 4 practicing on the west coast, and 3 practicing on the east coast. Three participants identified as 40–49 years old, three identified as 50–59 years old, and two identified as 60–69 years old. All participants identified as White/Caucasian. Participants were also asked about their history of supervising. The length of time supervising students ranged from 4–28 years, and the average of years supervising was 13.6. All supervisors reported supervising doctoral students (PsyD and PhD) from APA-accredited programs. Five supervisors also mentioned supervising other mental health professionals (e.g., LMHC, psychiatry students). See Table 1 for a description of individual supervisor characteristics.

Interviews ranged in length, lasting approximately 33–69 minutes in duration. Seven interviews were conducted over the phone, while one interview was conducted in person. All interviews were recorded using an external audio recorder, and then were transcribed into encrypted documents.

**Informed Consent and Confidentiality**

**Recruitment**

Participants who met the inclusion criteria for this study were sent a consent form via email (see Appendix B) and asked to set aside about 30-45 minutes for the interview. Each participant was asked to read over the confidentiality form, provide their signature, and return the signed form prior to the interview. For participants who did not return the form prior to the interview, I re-read the consent form and offered to answer any questions they had.

**Consent and Privacy**

Prior to recruitment and selection of participants, Institutional Review Board (IRB) approval was acquired from Antioch University New England. In line with IRB protocol,
participants were provided with a written informed consent that included a section for consent to audio record. Confidentiality and its limits were reviewed with each participant. All participants provided written consent for the audio recording of the phone interviews. Interviews were recorded using a digital audio recorder and were kept in a locked filing cabinet when not in use. The audio recordings were kept until the completion of this dissertation, and then destroyed. Interviews were transcribed into a password protected document. To protect anonymity, all names and places of employment were changed during transcription. Hard copy notes written during interviews were kept in a notebook that was also kept in a filing cabinet when not in use. Any notes taken did not include personal information (e.g., names or places of employment).

The emotional risk to participants was minimal. The content of the interview did not veer far from the scope of the participant’s professional practice or vary greatly from clinical discussions supervisors may have with colleagues. However, I did inquire about their experiences as a supervisor, and asked them to discuss moments where they may have caused their supervisee to feel shame. Discussing past conflicts or difficult interactions with students may lead to uncomfortable feelings. As such, all participants were given the option of not answering questions. None of the participants reported experiencing distress during the interview process and answered all questions.

Compensation

All participants were offered a $10 electronic gift card for their participation in this study. To receive this gift card, participants were told they would receive it via email after the completion of the interview. In addition, participants were offered the opportunity to receive a copy of the findings of this study once the dissertation is completed.
Interview Schedule

The use of a semi-structured interview was used as the primary method of data collection. This form of interviewing allows for greater flexibility and space for the interview to explore novel ideas, which often leads to richer data (Smith & Osborn, 2008). Instead of specific questions dictating the story that is told, semi-structured interviews allow the participants to be the expert and to tell their unique story of supervisory experiences. I created an interview schedule with a set of questions and prompts, which allowed me to think about potential difficulties or sensitive areas that might arise (see Appendix C). However, the interview was guided by the schedule rather than dictated by it.

The interview questions were divided into three sections. The first set of questions was straightforward and designed to elicit descriptive answers about the participant’s background, training, interest in supervision, as well as their thoughts and feelings about what this role means to them. Additionally, this set of questions was intended to help establish rapport and help the participants adjust to speaking about themselves, as supervisors. The middle set of questions was connected to participants’ experience of how shame enters supervision, their observations, reactions, and understanding of this emotion. The final set of questions asked participants to reflect on and describe an interaction between themselves and a supervisee who may have felt ashamed or embarrassed. Each set of questions was designed so that they were sufficiently specific, but also open-ended, so questions could arise organically to gather details specific to each unique narrative. At times, reflections were used to ensure that the researcher understood properly instead of relying on her own interpretation.

Procedures

A total of eight participants were recruited through email recruitment (e.g., listserv
posting) and convenience sampling (e.g., in-person networking). Once I was contacted about potential interest, the inclusion criterion was reviewed with the participant via email. If eligible, a date for the phone interview was scheduled. Before the interview, participants were also provided with written consent and asked to return it with their signature via email.

I interviewed each participant using a semi-structured interview schedule, which was estimated to take 30–45 minutes. However, the interviews ranged from 33–69 minutes, with the average interview being 52 minutes. All interviews were conducted via phone except for one, which was conducted in person at the participant’s workplace. Each interview began with reviewing confidentiality, answering any questions, and describing the incentive for participation. An mp3 recorder was used to audio record the interviews. Participants were told when the recording would begin, so they were aware of what was being recorded. Once the interview was complete, each participant was sent a $10 electronic gift card. As described above, the interviews consisted of a series of prewritten, uniform questions, as well as organic questions that were asked in response to the specific responses of each participant; no one interview was exactly the same.

Data Analysis

After the semi-structured interview was administered and audio-recorded, the data were analyzed using Smith et al.’s (2009) Interpretive Phenomenological Analysis. Their suggested approach includes: (a) data immersion, (b) initial noting, (c) identifying and developing emergent themes, (d) searching for connections across those themes, (e) repeating this process for all cases, and (f) identifying themes across cases. In this method, the first steps of analysis are designed to focus on a single case, and then compare across cases; the shift is noted below. The particular steps I followed are described below.
Step 1: Listening and Reading

Following the analytic process suggested by Smith et al. (2009), I first listened to each interview without taking notes, but noticing certain connections I was making internally and then letting them go in order to return to the participant’s narrative. My decision to not take notes during the first listen was to fully immerse myself in the story, rather than shift focus to making connections and identifying themes prematurely. Then, I listened in order to transcribe the interview. In order to reduce distractions of my own desire to identify themes, during this stage, I documented my own observations and reactions to the interviews in a journal. This process allowed me to bracket my own preconceptions and focus on the data by entering into each participant’s unique world. Next, I read the transcripts without taking notes, again, to fully immerse myself in the stories of the participants.

Step 2: Initial Noting

Once I listened, read, and re-read the data, I continued to familiarize myself with the data through initial noting. In this phase of analysis, I engaged with the transcript while always keeping the participant’s experience in mind. To do this, I explored semantic content, while also focusing on the specific language the participants used and keeping the context of their lived experience in mind. Further, I identified larger abstract concepts linking common patterns within a narrative.

The goal of this step is to “produce a comprehensive and detailed set of notes and comments on the data” (Smith et al., 2009, p. 83). Smith et al. propose that there are no specific rules or requirements to this step. This means, I did not yet identify specific meaning units or organize data. First, I read through the transcript while underlining text that felt important to the
participant’s experience as a supervisor and identified words and phrases that were repeated. I then noted why I thought this was important.

Exploratory commenting helped me engage with the text with rigor. Specifically, Smith et al. (2009) suggest a few techniques that helped me to see meanings underneath or hidden in the text. I used descriptive comments to focus on describing the content of what the participants said (e.g., key objects, events, or emotional responses), linguistic comments to focus on language and the use of metaphor, and conceptual comments to identify an overarching understanding or process from a series of particular experiences. With these strategies, I extracted patterns from the data.

Step 3: Developing Emergent Themes

I identified emergent themes by shifting my focus from the actual narrative text to my notes and comments. The goal of this step is to attempt to reduce the volume of detail while also maintaining the complexity of patterns, connections, and interrelationships (Smith et al., 2009). To do this, I broke apart the narrative flow of the interview by chunking data into themes. In order to preserve the essence of each story, many of these themes were expressed as phrases, which reflected the participants’ own words. However, my own interpretation was also used in my attempt to understand and describe their experiences. This process was completed for each individual case.

Step 4: Searching for Connections Across Emergent Themes

Once a set of themes was established for each case, I started mapping out how the emergent themes fit together. This step in analysis uses techniques to create a set of higher-level themes, called superordinate themes (Smith et al., 2009). To do this, I first typed all themes identified in Step 3 in chronological order. Then, I moved the themes around to form clusters of
related themes. I printed out the list and cut out each individual theme. By having all of the themes in front of me on paper, I could spatially analyze relationships, move themes around with ease, and see patterns that I might have missed.

The goal of this step was to organize emergent themes in a meaningful way that ultimately produced a structure connecting the most important and essential components of a participant’s story. In this level of analysis, I used a few specific methods recommended by Smith et al. (2009): (a) abstraction, (b) subsumption, (c) numeration, and (d) contextualization. By using abstraction, I grouped similar emergent themes together in order to create a new cluster (i.e., superordinate theme). Subsumption helped me critique my list of emergent themes and realize that some themes I had listed should be acquired into a superordinate theme. I used contextualization to help make connections between themes by attending to temporal, cultural, and narrative themes. Through the use of numeration, I used the frequency of themes as one type of indicator of importance. Once the final list of superordinate and emergent themes was created, I created a chart to organize and visualize the data.

**Step 5: Moving to the Next Case.**

Steps 1 through 4 were repeated for each following case.

**Step 6: Comparison with Secondary Coders.**

At this point in my analysis, I recruited two secondary coders familiar with qualitative analysis and IPA. One coder was a 36-year-old Caucasian female with a PsyD degree and the other was a 35-year-old Indian female with a Ph.D. in Counseling and Psychology and a LICSW. I had previous relationships with each coder through graduate school and internship training. Both coders used qualitative analysis in their dissertations (i.e., IPA and Most Significant Change Technique). Before analysis, I explained my analytic process to each coder.
and discussed questions they had regarding techniques and methods of the analysis. To protect the confidentiality of participants, the coders did not listen to the interviews and were provided with unidentified transcripts of each interview. Both coders replicated steps 2–5, with the exception of requiring coders to print out the text of emergent themes. This decision was influenced by my desire to allow analytic creativity and maintain rigor. Specifically, my hope was that coders would use their own creativity and method of identifying connections in the text that worked best for them, whether that be tangible (e.g., printed out themes or flash cards) or solely visual (e.g., using an excel or word document).

**Step 7: Looking for Patterns Across Cases**

Once emergent themes were identified for each single case, I shifted my focus to the whole data set. By visually laying out identified emergent themes from all participants, I identified emergent themes that appeared across data sets. Patterns were identified between cases. However, I noticed that some of the language I used to describe patterns were the same, or very similar. As a result, I often read and re-read sections of interviews and my own notes, making sure I attended to the unique stories. Subsumption was particularly useful during this stage, as visually seeing similar emergent themes led to the creation of larger superordinate themes. Having a visual also highlighted idiosyncrasies between participants’ stories, which were important to note.

Throughout this process of analysis, I also kept in mind my statement of purpose, as well as my biases. Once I created a master list of emergent and superordinate themes, I spent time thinking about my research and looking back at my bracketing journal. For instance, as it was my hope to understand ways supervisors manage shame within supervision, I reminded myself that it may not be quite so easy. I re-read my notes and verbatim quotes with sensitivity to hesitation,
uncertainty, or confusion that may be reflected in the type of language used. This process resulted in a master chart of superordinate and emergent themes (see Appendix E).

**Quality Control Procedures**

*Multiple Coders and Validity*

The process of analysis in IPA is a subjective task for each analyst, yet there are techniques to increase rigor and quality. Smith et al. (2009) refer to Yardley’s principles to describe how researchers can improve the quality of their work, as well as assessing its validity. Yardley (2000) describes that validity checks do not prescribe “the singular true account” (p. 218); they help the researcher(s) manage biases and find themes that are representative of the data. The use of secondary coders in the current study functioned to improve the quality of the interpretation of data by decreasing bias and allowing for multiple perspectives. The rigor of idiographic engagement (i.e., moving beyond a simple description to a deeper meaning) was also influenced by multiple coders and challenged the researchers to think about the importance of patterns within cases and between (Yardley, 2000). Additionally, multiple coders improved the internal coherence, which Smith and colleagues describe as the necessity for the themes presented being consistent and justified by the data. In the written analysis, the presence of verbatim transcripts (e.g., phrases, words, etc.) from the participants support each theme.

**Bracketing Biases**

Prior to collecting data, I acknowledged the importance of identifying my own biases and how they might impact the interview, as well as the coding. My own life experiences influence the lens through which I see the world and would likely impact this particular study. As a doctoral student, supervisee, and member of a cohort of other supervisees, I understood that my own experiences were likely to bias this process. In order to truly understand the participants and
enter into their world, I had to bracket my own preconceptions. The following list summarizes these experiences, assumptions, and biases:

1. I am a doctoral student in training, who had positive and negative experiences with supervisors. Before deciding this research topic, I listened to many experiences of my peers feeling shut down, stuck, unimportant, and not listened to by their supervisors. I did relate to some of the stories I heard, as I have felt ashamed in supervision.

2. My own experience as a supervisee reminded me that there are psychologists who can teach us all important lessons about how to be a supervisor. As a student I have felt valued by my supervisor and a worthy member of their team. I also had difficult conversations with supervisors and received critical feedback, which at the time, I knew wasn’t easy for either of us. Challenging conversations also led to closer relationships. I believe that difficult moments in supervision can lead to stronger relationships and important learning opportunities. One year, as a green supervisee, my supervisor said to me, “Melanie, I feel like I don’t know you that well, which is completely fine, but I just wanted to talk about it and also how this comes up in your clinical work.” Initially I was a bit shocked. With that one statement I felt important, learned more about what to bring up in supervision, and how self-disclosure can be used with my clients. I didn’t feel attacked or that I had been doing something wrong. This encounter, and many others, led me to believe that there are psychologists who are also great supervisors and have useful knowledge about this specific role.

3. I assumed that supervisors don’t reflect too much on their supervisees’ feeling states during supervision, including when they might feel embarrassed or ashamed. From my
own experiences, I knew supervisors have many responsibilities, and may not frequently reflect on how the emotions of their supervisees may impact the supervisory relationship.

4. I believe that some psychologists are not interested in being a supervisor, yet are required to do so as part of their job requirement. The level of interest in being a supervisor likely varies on a spectrum rather than being black and white (i.e., interested and not interested). However, I did assume that most participants in my sample would have some interest in this topic.

5. At certain points in my training, I felt like there were many supervisors who didn’t value the development of their supervisees. One of my peers described their experience as feeling like a “workhorse” and feeling like their purpose was to do “grunt work.” At times, I felt worried for their quality of training and angry that supervisors were oblivious to their impact on students. After hearing another one of my peers say, “I just stopped telling him [her supervisor] about some cases, because I knew he would just shut me down and want me to do it his way…,” I first felt shocked and angry, then wondered what would happen if her supervisor heard this. With time, I shifted from thinking based on my emotions to acting under the assumption that the intention of supervisors is not to harm or disempower supervisees. This shift helped manage my biases. While creating interview questions, I acted under the assumption that I didn’t know much about what was happening for supervisors and wanted to understand. My hope was to learn more about the supervisor’s experience and what was happening in their world.

6. I had previous relationships with 3 of the participants, which likely influenced the interviews. Although they were not direct supervisors of mine, they were psychologists and supervisors within training programs that I participated in. Consequently, rapport
between us had previously been built, which may have influenced their comfort level, as well as mine. Looking back, I had different assumptions for each person. However, based on my relationship with each participant, I assumed they wanted to help and I was grateful for the time they set aside. From what I knew, I also assumed they enjoyed supervising and valued training graduate students.

To mitigate potential influences of my own meaning making on the data, I created a journal for bracketing my own biases. Before each interview I wrote down my assumptions. Additionally, after I read each interview, I wrote down my own reactions and how the interview may have been influenced by my own preconceptions.

Results

Theme 1: Learning How to Supervise and Manage Shame

To better understand the lived experiences of supervisors and how the participants manage shame, they were asked about their style of supervision and how they learned to be a supervisor. Participants reported that past experiences with their own supervisors, in addition to their own clinical orientation, informed how they currently supervise. All participants reflected on past supervision experiences. Five participants mentioned a negative supervision experience influencing their style, and all 8 participants shared a positive experience with a previous supervisor. Additionally, 7 participants stated that their clinical orientation helped them conceptualize shame in supervision.

Most participants did not describe graduate school courses as influential in their learning to be a supervisor. However, four participants mentioned that graduate school courses helped them learn how to supervise, although only Participant 1 and 4 were able to elaborate with any detail. Participant 5 shared, “In graduate school I had training in narrative supervision, but it was
like a semester long course and it was interesting style of supervision.” He went on to describe additional supervision training during his post doc year that was specific to the clinical population he was treating, “When I was a post-doc we had a year-long training on being a supervisor…so we read a ton of articles on supervising, especially supervising youth in foster care.” Participant 4 spoke in depth about her positive experiences in graduate school for counseling psychology, as she attended supervision courses and received supervision of supervision during a year-long course. Participant 1 shared a vague memory of courses she took, “Graduate school was a while ago for me, but I do know that we talked about supervision and issues that come up and supervision having to do with multiculturalism and diversity differences of power privilege.” This was followed by her emphasizing the importance of her lived experiences, “I think most of my professional development around supervision has come through practice and through providing supervision. And from my own experience of having been supervised.” Lastly, one participant reflected on the absence of supervision instruction during her training and urged for additional formal training in supervision:

    You go from student to clinician to supervisor. And the missing link for me was the clinician to supervisor. There was no formal training. So, when you’re a supervisor all of a sudden, it’s the same thing the next day without formal training. You haven’t had the preparation to become that. I think there needs to be, and they’re starting to be, a lot more formal preparation to help with that transition. Because, you’re really not smarter just because somebody gave you the title.

Although graduate school courses were part of the learning process for most, they seemed to be less influential than their own experiences in supervision.
Negative and Positive Supervision Experiences

Apparent in all 8 interviews was the impact of past supervision experiences on the participants’ current supervision style. Both positive and negative experiences were shared, some in more detail than others. Participant 5 described his experience similar to that of learning from a coach when he was younger:

I learned to supervise like I learned how to coach. I learned to coach through past good and bad experiences. I also learned about who I am as a person. I learned from good coaches and bad coaches, I learned from good psychologists and bad psychologists.

A few participants spoke more specifically about positive and negative supervision experiences. For example, Participant 3 said, “I talk a lot about the importance of knowing that there’s a lot of learning and information to be gleaned from good and not-so-good supervision. We learn a lot about ourselves and about what not to do through poor supervision.” She provided specific memories from her experiences as a supervisee. First, she recounts a “bad” experience of being shamed by a past supervisor, that she now has “a deep appreciation for,”

I had one supervisor at my practicum experience who was really a brilliant man, but very disrespectful of time... He would come in sometimes two hours late [to supervision]. He would expect us to be sitting and waiting for him to be ready when he finally showed up. We had to do these long reports every week...and he had what I referred to as the ‘wall of shame’ where he put red lines on our report and then would tack them up on the wall for everyone to see.

On the other hand, with equal enthusiasm, this same participant shared a positive experience with a different supervisor. She identified specifics about what made this relationship impactful and worth modeling for her supervisees:
He was always open to hearing my ideas and my conceptualization of what I thought might be going on with people and trying different approaches. He would say things like, ‘I have my doubts if that would be successful, but go for it, see what happens’... And it was such a beautiful learning experience. I'm so glad that was my second experience from a supervisor rather than the first one, because it was such a beautiful way to really grow as a practitioner. It’s really his style that I emulate with my own supervisees.

Trusted relationships with past supervisors are mentors for many of the participants. Participant 2 shared positive experiences with supervisors and his training program; he felt others were invested in his professional development. The mentoring he received from past supervisors is now a role he embodies with his supervisees:

There was a level of trust with them. It was okay to bring in my best work, it was safe to bring in my not so good work, and it was safe to bring in, “I have no idea what I’m doing” work. I think a corollary to that would be that there was also a mentoring component to it. You know, there were times that we talked about cases obviously, but there were also times that we talked about me as a developing professional...My graduate program really emphasized that we are psychologist and training, so what does it mean to be a psychologist? That is a big part of what I got from my supervisors and mentors, and that’s definitely part of what I do with my students.

For some participants, it was certain statements and comments from supervisors that made a big impact. For instance, Participant 6 said:

I was testing a client and I couldn’t get everything in the first clinical interview. There was a lot of follow up questions that I had. I remember feeling like I should be getting it all. My supervisor said to me, “It really doesn’t matter. You just go back and ask follow
up questions and figure out what you missed.” I remember thinking: it’s such a small thing, but those little comments that normalized it’s a process and that you make mistakes. Those small statements were important to me.

**Using Clinical Orientation to Conceptualize Shame**

Seven out of 8 participants reported using their clinical orientation to help them understand shame and intervene when a supervisee may be feeling shameful. Participant 2 said, “I think that my supervisory style flows more out of my theoretical orientation and my general approach to even my clinical work.” He then explained how his clinical orientation informs his supervision:

I think my theoretical orientation carries over to my supervisory style. I’m very interpersonally focused. I’m a fan of Sullivan, Yalom, Lesch, and also Dan Siegel’s work in interpersonal neurobiology. So, genuineness and creating an environment where students don't feel they are performing, they feel that they are learning. So, my style is more collaborative, but I can be directive when needed. I feel like it’s important, just like the therapeutic environment, to feel safe and feel good to be yourself.

Participant 1 explained how she uses her clinical orientation to conceptualize shame and how to react:

It’s applying what I’ve learned as a therapist in my clinical orientation... I do bring to bear my understanding of emotions, coping skills, and interpersonal effectiveness. I consider myself to be a cognitive behavioral therapist and informed by different clinical approaches that, I just draw from all of them...that’s how I use my understanding to make sense of what’s going on in the supervisory interaction.
From talking with supervisors with differing styles, conceptualizing shame in supervision using their clinical orientation functioned as an important framework for intervening with intention.

Other participants described how they use their clinical orientation in conjunction with attending to the developmental needs of each student. Participant 4 discussed how she uses her clinical orientation to guide her style of intervening: “Although my aspiration was to be facilitative, I do supervision like I do therapy. I’m cognitive behavioral in orientation and behavioral, and kind of coachie [sic]. So, I did a fair amount of instruction and coaching.”

Participant 6 shared how he uses the developmental model in conjunction with his own clinical orientation to assess how best to intervene in supervision:

Well, I definitely follow the developmental model in terms of how I supervise. I would say in group and individual supervision I always think about: What is the person asking? Are they out of their league and need me to step in? Or, do they want me to reflect a bit with them?” I think about how much I should bring myself into the room in a more directive versus non-directive style. So, that’s something I’m always thinking about...So much of my training is focused on parents, and parents of children, and a lot of what impacts how I work with my clients is really the function of the brain, regulatory systems... The stuff Bruce Perry talks about. That shapes a lot of what I think about because it ties into attachment pretty neatly. Usually there is a common denominator in a lot of different situations that supervisees talk about. So, those are the two biggest influencers.

Although not enough participants spoke about the environment or the context of the clinical work to make it an emergent theme, in addition to Participant 6, two other participants mentioned how their workplace and the clinical populations served influence how they supervise
and intervene. Participant 6 mentions that his work with parents and children influences his supervision framework, while Participant 4 speaks about her work doing short-term therapy in a community college counseling program impacts her supervision style.

**Theme 2: The Supervisory Relationship is a Protective Factor**

All participants reported that the supervisory relationship was essential in their role as a supervisor, and intentionally established trust and safety in order to work through difficult moments with supervisees. For instance, Participant 5 spoke passionately about his emphasis on establishing a good relationship with his supervisee: “If you have a good relationship then you can bring up stuff. If you don’t, then people have to not tell the truth.” In addition, participants attempted to normalize mistakes, and in some cases specifically ask supervisees to share their “mess-ups.” Investing in supervisees’ professional development also emerged frequently in the narratives, as participants wanted students to develop their voices and welcomed their thoughts. For participants, investing in the supervisory relationship and in supervisees development acted as a protective factor for shame.

**“It’s all About the Relationship”: Trust and Safety**

When participants were asked to share their experiences with shame in supervision, as well as reflecting on their own past supervision experiences, their responses included themes of trust, safety, and relationships. In their own way, each person described a strong supervisory relationship as a protective factor for future ruptures, shameful moments, and difficult conversations. Participant 6 explained:

I think the most important thing I realized is that the relationship between the supervisor and supervisee is probably one of the most important things to get started. Otherwise there would be no trust. And when there are ruptures you won’t be able to resolve
them...If you have a good relationship where they are not embarrassed to be embarrassed in front of you, at a heightened level, then it’s going to be OK. They know that even if they did something that might be questionable, you’re there to help them sort out where to go next with it.

Participant 5 described his approach to supervision and the importance of relationships. Supervising students for over 20 years taught him that the supervisor-supervisee relationship was most important, and that trust was necessary to build a strong foundation. In this instance, he spoke about his role as supervisor and a training director, making him a liaison between all supervisors and supervisees. I asked him to share more about a particular event when a supervisee approached him with “problems” she was having with her primary supervisor:

I don’t feel there was enough trust. And you know, what’s the opposite of shame? I don’t know, but maybe it’s trust... I mean, the bigger thing for me with this whole thing is, it’s also why therapy works, but why relationships work. It’s about if I can say, “I screwed up” without it leading to power play or whatever it’s going to be.

Similar to other participants, trust was connected vulnerability and supervisee’s having a safe space to share mistakes or other vulnerabilities. Participant 3 shared her own experience as a supervisee and the lack of trust and safety she felt, which impacted her ability to acknowledge mistakes and learn:

So, we did not build up an atmosphere of trust. And, you know, when you don’t have trust with someone who is learning how to be a clinician, you’re not going to feel safe and say, “Hey, I think I made a mistake. I did this, and that happened.” That’s not conducive to learning in an environment to help you grow as a clinician.
A few participants highlighted the connection between safety and learning, as they pointed out that supervisees have knowledge gaps, and need supervisors to establish trust and safety so they can use supervision to make mistakes and learn. When speaking about his supervisory style, Participant 2 said, “I think setting an environment where students feel comfortable and safe to bring things in is really important.” Participant 4 shared a similar sentiment as she expressed creating safety and trust as an obligation:

Our job [as supervisors] is to create emotional safety so that people can do the work that they came to do. I, in fact, I do have more experience and I do have more knowledge about that domain, because the person is a trainee and they legitimately inhabit the place where they don't know yet. Even if they know some stuff, they’re not supposed to, what the hell. That’s our obligation.

Participant 8 shared her philosophy about supervision, the importance of safety when making mistakes, and its impact on shame. She explains that learning in supervision can lead to feelings of embarrassment, but if there’s a solid relationship, less shame should be felt. She stated:

My philosophy: It’s the relationship. If you can make it a safe open relationship, then I think it leads to less feelings of shame. Some embarrassment is going to happen because you’re learning. As trainees you feel like you're going to make mistakes and sometimes making a mistake is embarrassing. So, I think those things are going to happen. But, if you have a good relationship where they’re not embarrassed to be embarrassed in front of you, at a heightened level, then it’s going to be OK. They also know that even if they did something that might be questionable, that you’re there to help them sort out where to go next with it. It’s really important to develop a solid relationship where you feel like you can call me any time, you’re not bothering me, and I’m there for you, basically.
Establishing safety in the supervisory relationship is a proactive way to encourage supervisees to bring up—opposed to hide—mistakes and “questionable” decisions and learn from them.

**Creating a Safe Base: “You’re Supposed to Make Mistakes”**

This emergent theme was present in 5 of out the 8 participants. These participants spoke about the importance of normalizing, welcoming mistakes, and not expecting their supervisees to be perfect. When sharing their stories, the participants spoke about these techniques as part of their style, but underneath the context of their words was also the ways in which they build relationships with their supervisees. This theme appeared to be the *how* the participants establish safety and trust.

To create a safe space where mistakes are accepted, participants revealed their own preference for talking about difficult cases and “mess-ups” with their supervisees. Participant 7 shared that talking about clinical mistakes and “messy” cases is something she likes to do during interviews, as bringing in these mistakes into supervision is essential to learning:

> I think that I try to create a space where people feel like they can let their guard down and you know... And that they’re not expected to be perfect...I interview people for intern applicants and I always ask for a case that’s a little messy. Where did we fuck up and it didn’t go cleanly? Excuse my language. But I’m not really interested in the success stories. I think we all can have success, but it’s important to talk about the things that you can learn from and grow from. Being able to talk about many other kinds of negative things like the fuckups and the mistakes, it can lay the foundation.

She added that supervisors and supervisees work within larger organizations, and the culture of these systems can impact how intense supervisees feel shame. When asked how she’s experienced supervising students within a medical organization she said:
It depends. I supervise resident medical training and it's very shame based. So, they’re going to have a different experience than psychologists or other people where they are encouraged to ask questions and to be curious. I think that when it’s an expectation that trainees are there to learn, and not necessarily know things, that helps. Oh, and that they’re not expected to be perfect.

She connects the ideas of encouraging curiosity and making mistakes to help supervisees feel comfortable learning from them.

Other participants shared similar experiences of learning from mistakes, yet also wanting their supervisees to take responsibility for their learning. For example, Participant 3 said:

I think it’s really important to create an atmosphere of trust. I think it’s important to allow my supervisees to know that making mistakes is not only alright but that’s where some of the best lessons are learned. As long as they’re open to learning from their mistakes and understand that you’re working under my license and have respect for that. I have a lot of respect for their ideas.

Participant 4 described how she creates emotional safety by using certain strategies to normalize misunderstandings and welcome “taking risks,”

I’ve read about climate and emotional safety and what it is that we do to create that and put that into place. Things like build it into my supervision agreement, for example. I’ll say, “There’ll be these times when we’re going to need to disclose things to each other and that’s part of what we do.” It’s the same thing I do with my informed consent with clients and say, “Look there's times I'm not going to understand you, and I need you to tell me these things.” I try and get ahead of it a little bit, and to anticipate difficulty, normalize it, and invite the person to take those risks with me.
Participant 5 described his ideas between being human, making mistakes, and feeling shame. He shared how he responds to students who have made a mistake:

You’re supposed to make mistakes. You’re just supposed to. It happens, and I think that 99 out of 100 mistakes can be fixed and rectified. So, you added it up wrong on an IQ and we didn’t pick it up till after the report’s done? Well, you fix it, you screwed up. Those mistakes, I don’t see them. But that’s not to say that you should or shouldn’t feel shame over that. If it is [shame], then that’s something I want to recommend you go to a therapist, but that’s not shame that’s humanness.

**Developing Voices and the Professional Self**

In the process of building trust and safety within the supervisory relationship, seven participants spoke about wanting to help their students explore their own clinical style and to “find their own voices.” In listening to the participant’s experiences, this emergent theme seemed to be an important part of their process in developing a relationship with their supervisees, building trust, hearing supervisees thoughts, and making space to have vulnerable conversations. Interesting to note is that the specific phrase of “finding their voices” was mentioned by 5 participants. For instance, Participant 3 said, “I know that they’re finding their voices as clinicians and I’m not looking to have people mimic or emulate my style, but to find their own voice.” She described *how* she helps her supervisees to develop their own voices

You have to really listen to what they’re experience is and help them think about: "What do you think is going on? What do you think the diagnoses are here and what would you like to do?" I’ll also make suggestions or say, “You know, I think that maybe it’s not what’s going on. I think *this* is what’s going on.” Or “That approach really isn’t for the population, but let’s talk about why that might be.”
The idea of helping supervisees develop their voices by learning skills and applying knowledge was mentioned by other participants. Participant 4 explained her role of helping supervisees find their voice, which includes applying practical knowledge, knowing your scope of practice, and thinking through clinical decision making:

My expectation as a supervisor is that people would be strengthening themselves as generalists and knowing the limits of their scope of practice too... My role was to convey that knowledge, that practical knowledge, about: here we are with all this training and now you are trying to find your voice and really get into applying what you’ve been taught in a high tempo situation where there's a big volume of work to do.

Participant 7 shared her intention of helping students to find their “clinical voice” when supervising within a skills-based or evidence-based treatment:

I really want people to kind of develop their own voice in their clinical work. So, I definitely don’t like to smother people, but I think because I do tend to supervise a lot of people who are learning DBT, there are just like some fundamental hard skills they got to get. You know, I want people to be able to feel competent doing a DBT treatment, and there’s a lot of jazz involved.

In addition, she commented on her own enjoyment watching supervisees grow in different areas of their profession:

I really love watching people, kind of develop their professional maturity. And that means that it goes beyond just like a clinical assessment, sometimes it’s advocating on a team, negotiating career obstacles, or figuring out which direction they want to go. So, I think that there’s a lot of mentoring involved and there’s a lot of room to really see people gain new areas of growth and competence.
Participant 2 discussed his desire to help students find their own voices and the different roles he takes on as a supervisor. He goes on to share a specific framework he uses to help facilitate this process:

I feel like my role is to help students find their way of working with clients, their way of conceptualizing, their way of intervening, and their way of working. So, I feel like I’m part teacher, but I’m also part mentor in trying to help them. I always feel like really good training in psychotherapy helps you to sort of connect with your own style rather than adopting or replicating a supervisor’s style…So, I really like to help students by framing: “OK. Here’s what we think is going on with this particular client. Here’s what we need to accomplish. What’s the goal?”

This participant further described a specific example of how he intervened with a student who had a different style than him. In helping this student find her own clinical voice, he noted that his intention was to offer a possible approach, while letting the student decide on how she would intervene:

A group member was very rude to her and she tends to go to “what did I do wrong?” So, I said, “You know, I think that you need to be stronger than that. You need to be more challenging than that and more setting a firm boundary of I don’t understand. Try something like, ‘I don’t like for you to talk to me that way. Are you upset with me? Or are you aware of being upset with me?’” So, because my style is very different from hers, I said, “Look, I don’t want to tell you what to say. I want you, within those parameters of what we’re trying to accomplish in the dynamic, I want you to tell me what feels right to you.” So, I feel like my biggest goal is to help students connect with their own confidence in their own ways of being with people.
Allowing supervisees to work within their clinical orientation was used by some participants to help supervisees find their voices. Participant 1 described how she collaborates with her supervisee by working within her supervisees clinical orientation and respecting what they need, while also addressing important clinical issues.

I attempt to help each person I’m supervising grow their clinical skills within their identified preferred clinical orientation. We focus on emergent clinical concerns and any specific questions that they may have about the client the issues that have come up in the therapy session or future directions. I attempt to create an atmosphere that is collaborative where I respect what they bring to the interaction both in the clinical work they are doing and in the supervision.

In this instance, this participant also refers to respecting what supervisees want to bring into supervision, allowing them to share the space with what the supervisor would like to discuss.

Supporting the person, as well as the supervisees clinical voice was important for some participants. Participant 5 expressed his hopes for supervisees, while also acknowledging the challenges, “I just see it as I just see as a chance to meet [insert student name] and start them on a path of their own independence and feeling good about what to do. It’s a tough field, the field is tough today.” Participant 5 commented on his collaborative supervision style and the importance of helping to develop the supervisee as a clinician and supporting them as a person:

Obviously, I’d like to believe I have some knowledge to offer, but it’s collaborative. I mean, who wants to do what I do? Don’t do it my way. It might sound funny to call it collaborative, but it is...I’m absolutely not the supervisor who will say “This is what you’re doing and how you're going to do it.” I just, I would hate it and I’ll never do it that way...So I feel strongly that my role as a supervisor is to be available, to support the
students growth, to not force my views on them, but more to reinforce their development and their own views…

**Theme 3: Factors That Lead to Shame in and out of the Supervision Room**

Participants were asked, “What does supervisee shame mean to you?” and also to reflect on moments in supervision when they noticed a supervisee feel shame and how they knew. In these narratives, participants identified a variety of factors that, in their experiences, have contributed to supervisees feeling ashamed. The factors identified by at least half of the participants (i.e., 4 participants) are presented as emergent themes.

**Countertransference**

Six participants discussed how transference and countertransference can impact supervision and contribute to shameful feelings. This theme was expressed in a few different ways, as some participants directly referred to countertransference, while others described specific interactions between their supervisees and clients. One participant also explained how her own countertransference reaction impacted a supervisee.

Participant 2 described the impact that countertransference can have on a supervisee and how these feelings can lead to shame if the supervisee isn’t aware of how to utilize their emotional reactions. He reflected on his own shift in thinking when this occurs:

I also feel like sometimes students are having a counter transference reaction to a client that they’re shutting that down, they’re shaming that, and not using it as the clinical tool it can be. So, I think those two things are sort of the ways that if I hear shame. I go to, we may be looking at this in more black-and-white, either or, kind of way, or you don’t know what to do with your feelings that have come into play.
He also spoke about encountering supervisees who may not like a client or who have negative feelings toward a particular client and subsequently, they feel ashamed by this instead of tapping into their emotions “as clinical information to work with.” Certain clients or client populations may increase the possibility of shame for some supervisees. For instance, this participant explained that his supervisees work with children in group therapy and acknowledged how challenging it can be to work with children and teens who can lash out when angry, leading to strong emotional reactions and often shame. He shared a specific example when a supervisee felt that she must have made a mistake in response to a client’s “rude” comment.

Especially with kids and teens, being angry and being hurt. Really, any kind of emotional reaction to a client can trigger shame. Clients can react negatively, you know. There are clients who get angry at the therapist or like my student when the kid in group was rude to her. I think that it really hurt her feelings and threw her off. She lost some objectivity there and went to: “What did I do wrong?”

Other participants reflected on how challenging it can be to access countertransference for supervisees and the hesitation that some supervisors might feel to disclosing their own emotional reactions. When asked about moments when shame enters supervision, Participant 3 mentioned the hesitation that supervisees and supervisors might have in exploring their emotions.

There is projection and there is countertransference and transference. Not all supervisors and supervisees may be willing to look at this because it’s not a therapeutic relationship, but that can certainly come into play and certainly can cause shame responses in either supervisor or supervisee.
She also shared that “through parallel process” both the supervisee and supervisor can feel ashamed by their emotional reaction to the client. Similarly, Participant 6 explained the difficulty supervisees might have when deciding to be vulnerable and share their emotions in supervision. To symbolize this experience, he made a parallel between the vulnerable positions of clients and supervisees.

People’s whole history has been brought to the present with a client. They, like the supervisee, are figuring out: do they talk about it or not? If they talk about it and they reveal certain things about themselves that are still not completely resolved, how does that have an impact on them. So, that’s one piece that I think comes up: your own parts of your life that are so raw that get evoked in countertransference.

This analogy proposes that disclosing sensitive information with a person of power (i.e., supervisor) can lead to shame. Additionally, the supervisee may also feel ashamed of their ability—or inability—to cope with “raw” feelings rooted in personal histories.

Sharing a slightly different perspective, Participant 4 described her own countertransference in reaction to an “argument” with her supervisee around a clinical case that evoked shameful feelings and frustration, for her and the supervisee. She reflected on the interaction and her realization that countertransference was at play.

I found myself kind of arguing my point with some umf [sic] behind it, saying “In fact we need to view the student in context and not take his stuff totally at face value. Let’s factor in that there's a drama factor here going on.” That didn’t sit well with my supervisee. What I realized later on is that there was an assumption operating that none of us put our finger on, which is: a parent actually can compel an adolescent and young adult child to do something. But, this in fact is not true. I knew that very well from my own experience;
I had an adolescent and young-adult-children at that time. I knew that I could try to make them do things or get them to help or whatever needs to happen, to happen, but I couldn't make it happen. At the time, I couldn’t access that and articulate it well enough to my supervisee. And I know I frustrated my trainee with that interaction, well, disagreement about that topic. You know, I imagine her shame was up, because of my responses, but that’s where my countertransference came from.

For this participant, her own countertransference to a supervisee’s case impacted how she thought the supervisee should intervene leading to an “argument” and potential shameful feelings for the supervisee, as she was not entrusted to follow her own clinical direction.

**Sensitivity to Shame**

Five participants shared the experience of supervising students who were more sensitive to shame or experienced shameful feelings more often. Some participants shared specific examples from experiences with supervisees, while others spoke more theoretically about why, in their experience, shame might be felt intensely by some. For instance, Participant 7 said, “Also, certain people are more prone to feeling shame. The supervisees own psychological experience, personality, and experience matter.” In simple terms, she captured the shared belief that supervisees’ histories and own psychological makeup are “in” the supervision room, which can impact the intensity of how supervisees experience shame.

Participant 1 spoke about supervision in general as a vulnerable experience, which she acknowledged may lead to shame more intensely for some than others. Here, she linked being vulnerable with the possibility of feeling shame, “I really understand that it is just generally a vulnerable experience to be supervised and therefore especially for some supervisees. There may
be a fairly low threshold for emotions of shame and guilt to be evoked and I understand why it is.” She explained:

There are some people I’ve supervised where it’s not something they struggle with a lot and that for other supervisees they do suffer. And it gets in the way of their professional development, as well as makes them feel pretty miserable in the process.

Participant 8 also had the experience of supervising students who felt shame and embarrassment more frequently. She suggested that sensitivity to shame can be caused by a previous supervision experience. For instance, Participant 8 spoke about a supervisee who disclosed feeling shamed by her previous supervisor. Consequently, this participant reported being “on the lookout” for moments that may elicit shame. She said, “I was just sensitive to that. I was sensitive knowing that this could come up again where she’s embarrassed because the last [supervision] experience she had. And not just embarrassed, but embarrassed and making her feel really miserable about it.”

Participant 6 spent time reflecting on the differences between his current supervisees and their ability to sit with shame. He wondered about the supervisees who didn’t show shame as often, and what might be happening for them:

Other people, sometimes they may dip into shame in the sense that maybe they felt shameful, but I don't know, maybe it’s management. Maybe they manage it better, but I don't feel the same heaviness and they move quickly to the next topic. I don’t hear a lot of like, “I feel like I'm an imposter,” so maybe they’re better at hiding. I’m not sure.

When Participant 6 was asked to reflect on how he has noticed supervisee shame enter supervision he responded, “I mean, I think because it’s such a strong emotion, I think of certain people rather than it being a pervasive experience that I’ve encountered as a supervisor.” This
statement came alive when he provided a comparison between two current supervisees and their emotional reactions in response to a similar feedback style. First, he described the experience of wanting to help a supervisee grow and develop their conceptualization skills, but continually evoking shame instead:

I could tell that I was evoking shame by having these conversations. The person was somewhat aware of it, but wanted to do it their own way. But I brought it to the surface and made sure that we talked about it within supervision.

He compared this to his interactions with a different supervisee who he believed to move through shame quickly, or as he mentioned previously “dip” into shame:

I feel like this person feels pretty comfortable with me even when they touch into shame a little, or embarrassment. Maybe because we’re both probably more assertive? I’ve already given this person quite a bit of feedback that’s direct and I think they know that they are going to get direct feedback from me. So, there’s not a lot of toxicity built up. I think some of the frustration or challenges get talked through pretty quickly. I think this person prefers it that way too. “OK, we’ve talked about it, let’s move on.” So, I was even just comparing responses to shame. I feel like I see people dip into it and then move on. For some people some people it feels more pervasive and it’s sitting there a little bit more.

Mistakes, Feeling Like a Failure, and Wanting to be Competent

Apparent in 5 of the 8 interviews was the idea that supervisees want their supervisors, and others, to view them as competent and don’t want to disappoint their supervisors. Some participants also shared that supervisees may feel ashamed if they have failed others or that they are failures if they, as one participant said, “screw up.” Mistakes of all kinds can lead to feeling
ashamed, as Participant 7 states, “I think there are clinical issues people are ashamed of, and administrative ones.” In different ways each person described how the desire to appear confident and perceived failures evoked shame.

For some participants, failure was related to supervisees thinking they had failed a client, and for others it was failing a supervisor that led to shameful feelings. Participant 4 described the interactional relationship between wanting to appear competent, yet needing to be vulnerable (e.g., disclosing mistakes, knowledge gaps, challenges) in supervision: “And for very very [sic] good reasons there’s kind of this funny kind of line or dance or something about needing to be vulnerable because the [supervision] process is that way, but also needing to be competent.” Furthermore, Participant 2 also said that exposing vulnerabilities can feel like “I should have known how to do that,” possibly leading supervisees to feel like they have failed or that they have failed a supervisor.

Other participants shared the belief that perceived failure in clinical work can lead to shame and feeling incompetent. Participant 1 normalized the feeling of shame for supervisees, and all psychologists, who want to help others and make a difference, yet possibly not being able to do so.

I think it is relatively common, natural, and understandable emotion, especially for anybody who might be doing clinical work because the motivation is, presumably, for that individual to help make a difference in someone’s life. I believe that especially after years of advanced training, we all want to feel like we’re competent in some basic way. The time spent on training may also contribute to supervisees feeling like they “should” know things, as well as thinking that mistakes are reflective of their competence. Similarly, Participant 8 wondered about the relationship between confidence and shame: “I think sometimes it implies
a lack of confidence in themselves. I mean, you can be shameful and still be confident, I suspect. But, in my experience, there’s a lot of times that’s where that comes from.” Participant 8 and Participant 1 shared this belief that if supervisees aren’t confident in their skills or have doubts about their ability to help others, then shame may understandably arise.

Participant 2 shared one of his assumptions about supervisees feeling like failures in their clinical work when clients don’t improve quickly, which leads to the supervisee interpreting that as failure versus a typical process of working toward mental health.

I think they [supervisees] have this mistaken assumption that therapy is a linear progression toward health and improvement; That we start to work with people, and they get better and they don’t get worse along the way. I think there’s shame around “my client is not improving and so that means I am not doing it right,” because in the book, in the vignette, it worked.

Participant 2 continued to explain how the desire to appear competent can lead to shame by sharing a specific example of a student who continuously underperformed, despite feedback. After a conversation with the student’s director of clinical training and recommendation for a remediation plan the student said, “I have carried so much shame because there are basic things that I don’t know and I’m afraid that if I say I don’t know those things, they’ll kick me out.” This student’s shame about his knowledge gap led to feeling like he would be rejected or fail and kept him from accessing help and learning.

Feeling like a disappointment to a supervisor was also identified to evoke supervisee shame. Participant 5 spoke about the different ways supervisees may have felt shame in response to feeling like a disappointment, despite the importance he places on the supervisory relationship. He said:
I think if someone felt that they had let us down, then they would feel shame. I think that we are good to people in our internship or training, and we value the relationship part of it. So, if something wasn’t working, I could see that embarking some shame. Because, I think we can help anyone feel okay with a mistake. So, you didn’t get your report in on time? I’m thinking, “I don’t get 30 reports in on time.” That’s the least of my worries. You know what I mean? I absolutely fight to make sure that that level of shame isn’t there. See, I think it is shame relationship-wise. Like, somehow you feel like you let us down.

He explained how this has happened in the past:

Someone comes to me and is like I have to leave because of a medical illness or having a baby, and it’s funny, feeling shame about having a baby or whatever the circumstances might be. But it’s feeling like they can’t live up to what they wanted. We can feel shame a lot, I guess. Like my student feeling shame. I know she would feel lousy if she made a mistake, partially because that’s who she is and partially because she wants to please me.

**Power Differential and Being Evaluated**

Seven participants spoke about the power differential in supervision and how the evaluatory power that supervisors have can impact the relationship. Participant 1 said, “There’s also the difference in power in the room for the supervisor and supervisee. So again, that would lead quite naturally to the feelings of shame, and guilt.” Other participants describe more in detail their experience of how power dynamics affected their willingness to speak up in supervision. Participant 3 spoke from her own experience when she was shamed as a supervisee:

I think that there is a lot of hesitancy maybe to point out to a supervisor something that doesn’t feel good or the manner in which it’s delivered. There’s the power differential
and if you don’t agree, I mean, sometimes you get the supervisor that is, maybe a lot more cognitive behavioral and you’re psychodynamic and you just want to discuss maybe a different way of working it. It’s not, it’s not allowed. You have to work their way through it. Period.

Now, as a supervisor, Participant 3 described her own awareness of power over her supervisee, and how the evaluatory environment contributes to evoking shame. She said:

I think as a supervisor it’s very important to me to be aware of the power that you have and the effect that you have on the people that you're working with. So yeah, it’s a tricky tricky [sic] situation. There’s a sense of: I’m showing up for this, I’m being judged and being critiqued. Literally, they are being evaluated. Also, there’s this sense of: I have to know what I’m doing.

Participants described how the power associated with being in the position of supervising students can evoke shame. For example, Participant 5 shared that he felt “shocked” when he found out mid-year that his current supervisee had a “very tough” year at her prior training site. He described how his own power as a supervisor contributed to the supervisee keeping this information to herself, “She had a tough year, which of course she didn't tell me until she knew me. Because, she was like, “You’ll hold it against me,” not that I would hold it against her, but yeah... (sigh).” During this part of the interview, the participant often sighed, appearing almost troubled by his supervisee’s prior negative experience and feeling that she had to keep quiet based on feedback from a past supervisor. I asked him to elaborate on this interaction:

It shocked me because she’s a wonderfully nice person. And truly, I was like “How did it happen?” and we talked a lot about it ...The only thing that changed for me, is this awareness that even good people can struggle and even more so how important the
relationship is. It also clarified why every time [redacted student name] was like “Can I...
I have to leave early Friday,” she was shitting her pants. Of course, I said, “Just go! Why
are you anxious about that?” Now I know why. I didn’t know any of it. I’m like, “You
should have told me this three months ago” and she’s like, “I didn’t want to tell you.” I
said, “Why do you assume I’d think it was you? I know you, it had to be them right off
the bat.” But now I understand why she’s like, “Can I miss one day at Christmas?” and
I’m like, “Take the week... I don’t care.” You know, I don't think there’s any doubt that
she would have believed me, because she didn’t know me. She’s going to believe that it
would look like a black mark against her to say, “I had a bad year.”

He understood why this supervisee hid her past experience and explained, “I think that, just like
with kids or teens, there’s a bias that right away they’re at fault and the supervisor or program
director or head of the hospital is right and you’re wrong.” Participant 6 explained this bias as
“idealization,” when “shame can get evoked because people project mastery on to you or they
idealize you and then they devalue themselves.” His role as a director also contributes to the
power he has, and shame that may be evoked: “So it’s just a strange phenomenon where people
treat me differently because I’m a director, especially if they don’t know me. And then we have
to talk a little bit. I think certain people, just freeze.”

Participant 2 shared his conceptualization of how power in the supervisory relationship
can unconsciously impact a supervisee.

Maybe this is my interpersonal psychodynamic approach coming in and internalizing
that, but if we’re not parented appropriately, we automatically assume that there’s
something wrong with us. If we’re not supervised appropriately, you know, obviously on
a cognitive level I don’t know that students are walking around saying, “I’m a bad person
because my supervisors don’t give me time,” but on a deeper level that’s what it’s instilling in the student.

The comparison of a parent with a supervisor symbolizes the differences in power between a supervisor and supervisee, as well as the importance of the relationship as a whole. Given the importance of the relationship, this power dynamic can lead to a supervisee internalizing certain behaviors or patterns (e.g., forgetting about supervision, arriving late, imposing a “right” way to do therapy) within supervision, and feeling shame or defunct.

**Theme 4: Recognizing Shame Through Nonverbal and Verbal Cues**

Participants were asked about their experience in supervision when a supervisee may be feeling ashamed and how they made sense of what was happening in the room. In response to specific stories that were shared, I often inquired: “How did you know?” or “What made you think it was shame?” This theme largely concerns how supervisors pick up on shame or are cued into the shame supervisees may be feeling. Participants shared an array of specific reactions to shame. The emergent themes of ‘negative and critical statements’ and ‘avoidance reactions’ captures the nonverbal and verbal reactions described by participants.

**Negative and Critical Statements**

This theme consists of a variety of verbal statements and patterns that the participants picked up on during their years of supervising. Some participants shared specific statements, while others describe certain patterns of conversation or comments supervisees made.

Five participants used the word “defensive” when explaining how they knew a supervisee was feeling ashamed. Participant 1 reported that in supervision she is attuned to “whatever sort of like protective or defensive comments that they might make.” For her, “body language and word choice” can communicate an emotional shift. However, particular statements indicate when
shame is present: “For instance, they may say, ‘You know, you’re right, I really should have caught that’ or ‘I can’t believe I missed that’ or ‘I’m just you know I was really off my game. I can't believe...’” Similarly, Participant 2 revealed a pattern of responses that many students say before presenting a video of clinical work that cues him to the “nerves” or potential shame that they may be feeling.

I can sometimes pick up on cues that a student is nervous about showing me video. Sometimes they’ll talk a lot and they’ll do a lot of setup on the video and say, “Well, this day, I know this was going on and this happened, etc.” It sort of cues to me that they’re anxious about showing the video...So, I think there can be some hesitance, too. I think that, obviously shame around “This client is hard to work with,” “They don’t like me,” or “I don’t feel like it’s going well.” You know, they could be saying things like that, too. I’ve actually had students come in and they’ll preface a video with “this was an awful session” or present a client with, “I had a terrible session with so-and-so the other day.” As we unpack it, I’d say 7 times out of 10, it wasn’t an awful session. It was that either they had high ideals about what the outcome of the session should be, or their shame is causing them to be their own worst critic.

Hesitating before presenting a video and the presence of critical statements are both cues to feelings of shame.

Shame may also show up as general critical statements and a lack of confidence. Participant 6 reported that he’s cued into shame when he hears: I’m an imposter. He described certain statements and a pattern of thinking that signal the presence of shame.

This person told me about feeling like, “I’m not good enough. I am an imposter so...” Just telling me by using stronger type feeling words, “imposter” or “I don't know what I’m
doing” that would tend to reflect a feeling of shame to me…and it’s a heavier feeling too. It disrupts thinking when you are sitting in shame. It’s harder to think well. People’s thinking really start to become less clear. Yeah, they’re just feeling heavier. Then, you hear some of those same themes around, “I do feel like an imposter.”

Shame may be hidden under avoidance and frustration directed toward the self or towards others (e.g., clients). Participant 4 described a different way that she can recognize shame underneath other emotions and underneath specific patterns of (hypothetically) safer conversation.

It’s funny, the first thought that came up is like the initial thing that went through my head is: Oh, I don’t know. Then, as I sat a little longer naturally, I started thinking about instances where it was evident that people have that [feeling ashamed] happening, but it was like it was safer to share the frustrations and concerns about dealing with clients. It tends to be very internalized. It’s like people don't show what they are really invested into representing themselves as competent.

In contrast, two participants discussed moments when supervisees were “too agreeable,” idealized them, and presented clinical cases perfectly, which cued them into the presence of shame. For instance, Participant 7 shares her experience interacting with supervisees who present as “too packaged” or keep clinical cases neat when presenting information to their supervisor. For her, recognizing shame happens when a student presents cases that seem outwardly “neat.” This participant also suggests that what is not said in supervision can communicate shame.

You know, for some people, I get the sense that they’re hesitant to talk about interactions that either aren’t fully thought out on their end and they come with things that are too packaged…and not messy enough. The interactions are always a little too clean. So, I
think that there is how people present to supervisors and they’re trying to read your
reaction... I look at body language, I look at willingness to just kind of put themselves out
and let feelings or thoughts out.

Participant 3 mentioned that “they may be more apt to say what they think I want to hear rather
than something that actually unfolded,” which she explained is more likely to happen if there
isn’t enough trust and safety established. From her experience, if there is trust, then supervisees
will communicate more directly about the things they feel ashamed about. Participant 7 shared
this experience, although discusses the process of being idealized by supervisees, which he posits
is impacted by his position of power (i.e., program director): “So a supervisee can project on to
you and idealize you, and they lose a sense of their own knowledge. And through that
idealization process, I think shame is more likely when that occurs.”

**Withdrawing and Shutting Down**

Avoiding conversations or topics can also be a sign of shame. Participant 7 said, “So
there can be things that go on that aren’t talked about in supervision. I mean both volitionally
kind of hidden and kind of unintentionally just like ‘oh, we didn’t get to that.’” When people feel
ashamed, she says, “they tend to try and hide. So, whether it's not talking about something or
minimizing it or trying to avoid it, avoiding talking about certain things seems to be one of the
signs.” Participant 8 hopes supervisees use supervision to talk about mistakes and messy cases
and “avoiding talking about certain things seems to be one of the signs [of shame].”

For some participants, non-verbal communication cues them to attune to the emotions in
the room. All but one participant stated that they notice supervisees withdraw or shut down when
feeling shameful. Participant 7 said, “Nonverbal communication can tell you a lot. So, there’s a
kind of lack of eye contact or you know they’re blushing or they’re anxious.”
Shutting down and “getting quiet” were described as specific cues for shame. Participant 4 described her experience with supervisees who get quiet or quickly agree with what she has said, which may suggest a shutting down of their own thought process. She has noticed students “getting quiet and agreeing sometimes in combination...Responding shuts down. Sometimes that’s just because they are needing time to process. I mean, it doesn’t necessarily have to be about shame, but that’s what I might think.” Also important within the subtext of this quote is the underlying difficulty this participant experiences when she is unsure of what might be happening for the supervisee and acknowledges that she can’t be quite sure where the quietness is coming from. Participant 8 also shared her experience of supervisees avoiding to escape or withdraw from shame. She also shares her hope and preference for supervisees to acknowledge their mistakes:

I think nonverbal communication can tell you a lot. So, there’s a kind of lack of eye contact or they’re blushing or they’re anxious. Hopefully people can say “Oh, you know, I think I did something, and this is what it is” ... that’s a great sign when people are like, “Oh I totally messed up.” I love it when people put that out there.

Four participants spoke about a “feeling” or shift in the room that occurs, cueing them to question what might be going on emotionally for the supervisee. Participant 6 explained that with one student he saw “a lot of the body language of discomfort” when he brought up an area that the student lacked knowledge in. He went on to describe how supervision feels for him in the room when shame is present:

I think shame is going beyond embarrassment. I think I’ve seen a decent level of embarrassment, but I’ve also certainly seen shame... It’s more visceral, more powerful experience... You’re feeling like there’s something about yourself that’s not right or
defunct, rather than this is a skill set you can work on. It’s more personal and feels more un-liveable... to me supervisory shame would be a heavier feeling it’s something more personal. Like there’s something wrong with me and the way I’m practicing or doing things.

Participant 8 also shared the experience of feeling a shift in the supervisory relationship by expressing that she feels a “difference,” although isn’t able to identify one particular reason or cue for this feeling.

Sometimes the relationship changes all of a sudden and you don’t know why. So, maybe somebody is not as open, for example, in their communication or something’s different about the way they come into supervision and the way they communicate with you. You know, you’re going along, and you have this relationship and then all of a sudden, things are not the same.

**Theme 5: “We Need to Talk About it”**

Participants were asked to reflect on a past experience when they dealt with a supervisee who was feeling ashamed. During the interviews, some participants spontaneously shared specific interactions with supervisees and were often asked to elaborate on what they did or how they intervened. This superordinate theme organizes the common experiences between participants. Included in this theme are four emergent themes that represent shared ways of intervening and dealing with shame: (a) meeting them where they are at, (b) calling shame out and creating clarity, (c) using self-disclosure: modeling vulnerability and making mistakes, and (d) challenging the inner critic. All emergent themes were present in at least half of participant interviews.
Meeting Them Where They Are At

Five of the 8 participants reported that part of their experience when supervising is attending to the specific needs of their supervisees. Responses ranged from discussing the development of clinical skills, but also assessing their supervisees’ emotional needs.

Participant 2 mentioned the differences in his supervisory approach: “I probably tend to be more directive with my second-year student—my beginning psychotherapy student—than I am with my you know my third- and fourth-year students.” Participant 4 provided a metaphor of a “toolbox” to describe the skills a supervisee brings with them, and how this impacts her approach as a supervisor and how she chooses to intervene with students.

I did a fair amount of instruction and coaching. My intent depended on what people’s needs were coming in, because people would come in with a variety of experience in our particular population. Depending on what they had in their toolbox and where they were starting, there might be a lot more instruction in the initial part of the year. Then by the second half of the year, looking to transition to a more facilitative role. Because by the end of the year we wanted to be moving into a more collegial role because, that’s it. The expectation is that someone is then going to do the next step: licensure and the capacity that of independent practice.

Other participants focused on process versus the content of supervision. Participant 6 explained how he intuitively thinks about a supervisee’s reasoning for asking a question and what they might be (overtly and covertly) needing from him.

I would say in group and individual supervision I always think about: What is the person asking? Are they really asking because they are out of their league and need me to step in? or do they want me to reflect a bit with them? How much should I bring myself into
the room in a more directive versus non-directive style? So, those are some things I’m always thinking about.

In small ways, he assesses the supervisory relationship and the needs of the supervisee, reflecting on their knowledge of skill and emotional needs. Furthermore, he mentioned specific questions he asks himself to attune to the supervisee and the supervisory relationship:

There are the basic ways in which I try to just to see how things are going. How does the space feel? Are they comfortable talking to me? Are they comfortable talking about the countertransference or more vulnerable issues? Is it deepening in that sense? Or, before they ask me what I think, do they have a couple of formulations? So, I’m looking for those basic levels of markers or signifiers that the relationship is progressing.

Assessing the emotional needs of the supervisee was also important to other participants. Participant 3 described how supervisees are unique and present differently, which impacts how she works with each person.

I guess I feel like I’m learning all the time. I work differently with each student to some degree because their needs are different. They are different in the room. Some people present kind of stand offish and I’m going to just be very professional. Others are a little more comfortable bringing in if they’re having a hard day or if “a patient I was sitting with really triggered some issues with my mom and I don’t know how to separate that.”

So, everyone really kind of shows up differently.

Similarly, Participant 8 said, “Well your interactions are a bit different with each student, of course, because everybody is an individual and everybody likes to hear things differently.” The different emotional needs of supervisees impact this participant’s style of feedback. However, she also noted important consistencies when interacting with supervisees:
I think the most important thing is to be genuine, validate, honest and direct. Those are the common elements to me with all the students I supervise. And listen, you have to listen and see where they’re coming from and start there.

At the end of this quote, the concept of listening to “see where they’re coming from” is similar to that of “meeting supervisees where they are at.” She is trying to understand where they are or what their thought process is, before taking the next step.

**Normalizing Shame and Creating Clarity**

When participants noticed supervisees feeling ashamed, all reported wanting to address and normalize shame, as well as talk about it with supervisees. However, within this shared experience, the approaches differed. For instance, participants described wanting to help their students feel better, normalize feelings of shame, and clarify their thoughts or help problem solve to move through being stuck in shameful feelings. Participant 3 described an interaction she had with a supervisee who felt ashamed for feeling overwhelmed and stressed with balancing family life and clinical work; In response to her supervisee she said, “Where else were you going to bring this in? Of course, you bring it in here. This is part of what we do. We are human beings being clinicians. You aren’t supposed to be perfect.” The almost sarcastic tone of this statement, that is less noticeable in writing, is also important to comment on. The use of humor seemed to be used to help lighten the heaviness and as a way to connect with the supervisee. When reflecting on the interviews, it was evident that all participants wanted to address shame and help supervisees move forward to a better and less-shameful place. The quotes selected for this theme attempt to capture how supervisees managed to talk about it and move through shame.

Some participants shared how they help supervisees make sense of their shame, normalize the feeling, and encourage them to be vulnerable. Participant 1 spoke about the
importance of modeling, inviting questions, and using a metaphor to help her supervisees learn about shame.

I model and also try to bring up what I believe to be the most effective way to manage feelings of shame, which is basically taking an opposite action and stating what I think… The emotion compels us to draw inward and to keep things to ourselves where upsetting experiences dwell. So, I invite individuals to come forward with their concerns or questions so that it’s less upsetting to them. Also, to help them draw a parallel between being a supervisee and being a client. To come forward with their concerns because in the light of the day, it tends to be easier to manage than one might fear.

Participant 6 also described the importance of “talking through” shame. He said, “So a lot of what I tried to do is bring up the tension into the room, in the supervision, to talk about it just knowing that hopefully talking about it would make you feel a little bit better.” Furthermore, when intervening, he described wanting to “bring some understanding to light.” Participant 7 acknowledged that navigating shame “is a very painful process,” but must be done in order to learn and grow. Using her clinical orientation as a framework, she also explained the importance of bringing shame into the room to “shed light” on important things.

You know, part of what we do as therapists is talk about everything. My goal is that when people experience shame, we’re able to talk through it and leave in a less shameful place than they entered. You know, from a DBT [Dialectical Behavioral Therapy] perspective... You want to use opposite action to shame and do exposure. I consider it healthy when people are able to talk about it directly and shed light on things that they might want to flip the switch off for. So, I think being able to talk about it in supervision is really key to growth as a therapist.
Important to note is the symbol of “light” in the three experiences above. For these participants, the symbol of light may illustrate emotional clarity and gaining an understanding of what might be happening. Although not explicitly stated, the paradox of this image could be darkness, a state of confusion and shame.

A few participants detailed their thought process in supervision, illustrating the need for supervisors to help gain clarity and understanding around the shame, as well as how to move forward. Participant 6 spoke directly about the importance of his own emotional tolerance in supervision, which he explained, impacts his ability to think and gain clarity around the impact shame is having on a supervisee.

First off, I think I have to be somewhat comfortable with someone having the feeling that they are going to have. But when they get to the point where they’re really impacting their ability to think on their feet or grapple with a situation, that’s more of a problem for them. As a supervisor, that’s when I feel like I have to kind of mobilize someone to get them out of that place or to really focus on: Why are we there? Why did we get there? Can we bring some understanding to light? Hopefully it dissipates that feeling of shame if it can be contextualized and understood a little bit better. So those are times where I feel like I need to be more active.

Participant 4 reflected on her tendency to use here-and-now comments with the supervisees or to ask questions and wonder out loud about the supervisee’s experience.

Sometimes I would just miss it, but sometimes I would try to inquire about it just to say, “So, how is this sitting with you?” or “How are you feeling about what’s happening right now?” ... Just ask facilitative questions. Occasionally, I would just say, “You look uncomfortable with that” or “I find myself wondering if you’re uncomfortable.” To
observe it and be curious about it and try to give permission for the possibility that that was happening and that it was legitimate.

This participant also introduced the possibility that she may miss an opportunity to address or notice shame in the room, so exploring the supervisee’s experience and asking facilitative questions potentially provides clarity for the supervisor and supervisee.

Participant 8 shared a specific example with a supervisee who she described as sensitive to shame, to illustrate the importance of validation and offering extra clinical support.

First thing is I really tried to validate somebody’s feelings like that when they have that shame. In this instance, we had a relationship already, so she was able to talk about it a little bit more. As it turned out, she did fine in the situation, there was just some polishing to do. She actually did fine, but she was doubting herself because of her past experiences... I was able to coach her and help her so she could feel secure in her interactions until things got back on track.

Feedback on clinical work and additional coaching during challenging interactions helped the supervisee work through difficult clinical interactions instead of letting shame take over. Regarding her use of validation, although validation is not the exact same concept of normalizing, an important component of this clinical tool is to reflect and make sense of emotions, given the larger context.

**Using Self-Disclosure: Modeling Vulnerability and Making Mistakes**

Five participants discussed using their own stories and “mess ups” to help normalize making mistakes and shameful feelings. Participant 4 stated:

I certainly used a lot of teaching stories that came from those previous experiences. You know, I would share a lot... I have teaching stories and I have stuff that I self-disclose.
There are certain things both in therapy and in supervision I disclose. I shared a lot about my own screw ups or my own perplexity or my own process with stuff.

This participant continued to speak about her ability to use genuineness in situations to model for her supervisee how challenging clinical work can be, and normalize feeling ashamed, stuck, or unsure of what to do. She described the interaction:

One of the greatest clinical interventions that got the most applause was when somebody was in tremendous anxiety and anguish, and they looked up at me and said, “What should I do?” I don't know why I said this, but it popped out, “Fuck if I know.” Now, this was someone who I worked with for a while and we had safety. I wouldn’t normally say that type of stuff, but it was just so there. I’m old enough to have had a lot of humanistic training it’s just about the genuineness. So, he laughed, and it helped him catch his breath… So, I think part of dealing with shame is that it demystifies our fallibility, our ignorance. It’s like you’re out there working on it opens all that stuff up. Makes us, you know, not freak out, when we’re freaking out.

Again, the use of humor is woven into how the supervisor addressed shame by lightening the heaviness that shame can create. In this case, humor and sharing laughter also helped the supervisor to connect with the supervisee and engage in problem solving instead of “freaking out.” Using humor also models one way to cope with feeling stuck and how to respond to making mistakes.

Participant 5 stated that he had a supervisee who had a “bad experience” with a supervisor the year prior and “she was really negatively affected by that.” He described how he used self-disclosure to model his own vulnerability with clinical work:
Now, my current supervisee does these great reports and they’re 12 pages long and she’s like “I don’t think this is good,” and I’m thinking, “What are you talking about?” I tell her, “I’m embarrassed that I have to go to these meetings and show them my reports after reading yours.” And, I don’t say that to make her feel good. She does a great job and some days she can write a much better report than I do.

Participant 6 explained the importance of modeling in his own supervision, as well as acknowledging his own mistakes, fallibilities, and repairing relationships.

I think it’s a big responsibility in terms of trying to model how to be a professional, especially in a place that’s really difficult to work. In terms of just the stress, trauma, and vicarious trauma I think a lot of us unfortunately pick up or manifest. So, I think that’s probably one of the most important things to serve as a good model. You know, it doesn’t mean I’m doing everything right, but I think one of the big things is acknowledging when you make mistakes, especially if it’s a big one. Also, if you’re a little behind or if you got something not quite right in supervision. I had that recently where I think I was a little frustrated and it came out. I just followed up with the person the following supervision. It wasn’t big, but I think that’s a model for therapy.

Participant 7 shared her tendency to normalize potential shameful feelings or thoughts by revealing her own mistakes and voicing her genuine responses to cases that a supervisee may be thinking, but hiding.

There are always things that we do that when you say it out loud you know you feel ashamed about any of it. It’s really important to be able to talk about that. Giving examples or saying things like, “Wow, after that patient told you that you were a horrible therapist, I can imagine you really wanting to get the hell out of the room.” Or being
angry, or you know, like putting it out there like, “How did you feel?” and just asking. I’ll share similar experiences or disaster stories of times I fucked up. I try to normalize it from top to bottom.

Similarly, Participant 8 suggested that being vulnerable from the start of the supervisory relationship is the “best.” She said, “We both know up front what is the best way to talk about things. Also, making myself a little bit vulnerable too, if the opportunity presents itself, so they can feel like there’s some type of trust in our relationship.”

**Challenging the Inner Critic**

Four participants shared their experience of helping supervisees challenge an inner critic. This inner critic was articulated differently for each participant, yet all expressed wanting to either challenge negative thinking or lack of confidence that supervisees expressed when feeling ashamed. Participant 2 reported that shame frequently arises for supervisees when they present videos of cases or clinical work, evidenced by voicing doubts (e.g., “I did a terrible job”). He described how he responds:

I think the majority of the time my feedback is: “Okay, I understand how you think that didn’t go well, but let me play devil’s advocate with you for a second. Let me let me point out things that I hear that did go well” or “Let me point out things in your video that you think is awful, that I think are signs of a good bond with your client and that things are progressing.”

Participant 4 shared a specific experience with a supervisee who was being “very defensive” in response to feedback, which led to “arguing her case,” “tension,” and “a remediation plan.” This participant spoke in detail about this situation and the different ways she intervened trying to balance maintaining the supervisory relationship with the clinical-work issues.
Which I think we resolved very successfully and in kind of stayed present stayed focused.
I said, “Here’s what we need, here’s why we need it. We are not trying to get rid of you.
We’re trying to get our needs met and we want you to get your needs met because we need you. We need you here doing what you’re doing. You also need the capacity to adapt to settings.” Reaffirming and reiterating and being very clear about my intent. It was exhausting, but it had a positive outcome. We worked up a plan and things improved.

This participant explicitly told the supervisee “we need you here,” challenging any hidden critical thoughts that the supervisee might be having (e.g., “They are trying to get rid of me” or “I don’t belong here”). In addition, this participant expressed the importance of constantly reiterating her intention when giving feedback and with the remediation plan, so neither would be interpreted or construed differently by the supervisee.

Other participants wanted their supervisees to feel confident and “feel better” about their mistakes. Participant 5 said:

If a situation occurred when the supervisee says, “I screwed up and the kid won’t talk to me” or some other scenario, I will very strongly do two things. I will try to figure out what went wrong and why, and then figure out how to help you feel either better about the situation or feel less bad. You’re learning and this is why you do things...So, my whole goal is to help the supervisee feel competent and that mistakes happen, and that it doesn’t define you. We’ve all made them. My whole focus outside of playing out what happened would be: How to make you feel better.

He is clear about his “goal” of wanting supervisees to feel competent and better about mistakes that are made. Helping supervisees problem solve, or “playing out what happened” with the supervisee in conjunction with normalizing mistakes and challenging negative thoughts (e.g.,
Participant 8 linked confidence with shame, which impacts how she intervenes. She stated:

I think sometimes it implies a lack of confidence in themselves. I mean, you can be shameful and still be confident, I suspect. But, in my experience, there’s a lot of times that’s where that comes from. So, trying to validate them, but also help them look at: Is there evidence that you feel this way? Is there evidence that you messed up or did something wrong, bad, or should feel ashamed about what you did? I’m kind of thinking of that model of, you know, brief cognitive restructuring. I think that’s important to do because sometimes a feeling is a feeling and you feel that way, but look and see. I like to push them to think about: Is that really the feeling or what else is going on? So, it’s not therapy, but examining their own responses to their clinical experiences.

She mentioned wanting to help make sense of the supervisee’s shameful emotion, but also encourage them to explore their shame and help them challenge their thinking if need be.

**Theme 6: Shame Can Help and Hinder Growth**

Participants were asked how shame has impacted supervision and their relationship with supervisees. Many participants spoke about the destructive nature of shame in supervision, yet the positive aspects of shame and potential utility of the emotion was also part of the narratives. Participant 4 provides a dialectic of how shame can impact supervision:

It can be this really powerful force for good. It can be an opportunity to get people more to help us be more and more comfortable with our discomfort. To practice our facility of our healing curiosity with ourselves as well as with other people... It’s just it’s such an
avenue to address those kinds of things. And, it does the same thing it does in everyone else, it shuts people down and shuts the supervisor down. It did in my case at times. So, a great force for good, but it also can be destructive or the obstacle.

The following series of quotes highlights the different ways that supervisors described the destructive nature of shame, as well as its “use for good.”

**Preventing Growth**

Most participants reported that shame more often can be destructive to the supervisee and their ability to learn. Participant 4 commented on her own beliefs about shame and how it can get in the way: “Shame is a pretty internal experience, it likes to hide, so it’s often the case where many things don’t get resolved if they’re not shown or noticed.” Participant 1 shared a specific example of how shame went unresolved and hindered the growth of her supervisee:

I think he broadly struggles a lot with feelings of shame and guilt. And over time it has affected the supervision of him and his ability to learn from supervision. So, it is a barrier to ongoing collaboration. Despite my efforts to contextualize and to invite him to accept feedback as a growth opportunity even though it can be uncomfortable.

Despite her attempts to intervene and provide context to difficult conversations, shame (and guilt) has negatively impacted the learning potential of supervision.

Shame can impact the utility of supervision and how effective the supervisor can be. Participant 1 stated:

It’s probably particularly destructive to the supervisory relationship because not only does that leave supervisees potentially really struggling, but again because I think of the tendency when you feel shame to be withdrawn and to not be forthcoming or able to receive feedback easily. It really does undermine the ability for good supervision to
occur. It’s both hard for the supervisee and then it’s hard for the supervisor to have a real sense of what’s going on and to give helpful and effective feedback.

Participant 6 considered how shame can lead to shutting down of supervisees and their own ability to solve problems: “I could see someone feeling ashamed and some learned helplessness. And then the supervisor just takes control and just says okay do this and this.” Although being directive can be effective and helpful, he eludes to the pattern of shame pulling for supervisors to impart information instead of helping the supervisee access their own thoughts.

Other participants described shame’s impact on the well-being of supervisees. Participant 2 revealed how feeling shameful and inadequate can impact emotional well-being:

I’ve had students report, you know I would link this to shame, losing sleep over clients. I mean, I can remember losing some sleep over clients myself you know. But, that feeling that you didn’t do well enough or if you feel like you didn’t adequately serve a client where you ruptured a relationship somehow. That affects your own physical and emotional well-being.

Participant 5 also noticed the negative impacts of a previous shameful supervision experience on a supervisee’s well-being. He often noticed his supervisee shying away from asking certain questions (e.g., “for a day off during the holidays”) and said, “It’s too strong to say PTSD, but I found out that she was really affected by that and I would have been too.” Similarly, Participant 8 described shame as potentially destructive when sharing an instance of how shame negatively impacted her supervisee. Fortunately, this participant was aware of her supervisees sensitivity to shame due to past “shaming experiences in supervision.” She said, “You know, not sleeping and things like that. So, I was watching for that because I wanted to address it right away so that she would be able to work past that and be there.” On the other hand, this participant also described
how intervening and working through shameful feelings helped her supervisee gain more confidence: “As we get towards the end of her training year she will become, well, *has* become more confident in her own skills and abilities to consult when needed.”

Shame can shut down thinking and emotions, yet some participants suggested that there is still room for growth. Participant 2 described how shame can get in the way of using emotions as a clinical tool:

The shame can shut the student down and cause them to retreat within themselves, not get the help they need, not get the guidance they need. And also, not understand the dynamic that’s going on between them and the client and missing an opportunity to read what their reaction is to the client and utilize that in a clinical manner.

Here, this participant eludes to the utility of emotions and the possibility of shame being used as a clinical tool. This opens up the question: Is shame all bad?

**Positive Aspects of Shame**

Five participants described how shame can be a helpful emotion for supervisees and for the supervisory relationship. For instance, Participant 4 said, “It can also be an opportunity for self-compassion. Immediately an opportunity for self-compassion for having to wrestle with issues around vulnerability, breaking down the ‘I’m the clinician I know stuff.’”

Participant 6 mentioned that supervisees can learn from challenging experiences and stated, “A certain amount of this is necessary almost to get to a better place. Like, you have to experience some challenging supervisory relationship to learn from it. This is important.”

Participant 3 shared an example: “It was more shame that they felt in their practical experience and were reticent to bring it in to the supervision, but did. What they shared with me was that they were happy to have it normalized.” Although the supervisee was hesitant, they were open
and willing to discuss it in supervision, which led to a positive and normalizing experience.

A similar experience was shared by Participant 7: “I think that she felt supported and it was beneficial. I was glad that she trusted me, and I shared that with her. I think it furthered our work together.” Talking about shame in supervision created a shared trust for Participant 7 and her supervisee, furthering their relationship and the supervision. Furthermore, Participant 8 expressed gratitude for the strengthening of her supervisory relationship: “Well, luckily it went well (laughs), so it just strengthened our relationship. And I feel that she even feels more confident coming to me and less embarrassed about things.”

**Theme 7: Feeling Stuck**

Participants revealed that there were times when they felt frustrated and stuck when shame was present in supervision. They described feelings of frustration and self-doubt. Seven participants shared the challenges of shame arising in supervision and the importance of accessing support from others. For some participants, this was expressed by feeling hesitant, unsure, and frustrated. In addition, for the participants who spoke about feeling stuck, consulting and collaborating with others was a common and important part of the process. Thus, within this superordinate theme is an emergent theme: “collaboration and consultation.”

**Uncertainty and Frustration**

Feelings of frustration and uncertainty around intervening with shame was a common experience. Participant 2 described his own emotional reaction to a supervisee and the importance of his own emotional management:

I feel like I was able to manage my frustration so that my interactions with him were civil, and not overly negative. All along I was firm and very direct with him about where he had not performed well, but I was also able to manage my own frustration with reports
that just weren’t up to minimum standards. I think because I managed my own frustrations, and the relationship was strong enough, that when we had that difficult conversation, he was able to come clean.

Participant 6 also shared his frustrations and the impact his feelings had on the supervisory relationship.

I mean, I don’t think I managed it well, but I didn’t know how to figure it out. I was really like constantly trying to figure out... I think that was part of the challenge and I probably needed more reflection. Like, “why is this evoking so much frustration?” Because, I think I got frustrated. I wonder if that would have been picked up in one way or another, just throughout the relationship. Because I think personally, I was probably feeling like: “What am I doing as a supervisor that I can’t help this person?” I haven’t found the port of entry. There’s not enough trust. It didn’t feel like we had that...I mean, I wouldn’t say that I really managed it particularly well. But I do think I knew that no matter what, it didn’t feel like there is an easy solution and that it was important that we kept talking about it.

Being unable to intervene effectively with a shameful supervisee led to frustration and contributed to this participant doubting their own skills as a supervisor. Participant 1 described the emotional impact of supervising a frequently ashamed supervisee:

It’s very draining and I think it makes it hard for me to stay as invested in the process as I’d like to be because it’s draining and ultimately not so very rewarding. I also think it interferes with my effectiveness as a supervisor.

Other participants spoke about their feelings of uncertainty around intervening with shame, as well as their effectiveness in supervision. Participant 4 revealed her own doubts that
can arise when faced with a challenging interaction and the presence of a gap between what she wants to say or do and how it is received by the supervisee:

I need to acknowledge that at times feel like, “oh man I don’t have the skills for this.”

This is pointing out to me a place where I don’t have on tap what I want to do to be able to do…I could just see what I wanted to be able to do, what I wanted to be able to say or how I wanted to engage the person. To even say, “Hey, here’s what I’m experiencing,” “Here are the things that I’m thinking,” or “Here’s my observation,” and to be able to communicate that clearly. I think part of what would happen is that it would create anxiety in part, and so we’d both choke a little.

**Seeking Support**

Five participants spoke about the importance of seeking support through consultation and collaboration when they felt stuck. Reaching out to colleagues for support was a common and reportedly helpful tool for some supervisors. Participant 2 described an example when consulting with a colleague was particularly advantageous:

I had to process that with my co-worker and with another colleague, you know, just about “Hey, I’m really having some negative reactions to this student and his lack of follow through and lack of awareness of things and his knowledge,” and things like that. So, I felt that processing through that with people and that I had a decent relationship with him even through my frustration was helpful.

Participant 5 reported that the team of psychologists who he works with are “good people” and that “we always help each other out.” On the other hand, Participant 4 stated that she didn’t have a strong support system of colleagues who were familiar with the type of work she was doing. In
order to create a support system, she created an association of mental health professionals online. She detailed the purpose and benefits of this support system:

So, what we did was form this association, but it evolved out of an informal thing that was already running. We would meet together, we had a listserv, and we would call each other. I knew that if I was up against something, and I did on several times, I had enough emotional safety with my friends over the years that I could put out an email just to my subset of other people and get good supervision. And if I was tearing my hair, I had the safety to go to just vent in an appropriate way. You didn’t have to be careful. I had to be professional, but I could bitch. It really helped. It really helped. And then people would say if they could hear what the issue was and support.

For some participants, a consultation group was an important place for consultation. Participant 6 worked with other supervisors to create a group for supervising psychologists to meet and “help people feel more comfortable talking about their roles and talking about difficult situations.” This participant also revealed that he “steals supervisory tricks” from other supervisors when he is feeling stuck in supervision and asks his colleagues about what they are “doing” with supervisees in supervision. Consulting with others was also used as a learning tool for Participant 8. She spoke about her own gaps in knowledge as a beginning supervisor who had no formal training. She compared her feeling of becoming a supervisor to turning 18 years old: “It’s like when you are 17, it’s your birthday, and you are going to be 18, but you’re just a day older, it’s not that you know more. Now, you have all these responsibilities.” Particularly when she first became a supervisor, consulting was described as “very important.”
Discussion

This study examined the accounts of eight psychologists who supervise graduate students, and their experience and management of supervisee shame in supervision. Their responses highlight the uniqueness of each supervisor’s style, their experience of supervising, and the many ways shame can influence and be dealt with in supervision. Emergent themes were identified through semi-structured interviews that captured similarities across narratives.

This explores and expands on themes that were identified through attention to the research questions:

1. What is the experience of supervisors in supervision?
2. How do supervisors notice shame?
3. How do supervisors manage shame?
4. How can shame impact supervision?

In this section, I explore superordinate and emergent themes in the context of the literature. Reactions to shame are discussed using Nathanson’s (1992) Compass of Shame Model, with the intention of providing an applicable framework for supervisors and supervisees. Implications for supervisory practice are included within the context of themes. Lastly, study limitations and future research will be discussed.

Supervisors Learn from Experience

When exploring how supervisors manage shame, the experience of learning how to supervise provided a deeper understanding of this experience. This portion of the interview helped to understand the “why” and “how” they manage shame rather than the “what” and “when.” There did not seem to be one simple method of teaching or learning that shaped their
supervision style, but a combination of past experiences and theoretical models: (a) being a supervisee, (b) graduate school classes, (c) supervision models, (d) clinical orientation, (e) self-teaching through research, (f) collaborating with other psychologists, and (g) learning through their current experiences with supervisees. Their understanding and management of shame was influenced by a culmination of education, clinical training, and lived-experiences of being a supervisee.

The evolution of supervision models and supervision training was reflected in this study. Although supervision has long been acknowledged for its influential role in graduate training, and acknowledged by APA as a clinical competence, training continues to vary across programs and degree (e.g., school, clinical, counseling; Falender, 2018). In this study, generational differences were noted, as older participants did not attend training programs that offered classes in supervision theory and learned through “osmosis” and “by doing;” one participant described her learning as “patchwork.” Supervisors with less than 10 years of experience reported more educational experiences in graduate school (i.e., attending a supervision-of-supervision class, discussing specific supervision models in classes). Falender (2018) posits that the variability in supervision training and overall lack of programmatic attention to supervision training may be due to generational differences in training of most practicing supervisors. For instance, in 2016, the mean age of practicing psychologists was 50, which means many supervisors completed graduate training prior to the shift of supervision competencies (APA, 2015). Similar differences were found in this study, albeit this was a smaller sample.

A unique experience was described by one participant who received her PhD in counseling psychology. She received intensive training in supervision in the form of a “supervision practicum.” As a result, she felt confident in her skills and expressed her overall
opinion that compared to other psychology degrees, counseling programs focus more heavily on developing competence in supervision. Interestingly, the difference in supervision training has actually been documented, as Crook-Lyon and colleagues (2011) found that interns at counseling centers had higher rates of supervision training related experiences. Supervision also seems to be variable in other specialized areas of psychology. For instance, over 84% of practicing neuropsychologists reported clinical supervision was discussed in graduate school only minimally or not at all (Shultz et al., 2014). There seems to be continued variability in the supervision courses and training opportunities that are offered in graduate school. Rings et al. (2009) surveyed 184 predoctoral psychology internship directors on their view of competency based supervision suggested by Falender et al. (2004). There was an overall consensus with the importance of adapting a competency based framework. However, they also found that supervisors who received coursework in supervision were significantly more likely to agree with its importance than those who had no training. Although training in supervision varies, it is clear that experiences as a supervisee and as a student have a lasting impact that influence how the psychologist views supervision, as well as their own their supervision style.

In learning how to be a supervisor, participants spoke most passionately about their negative and positive experiences with past supervisors. This is a shared experience for many supervisors, as it is common for professional psychologists to learn to supervise through osmosis in the course of their own supervisee or supervisor experience (Falender, 2018; Falender & Shafranske, 2004). More than half of participants remembered a negative experience with past supervisors. One participant mentioned that, in retrospect, she learned “what not to do.” Interestingly, past negative supervisory events seemed just as useful for learning about how they wanted to act as a supervisor, as few mentioned, “I never wanted to make someone feel that
way." All participants described positive experiences with a supervisor that shaped their own supervisory style; many were referred to as mentors. Across cases, participants identified at least one “mentor” who influenced their professional development and more specifically, how they intervene as a supervisor. Participant’s own positive experiences with supervisors, seemed to help them “bounce back” after negative experiences as a supervisee. Knowing what they didn’t want in supervision, as well as what they did want, seemed to be an important factor in learning from negative experiences. Although clinical knowledge and skills are not as easily transferable as the master-apprentice model implies (Falender & Shafranske, 2004), the supervisory relationship continues to be an important part of what makes supervision “work.”

Clinical orientation also impacted how they conceptualized their role as a supervisor, as well as how they understood shame and approached emotional content in supervision. When intervening with supervisee shame, it makes sense that supervisors respond in a manner that is consistent with their clinical orientation, as it informs what they observe and their selection of clinical information that is discussed, as well as its meanings and relevance (Falender & Shafranske, 2004). For instance, those participants who practiced in shorter term models using Cognitive Behavioral Therapy described their style as “coaching” and their tendency to be more directive. In this study, Participant 1 described her training in DBT and when interviewing with shame she helps her supervisee “act opposite to shame” in supervision; this is a DBT skill. In contrast, those with an interpersonal orientation in longer-term treatment models tended to focus on process and interpersonal dynamics in supervision sessions. Here, Participant 4 shared that his supervision style “flowed” from his interpersonally focused orientation to clinician work, and he tries to minimize shame by creating a collaborative and genuine environment where supervisees can learn from their mistakes.
The Supervisory Relationship as a Secure Base

Hidden in the content of what supervisors described was a sense of what it feels like to be a supervisor. Supervisors in this study described a sense of responsibility for their supervisee(s), as well as feelings of liking and caring, safety, and exploration. Each supervisor expressed an investment in their supervisees’ success; a trait of “good supervision” (Falender & Shafranske, 2004). This parallels Bordin’s (1983) emphasis on emotional bonds within the working alliance. In this study, participants were impacted by their supervisees, which presented itself through the content of their narratives, as well as their use of emotionally laden language such as “love” and “hate,” as well as through swearing while discussing particularly memorable interactions. Although I only heard one side of the story, the experiences described by participants seemed to reflect an attachment relationship.

Participants unanimously believed that establishing a strong relationship with supervisees was essential for growth, and particularly helpful when working through shame. What was most striking about their descriptions was the comparison of the supervisor–supervisee relationship to a parent–child relationship. Three participants directly used the parent–child relationship when explaining this dynamic. For instance, one participant described the feeling of supervising similar to that of parenting and not wanting to “mess up.” Most shared their desire to “help them [the supervisee] feel better,” to “validate,” and to help their supervisees grow and develop confidence. One participant even described her “love” for being able to witness the professional growth of her supervisees. Being able to manage and work through supervisee shame was impacted by the quality of the supervisory relationship. Participants intentionally worked to establish a strong working alliance which included safety, vulnerability, trust, validation, investing in professional growth, and consistency. This felt-experience fits well with an
attachment lens and provides a theoretical framework to understand the importance of the emotional bond that Bordin (1983) described.

The emergent themes of trust, safety, exploration, as well as the use of emotional language, highlighted the importance of the supervisory relationship. Watkins (1993) described the function of the supervisor secure-base was to ground, support and soothe, and orient the supervisee while providing protection and security, encouraging exploration, and inspiring wonder and awe in who they are and who they will be as a therapist. If the supervisory alliance is strong and consistent, supervisees have independence yet can return to their supervisor to share mistakes, discuss challenges, and learn from them.

The theme of establishing trust and safety was mentioned time and time again. Bennett and Saks (2006) hypothesized that the dynamics of the supervisory relationship activate the internal working models of attachment for the supervisee and supervisor. Using this framework, they argued that by providing trust and safety, the supervisor can better assess the student goals and their readiness to explore, as well as their emotional needs. “Just as a circle of security with the caregiver enables a young child to develop autonomy and a sense of self, the circle of security within supervision enables the inexperienced student to develop a professional sense of self and confidence” (Bennett & Saks, 2006, p. 673). For the supervisee to take risks and share vulnerabilities, Mangione and colleagues (2011) found that a felt sense of safety and support are essential conditions, which includes genuine support for the professional and person, and ongoing conversations about how evaluation and power impact the supervisory relationship. Participants in this study described how they developed safety and trust: by “being there,” “making sure they had a good year,” “talking about mistakes,” “sharing my own fuck-ups,” “providing extra coaching,” and making room for the supervisees’ own goals and professional
selves. Across narratives, this investment in the supervisory relationship seemed to be framed as a protective factor for the negative impacts shame can have on supervision (e.g., nondisclosure, hiding, avoiding). As one participant described, “there’s nothing we can’t work through.”

Participants encouraged clinical and professional exploration. The language participants used to describe how they supervise was unique, yet one phrase appeared across all cases: “I want to help them find their voice.” Participants were invested in skill building and teaching, while also making space for the supervisee to have their own thoughts, conceptualize differently, and try out interventions. Bernard and Goodyear (2018) describe that when supervisors can find a balance between support and challenge, supervisees feel less anxious and are less resistant to feedback or change. A balanced supervision might include asking supervisees for their thoughts and opinions, making space in supervision for supervisee agenda items, attending to the whole-person rather than solely the clinician, and proposing clinical ideas, conceptualizations, and interventions yet not enforcing them. Mangione et al. (2011) interview supervisee and supervisor dyads and found “shades of collaboration” when the supervisors described “invitational language” expressing interest in the supervisee’s process, thoughts and feelings. The participants in this study described similar invitations and intentions to hear their supervisees ideas and help them develop their voice. However, Mangione and colleagues (2011) remind us that this invitation can feel like criticism or a quiz versus a true joining in collaboration. Although we don’t know how the participants’ invitations were perceived, the investment in the clinical and professional development of their supervisees was a factor in their assurance that supervisees would feel comfortable sharing mistakes and ask for support when needed.
Noticing Shame

When asked how participants noticed shame, participants identified a combination of feelings (e.g., countertransference), verbal cues, and nonverbal cues. Shame was defined as a shutting down, painful, and destructive emotion. The feeling of “heaviness” and feeling stuck were often described as an emotional reaction or countertransferential feeling. Furthermore, a few participants spoke about shame as a “painful” experience. This felt experience of shame being in the room parallels a description by Graff (2008) who said that shame feels like “a weight, a heaviness, a burden, pressing down often at the top of the back…” (p. 79). Based on qualitative interviews, Brown (2006) also conceptualized this feeling: “shame is the intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging” (p. 5). In this study, self-awareness and being mindful of countertransference were used to tap into the presence of shame.

A significant segment of the findings in this study concerned a series of reactions to shame that supervisors have observed over the years. This superordinate theme is particularly useful for future supervisors, as it highlights specific reactions to shame. When asked how supervisors noticed shame, they described many experiences that fit well within Nathanson’s (1992) Compass of Shame model. As previously mentioned in the literature review, the Compass of Shame conceptualizes reactions to shame: *withdrawal, avoidance, attack on self, or attack on others*. Hahn (2001) also found Nathanson’s model useful for identifying shame and used vignettes to help readers better understand how shame can impact supervision. In this study, participant descriptions also fit well within Nathanson’s model and their reactions are discussed in detail to provide a framework for supervisors—and supervisees alike— to understand reactions to shame.
Participants described various withdrawal reactions. Most common was the reaction of supervisees who “shut down,” which looked like having difficulty thinking and problem solving, and feeling stuck. Mild forms of withdrawal were described as minimal eye contact or a shift in eye contact, hunched-over posture, quieter voice, shifting or fidgeting, and blushing. Hahn (2001) noted that “Tardiness, mundane forgetfulness, and failure to bring in tapes also should not be overlooked as possible ways of withdrawing from the interpersonal nature of supervision” (p. 275). It is important to keep in mind the skill level and development of each supervisee, as supervisors may mistakenly assume an inactive supervisee is lacking knowledge and respond by lecturing or asking questions; however, shame may be behind the inactivity. This type of supervisor response can undermine supervisee’s self-confidence and evoke underlying shame, reinforcing the withdrawal defense (Hahn, 2001).

Avoidant reactions are used to prevent exposure and humiliation. Some participants were cued into shame when supervisees focused on surface level topics and refrained from talking about specific cases or certain topics. To avoid, they also reported that when presenting clinical work supervisees may talk a lot, provide reasons for their tape being bad, or spend a great deal of time explaining a tape. Furthermore, supervisees may avoid through advice seeking and wanting the supervisor to impart information versus collaboratively work through a problem. Hahn (2001) also observed these reactions and noted that supervisees do this in order to avoid their own lack of knowledge and feelings of vulnerability. Again, it is important to consider the development of the supervisee when conceptualizing this reaction, as newer supervisees need more teaching and lack the skills needed to conceptualize (Falender & Shafranske, 2004).

Reactions of attacking-the-self included self-critical and self-blaming statements, which occur on a continuum of mild (e.g., “I was having an off day” and “I don’t think this is very
good”) to severe (e.g., “This is a terrible tape” and “They are never going to get better and it’s my fault”). However, self-critical thoughts may not be vocalized, particularly if the working alliance is not strong (Farber 2006; Hess et al., 2008; Knox 2015; Mehr et al., 2015). Hahn (2001) provides a different idea of attacking the self, and states that deferring to supervisors can be a mild form of attack on the self; deferring to the supervisor minimizes the supervisee’s belief in their own ideas and abilities. By focusing on mistakes, supervisees may become preoccupied with wanting to be accepted by their supervisor and perceive themselves as inadequate or unworthy.

The reaction of attacking others can be particularly harmful to the supervisory relationship (Nathanson, 1992). Participants reported instances when supervisees appeared defensive, angry, and frustrated with the supervisor or the client. One participant explained that if a supervisee often feels frustrated with the client, there may actually be shame and self-doubt hiding underneath the anger. Hahn (2001) explained that shame can also lead supervisees to dismiss supervisor suggestions and blame others (e.g., clients, supervisor) whereby the supervisee externalizes or projects their inadequate feelings onto their supervisor. When supervisors react to these emotions instead of reflecting on the dynamic, the supervisor may experience their own feelings of helplessness and self-doubt. If this reaction is not explored in supervision and identified as a reaction to shame, the supervision may deteriorate, as each person will blame the other (Hahn, 2001).

**Intervening with Shame**

Shame can be a useful emotion when addressed effectively in supervision. Participants shared a variety of topics that were potentially shame-inducing, yet able to work through, including (a) giving critical feedback, (b) difficult clients, (c) administrative errors, (d) viewing a
videotaped therapy session, (e) multiple roles in the workplace, (f) personal stressors, (g) asking for help/feeling stuck, and (h) lack of knowledge. Because shame events are apt to affect the supervisee’s sense of professional self, efforts are needed to reinforce or rebuild their sense of self-efficacy. It is also helpful to normalize the supervisee’s experience, underscoring that therapists are human and that mistakes, even significant ones, are bound to happen. Two participants described how their supervisory relationships were strengthened when they worked through shameful feelings with a supervisee. For example, one supervisor said, “It can be this really powerful force for good. It can be an opportunity to get people to help us be more and more comfortable with our discomfort.” Tangney and Dearing (2002) explain that moments of shame can be viewed as an opportunity for nonjudgmental inquiry and professional growth.

Supervisors used a number of techniques when intervening with shame. Participants believed that their use of self-disclosure was essential to building a solid working alliance, establishing trust, and needed for successful supervision. The utility of supervisory self-disclosure has been proven time and time again (e.g., Farber, 2006; Ganzer & Omstein, 2004; Ladany & Walker, 2001). In supervision, self-disclosure can function to socialize, instruct, and to model and provide empathetic support to supervisees (Bordin, 1983; Clevinger et al., 2019; Knox et al., 2011). Participants in this study explained how their own use of self-disclosure was used to normalize mistakes, to normalize shameful feelings, to create safety, and model vulnerability. Their use of self-disclosure was also used to “normalize” their supervisees’ feelings and actions, which seemed like a type of socialization to the imperfect world of a psychologist. To build a strong working alliance based on trust, or to help supervisees feel less alone in shame, supervisors shared their genuine experiences of what it is like to be a psychologist; as one participant said, “it’s not perfect and we all make mistakes.”
Using self-disclosure to fend against shame makes sense in the context of shame literature. This fits with Brown’s (2006) theory, which states that creating critical awareness by demystifying, contextualizing, and normalizing shame can foster resilience against shame. Normalizing mistakes or other shameful events in supervision can also dissipate shameful feelings and strengthen the supervisory relationship. For instance, Knox and colleagues (2008) interviewed 16 supervisors on their use of self-disclosure and found that supervisor self-disclosure was found to increase supervisees’ willingness to take risks and be vulnerable, and strengthened the relationship (Knox et al., 2008). Disclosing information about what it feels like to be a psychologist helps to redefine a potentially idealized picture of what supervisees have in mind. Tangney and Dearing (2002) have extensively researched shame, and believe that “for supervisee shame experiences to be fully understood, the supervisor must facilitate exploration, deepening the supervisee’s understanding of his or her reactions and exploring possible links to previous shame events in the supervisee’s life (i.e., countertransference)” (p. 397).

Participants described various interventions that parallel methods and techniques of relational supervisors. For instance, participants expressed the importance of discussing power, showing up authentically, and wanting to help their supervisees find their voices. Mangione and colleagues (2011) argue that ongoing reflexivity, authenticity, and collaboration within the supervisory relationship can help to ease the stress of more difficult conversations. However, given supervisees’ vulnerability and the power differential, they are unlikely to initiate a reflexive conversation. The supervisor is in the more powerful position and is responsible for initiating, modeling, and setting expectations for talking about supervision and the supervisory relationship.
Reflexivity “models for the supervisee the importance of checking in with the other person in the relationship, helps to build that relationship, and affirms the meaningfulness of both participants’ perspectives” (Mangione et al., 2011, p. 163). Sarnat (2016) shares that relational psychodynamic supervisors prioritize methods and techniques that encourage the supervisee to express their ideas and be open about their difficulties, as well as attend to supervisee anxiety and shame. She explains that, “Rather than expecting the supervisee to comply with her ideas about the patient and technique, as a more classical supervisor might, the relational supervisor draws out the supervisee’s ideas and is interested in exploring differences” (p. 48). Relational methods of supervision may be useful in intervening with shame, as well as reduce the destruction shame can have on the relationship. Given that conflicts will inevitably arise in supervision, using relational methods and reflexivity from the start of the relationship allows for the discussion of negative emotions, such as shame, power dynamics, as well as developing a trusting relationship where conflict can be managed.

Given the heavy feeling that accompanies shame, many supervisors felt shame in the room. In supervision, countertransference is inevitable, and discussion of emotions can be a useful tool. Participants described their desire to be self-aware and tap into countertransference in order to intervene. For supervisors who may not be psychodynamically trained, Falender and Shafranske (2004) used the term “reactivity” to help describe the phenomenon of atypical emotional response. Collaborating with the supervisee to explore factors contributing to this emotional reaction can be useful and helps to identify shame. Furthermore, Alonso and Rutan (1988) reminds us that it would benefit supervisors to tap into their own shame, as even the most seasoned psychologists are impacted by parallel processes in supervision, whereby the supervisee recreates that client’s problems in supervision. As supervisors, developing
self-awareness and understanding triggers for emotional reactivity is best practice for effective supervision and life-long learning (Falender & Shafranske, 2004).

Supervisee factors contribute to how participants intervened with shame. Many participants described interactions with supervisees where shame was destructive, and negatively impacted the supervisory relationship. At times, supervisors felt stuck due to the challenge of knowing how to intervene effectively with supervisees who often were in situations that could elicit shame or embarrassment and were unreceptive to feedback. This makes sense as shame-prone individuals expect greater risks for disclosing a secret or mistake (DeLong & Kahn, 2014) and tend to hide secrets (Hook & Andrews, 2005). Bilodeau and colleagues (2012) found that supervisees who are shame-prone may have particular difficulties developing a strong working alliance, as they may idealize supervisors at first and struggle to move past shame, keeping their supervisor at a distance. Participants who were unable to work past shame discussed moments when intense feelings of shame led to difficulties with supervisees accepting feedback, following through with feedback, engaging in self-reflection, and talking about shame with a supervisor.

In this study, two participants described situations where shame was particularly destructive, and they were unable to find an effective solution. These situations included a supervisee who was unreceptive and defensive to critical feedback in response to a manualized therapy, and inadequate performance with clinical work and psychological assessment that did not improve with instruction of skill, modeling, or problem-solving. In both situations, shame was heightened for a prolonged time period, the supervisee was lacking more knowledge typical for their development, and reactions to shame in supervision largely included withdrawal and avoidance. More than half of the participants in this study shared the experience of having a
supervisee who was sensitive to shame, despite “contextualizing the emotion” or “inviting mistakes and feedback.” The strength of the relationship and the intensity of shame felt by the supervisee were both identified as factors contributing to the management of shame.

Despite having knowledge and an understanding of shame, participants described a sense of confusion and uncertainty. As one participant stated, “it’s hard to know if they [supervisees] don’t tell us.” Many participants often used qualifiers when asked about the success of their interventions, stating “I think it went well,” “I really just gave my best guess,” or “I hope they would have told me if I wasn’t being helpful.” Talbot (1995) shared this challenge and explained that shame may occur even when supervisors are careful to act in a non-shaming manner (e.g., using empathy and understanding). Some participants wondered if they had managed shame well and questioned their effectiveness. There was a sense of “hope” that they had managed difficult interactions well, and that supervisees would have told them if there was a conflict. Generally, even when supervisors felt confident about how they had responded to shame, they expressed some uncertainty around knowing if they had been helpful. Feedback from supervisees was welcomed and appreciated, otherwise supervisors were left guessing and assuming.

**The Balancing Act of Supervision**

Role confusion can impact how shame is dealt with, as well as the supervisor’s ability to intervene effectively (Ladany & Friedlander, 1995). Although the challenges with multiple roles was not a frequent theme that emerged, more than half of the participants mentioned different roles in describing their roles and how they interacted with supervisees. I believe this is important to briefly discuss, as supervisors wear many metaphorical hats, which can impact how and why shame might enter supervision. In Carol Falender’s (2018) continuing education course on becoming a better supervisor, she describes the importance of understanding the multiple
roles of a clinical supervisor: consultant, mentor, teacher, team member, evaluator, and administrator. However, distinguishing these roles can be challenging. For instance, supervisors are attempting to build a strong emotional bond and create a safe space for supervisees to share mistakes, while also being in a powerful evaluative role. One participant described managing these roles as a “balancing act.” She spoke about the importance of flexibility, yet knowing where you stand when you put on a different “hat.” Overall, the message was clear: Boundaries are important.

Setting boundaries is an important element of effective supervision (Falender & Shafranske, 2004) for the supervisor and supervisee. When supervisees are unclear of the roles and boundaries, this can lead to ethical violations and harm. When intervening with shame, two participants described the importance of distinguishing their role of a therapist from a supervisor; each person had a clear understanding of what this looked like for them. It is the supervisor’s responsibility to hold and communicate the boundary of supervision versus therapy, as a supervisee may be unaware of the difference (Falender & Shafranske, 2004). Furthermore, supervisees do not always know how to utilize supervision and may not know what they should do to have effective supervision (Sweeney & Creaner, 2014). As a result, they may not know what they should and should not disclose to their supervisors (Knox, 2015). To clarify roles and define expectations, the use of a supervision contract is now required as a way to introduce the supervisee to the process of supervision by setting expectations, identifying goals, and outlining the structure of supervision (Falender & Shafranske, 2012). Creating a supervisory contract and outlining expectations and roles of the supervisee and supervisor is recommended. Furthermore, educating supervisees about the function of processing emotions, like shame, is another
technique that normalizes these emotions, increases knowledge, and creates a collaborative atmosphere.

Despite training and best efforts, supervision is complex, and intervening can be frustrating. The challenges a supervisor faces are well documented (e.g., Ellis, 2006; Grant et al., 2012; Skjerve et al., 2009), particularly as client welfare and the development of a supervisee are both a responsibility. In discussing the multiple roles of supervisors, Falender (2016) urges supervisors to consult with unbiased parties. To cope with the challenges of managing shame, many participants turned to co-workers, consultation teams, or mentors for support. When did they seek support? Responses included: When feeling stuck, unable to manage their own emotional responses, not knowing how to intervene, and needing to vent. Even the most seasoned supervisors spoke about the importance of reaching out to others for support. Feeling stuck and at a loss was present across all cases. However, not all supervisors had access to co-workers or other psychologists that were familiar with their type of organization or clinical population. For instance, one supervisor didn’t have colleagues “in-house” to consult with, so she created a virtual consultation team via an email chain for supervision support. The general theme was: If you don’t have a mentor, co-workers, or other professionals to consult with, find them!

**Future Clinical Implications**

This study has several implications for the future. First, supervisors can utilize the Shame Compass Theory to conceptualize shame reactions during supervision. Supervisors can also provide psychoeducation around shame to help supervisees gain self-awareness around their own reactions to shame, as well as better understand their own emotional reactions. Inviting supervisees to engage in this process allows for collaboration and normalizes potentially
isolating feelings of shame. Additionally, developing an awareness of shame can also be useful in building empathy for clients and understanding how shame can impact a therapeutic relationship (Tangney & Dearing, 2002).

Results suggest that investing in the supervisory working alliance can dissipate feelings of shame, acting as a proactive intervention. Investing in this emotional bond is needed to create safety for disclosing mistakes and sharing difficult clinical cases that facilitate learning. In particular, self-disclosing and normalizing mistakes seem to be essential components of creating safety. Creating a space for supervisees to “find their voice” can also provide a framework for their ideas to be respected in a power-imbalance relationship. This may be particularly important for supervision frameworks that tend to be more structured and problem-focused or skill focused.

Supervisors have a challenging position. They can be left guessing as to how effective their interventions were, as supervisees do not always provide feedback. As such, engaging in self-reflective practices as a self-assessment is often beneficial to supervisor’s development (Falender & Shafranske, 2012). However, we can imagine that this may not happen as often as one would hope. In this study, participants shared their hopes to reflect more, and made statements such as “I haven’t thought about this too much...but I’m glad I did.” When possible, take time to reflect, as Watkins (2012) states that “ongoing supervisory growth is most apt to happen when ongoing deliberate efforts are made to challenge and cultivate supervision skills and perspectives over time” (p. 77).

Limitations

The results should be considered in light of this study’s limitations. The small sample size of eight participants limits generalizability of study results. Additionally, I previously
worked with three participants, which may have impacted the interview and responses to answers. Further, only three participants had experiences with shame that they deemed “unsuccessful.” It is possible that a larger sample size may have captured additional ruptures related to shame.

Due to convenience and practicality (e.g., time, location), most participants opted for telephone interviews. If this study were to be replicated, interviews should take place in person in order to account for nonverbal forms of communication. These interviews may have provided participants with an opportunity to process their experiences with difficult moments in supervision and the role they played in the interaction. It would be important to capture the subtleties of communication that may result from sharing an experience that was painful or unsuccessful (e.g., eye contact, guardedness, silence).

It is fair to assume that the participants who were interested in this study had a level of investment in their role as a supervisor. Actually, when asked, each supervisor expressed that they wanted to be in a supervisory role. Not surprisingly, participants were engaged in the interview, thoughtful about their answers, and generally self-reflective. It would not be unreasonable to expect that a correlation might exist between their commitment to supervision and their ability to intervene with shame and identify various shame cues.

Perhaps the greatest limitation of the current study was that it did not account for the supervisee’s perspective. The aim of this study was to better understand the supervisor’s experience of managing shame, yet it is impossible to deny that we truly do not know if their interventions were effective in reducing shameful feelings. It is quite possible that supervisors and supervisees have different experiences of how shame feels and how it is best managed.
Looking into the experience of supervisor–supervisee dyads would provide a unique view into the experience of both supervisors and supervisees.
References


Appendix A: Recruitment Email

Subject: Seeking supervisors to participate in a qualitative research study

Hello,

My name is Melanie Harkins and I am a doctoral candidate in the Clinical Psychology program at Antioch University New England. I am recruiting participants for my dissertation titled, “Shame in Supervision: What is hidden within?” which has been approved by the Antioch University Institutional Review Board.

The focus of this dissertation is to explore shame in supervision from the perspective of the supervisor. By conducting a qualitative study, my hope is to learn more about how supervisors understand and manage supervisee shame. To do this, I will conduct and analyze interviews with current supervisors of counseling and/or clinical psychology doctoral students.

To be eligible to participate, you must be a licensed psychologist who is currently supervising counseling and/or clinical psychology doctoral students and has at least 3 years of postdoctoral experience supervising these students. Participation in this study is voluntary and may be withdrawn at any time without penalty. Should you choose to participate, this study will involve a 30 to 45-minute interview over the phone or via Skype to discuss the experience of providing supervision, and speaking about moments a supervisee may have felt shame or embarrassment. All responses are confidential and will be de-identified.

If you are interested in participating or have any questions regarding the study, please contact me by email at XXX. You can also contact my supervisor, XXX, at XXX. If you have any questions about your rights as a research participant, you may contact XXX., Chair of the Antioch University New England IRB, at XXX.

Thank you for your time,

Melanie Harkins, MS
Doctoral Candidate
Antioch University New England
Appendix B: Oral Consent Script

Introduction:
Hello. I’m Melanie Harkins, and I am conducting interviews to learn more about the supervisor’s experience when supervisees may feel ashamed during supervision. During this interview, I will begin by asking you about your supervisory style, and then will ask more explicit questions about how you identify and manage supervisee shame. My goal is to just learn more about your experience. I’m conducting this study as part of my dissertation at Antioch University New England’s Clinical Psychology program, and I am working under the direction of XXX of the Clinical Psychology Program.

What will happen during the study?
I’m inviting you to do a one-on-one telephone or Skype interview that will take about 30–45 minutes. I will ask you questions about your training in the practice of supervision, as well as specific interactions with students who you have supervised.

During the interview, I will take handwritten notes to record your answers, as well as use a digital audio recorder and a MP3 recorder to make sure I don’t miss what you say. After the interview is complete it will also be transcribed into an electronic document where it will be kept in a secured cloud storage system.

Are there any risks to doing this study?
The risks involved in participating in this study are minimal. During the interview, I will ask questions about your experiences as a supervisor, and to discuss potentially difficult moments with a supervisee. Discussing past conflicts or difficult interactions may lead to uncomfortable feelings or to feel shame. That being said, you do not have to answer questions that make you feel uncomfortable or that you do not want to answer. You can also withdraw at any time with no consequence.

To protect your privacy, I will keep the information you tell me during the interview confidential. Any personally identifiable information will be de-identified and protected. For instance, your name, place of employment, or any student name will be changed to pseudonyms. If it is okay with you, I will use direct quotes from you in the written-up results, but the quotes will not include any identifiable information. Furthermore, any data from this research - shared or published - will be the combined data of all participants. That means it will be reported for the whole group not for individual persons.

Benefits:
You will not be financially compensated for your participation in this study. It is unlikely that there will be direct benefits to you; however, by better understanding how supervisors experience supervisee shame, this study may lead to or offer practical knowledge that may inform how psychologists are trained in how to intervene during difficult interactions.

How does that sound? (answer any questions or continue)
Let’s review:
- Your participation in this study is voluntary.
- You can decide to stop at any time.
- If you decide to stop participating, there will be no consequences to you.
- If you decide to stop we will ask you how you would like us to handle the data collected up to that point.
- This could include returning it to you, destroying it or using the data collected up to that point.
- If you do not want to answer some of the questions you do not have to, but you can still be in the study.
- If you have any questions about this study or would like more information you can call me, Melanie Harkins at XXX. You may also reach my supervisor, XXX with any questions XXX.

This study has been reviewed and approved by the Antioch University New England Institutional Review Board. If you have concerns or questions about your rights as a participant or about the way the study is conducted, you may contact:

Consent questions:
- Do you have any questions or would like any additional details?
- Do you agree to participate in this study knowing that you can withdraw at any point with no consequences to you? (Check box below based on answer)
  - Yes  [If yes, begin the interview.]
  - No  [If no, thank the participant for his/her time.]

____________________________________  _______________________
Signature of Representative          Date

_____________________________________
Pseudonym (i.e., Interview 1, 2, 3, etc.)
Appendix C: Semi-Structured Interview

The researcher will briefly introduce herself and the structure of the interview: “During this interview, I will begin by asking you about your supervisory style, and then will ask more explicit questions about how you identify and manage supervisee shame.” Then, the interview will begin with a series of questions that aim to understand how the supervisor may interact with their supervisee and how they conceptualize their role as a supervisor.

The questions are as follows:

1. Please describe your supervisory style (i.e., How do you generally work with supervisees, your theoretical approach to supervision)?

2. Please describe any formal or informal training experiences you received in supervision.
   a. What did this training suggest regarding shame within the supervisory relationship?
   b. What, if at all, did this training suggest regarding how supervisors manage supervisee shame?

3. Please describe how your past experiences as a supervisee has influenced your supervision style.

4. In your current role as a supervisor, in what ways do you notice shame enter the supervisory relationship? How does shame enter your relationship with supervisees?
   a. How do you or would you know if a supervisee was feeling ashamed?
   b. What do you observe?

5. What factors do you believe contribute to supervisee shame?

6. Please describe how you think shame influences the supervisee.
   a. How might it influence the supervisory relationship?
   b. How might it influence clinical work?
   c. How might it influence the supervisee’s professional identity?
7. Generally, please describe how you intervene when a supervisee may be feeling ashamed or embarrassed.

8. Have you dealt with a conflict or situation where a supervisee felt or might have felt ashamed?
   a. Please describe your relationship with this supervisee before the event.
   b. How did you notice your supervisee’s emotional experience/feelings of shame?
   c. Please describe the decision-making process you went through and how you managed this situation.
   d. How did this interaction affect you?
   e. How did this interaction appear to affect the supervisee?
   f. How did this interaction impact the supervisory relationship?
   g. How, if at all, did this interaction affect your supervisory style or future interactions with supervisees?
   h. Would you categorize this event as having a positive or negative impact?
   i. Looking back, would you do anything differently?
   j. How did this impact your supervisory style?

9. How did your training help you prepare for this event or how to manage supervisee shame?

10. Looking back, what might have been helpful to know prior to this event?

11. Please provide some basic demographics of your supervisee. For example, (e.g., age, sex, race/ethnicity, year in program, type of program [e.g., PhD in counseling, PhD in clinical psychology, or PsyD], clinical experience, length of supervision relationship at time of disclosure, total length of supervision relationship).
a. How might any of these factors influenced how the supervisee felt?

12. Is there anything else you wish to say regarding shame influences the supervisory hour?

13. Was there anything else that I didn’t mention that impacts how you manage supervisee shame or how you have learned to manage supervisee shame?

14. Why did you participate in this research?

15. What was it like to participate in this interview (e.g., reactions, thoughts, feelings)?
## Appendix D

**Table 1**

*Participant Demographics*

<table>
<thead>
<tr>
<th>Participant Number</th>
<th>Age Range</th>
<th>Racial Identity</th>
<th>Gender</th>
<th>Supervising Environment</th>
<th>Degree</th>
<th>Years Supervising</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>40–45</td>
<td>White</td>
<td>Female</td>
<td>College Counseling</td>
<td>PhD Clinical Psychology</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>50–55</td>
<td>White</td>
<td>Male</td>
<td>Group Practice and Academic Institution</td>
<td>PsyD</td>
<td>12</td>
</tr>
<tr>
<td>3</td>
<td>56–60</td>
<td>White</td>
<td>Female</td>
<td>Academic Institution and Outpatient Counseling Center</td>
<td>PsyD</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>61–65</td>
<td>White</td>
<td>Female</td>
<td>Community College Counseling</td>
<td>PhD Counseling Psychology</td>
<td>16</td>
</tr>
<tr>
<td>5</td>
<td>56–60</td>
<td>White</td>
<td>Male</td>
<td>Public School System</td>
<td>PhD Clinical Psychology</td>
<td>23</td>
</tr>
<tr>
<td>6</td>
<td>46–50</td>
<td>White</td>
<td>Male</td>
<td>Residential Treatment Center</td>
<td>PsyD</td>
<td>7</td>
</tr>
<tr>
<td>7</td>
<td>40–45</td>
<td>White</td>
<td>Female</td>
<td>Psychiatric Hospital and Medical School</td>
<td>PsyD</td>
<td>10–15</td>
</tr>
<tr>
<td>8</td>
<td>66–70</td>
<td>White</td>
<td>Female</td>
<td>Residential Treatment Center</td>
<td>PhD Clinical and Educational Psychology</td>
<td>28</td>
</tr>
</tbody>
</table>
Appendix E

Table 2
Superordinate and Emergent Themes

<table>
<thead>
<tr>
<th>Superordinate Themes</th>
<th>Emergent Themes</th>
<th>Example Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning How to Supervise and Manage Shame (N=8)</td>
<td>Negative and Positive Supervision Experiences (N=8)</td>
<td>“I learned to supervise like I learned how to coach. I learned to coach through past good and bad experiences. I also learned about who I am as a person. I learned from good coaches and bad coaches, I learned from good psychologists and bad psychologists.” (P5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I talk a lot about the importance of knowing that there’s a lot of learning and information to be gleaned from good and not-so-good supervision. We learn a lot about ourselves and about what not to do through poor supervision.” (P3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I think that the foundation was laid in my own supervision in graduate school…I feel like I had good role models for supervision throughout graduate school and internship as well...There was a level of trust with them. It was okay to bring in my best work, it was safe to bring in my not so good work, and it was safe to bring in, ‘I have no idea what I’m doing’ work. I think a corollary to that would be that there was also a mentoring component to it. You know, there were times that we talked about cases obviously, but there were also times that we talked about me as a developing professional…” (P2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“…My supervisor said to me, ‘It really doesn’t matter. You just go back and ask follow up questions and figure out what you missed.’ I remember thinking: it’s such a small thing, but those little comments that normalized it’s a process and that you make mistakes. Those small statements were important to me…” (P6)</td>
</tr>
<tr>
<td>Using Clinical Orientation to Conceptualize Shame (N=7)</td>
<td></td>
<td>“I think my theoretical orientation carries over to my supervisory style. I’m very interpersonally focused. I’m a fan of Sullivan, Yalom, Lesch, and also Dan Seigels work in interpersonal neurobiology. So, genuineness and creating an environment where students don’t feel they are performing, they feel that they are learning…” (P2)</td>
</tr>
</tbody>
</table>
There are a lot of similarities I think in the way that I learn about clinical work and solve problems clinically that I do with supervision.” (P2)

“...I do bring to bear my understanding of emotions, coping skills, and interpersonal effectiveness. I consider myself to be a cognitive behavioral therapist and informed by a different clinical approaches, that I just draw from all of them.” (P1)

“Although my aspiration was to be facilitative, I do supervision like I do therapy. I’m cog-B [sic] in orientation and behavioral and kind of coachie. So, I did a fair amount of instruction and coaching.” (P4)

“So much of my training is focused on parents and parents of children, and a lot of what impacts how I work with my clients is really the function of the brain, regulatory systems... The stuff Bruce Perry talks about. That shapes a lot of what I think about because it ties into attachment pretty neatly. Usually there is a common denominator in a lot of different situations that supervisees talk about. So, those are the two biggest influencers.” (P6)

“It’s all About the Relationship”
(N=8)  Trust and Safety as a Protective Factor
(N=8)  "If you have a good relationship then you can bring up stuff. If you don’t then people have to not tell the truth.” (P5)

“The better your relationship the less shame you would have if you really made a mistake.” (P5)

“We’ve had a few difficult situations and I would venture to say that when I’ve had to be called in to help them. When you think back to it it’s been because either the student felt not supported, not heard, and not connected enough with their supervisor to come up with a resolution.” (P5)

“I think the most important thing I realized is that the relationship between the supervisor and supervisee is probably one of the most important things to get started. Otherwise there would be no trust. And when
<table>
<thead>
<tr>
<th>Superordinate Themes</th>
<th>Emergent Themes</th>
<th>Example Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>there’s ruptures you won’t be able to resolve them...If you have a good relationship where they’re not embarrassed to be embarrassed in front of you, at a heightened level, then it’s going to be OK.” (P6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“So, we did not build up an atmosphere of trust. And, you know, when you don’t have trust with someone who’s learning how to be a clinician, you’re not going to feel safe and say, ‘Hey, I think I made a mistake. I did this, and that happened.’ That’s not conducive to learning in an environment to help you grow as a clinician.” (P3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Our job [as supervisors] is to create emotional safety so that people can do the work that they came to do. I, in fact, I do have more experience and I do have more knowledge about that domain, because the person is a trainee and they legitimately inhabit the place where they don’t know yet. Even if they know some stuff, they’re not supposed to, what the hell. That’s our obligation.” (P2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“But, also at the same time how it’s really important to develop a solid relationship where you feel like you can call me any time, you’re not bothering me, and I’m there for you, basically.” (P8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“My philosophy...It’s the relationship. If you can make it a safe open relationship then I think it leads to less feelings of shame...But if you have a good relationship where they’re not embarrassed to be embarrassed in front of you, at a heightened level, then it’s going to be okay.” (P8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creating a Safe Base: “You’re Supposed to Make Mistakes” (N=5)</td>
<td>“I think that I try to create a space where people feel like they can let their guard down and you know...And that they’re not expected to be perfect...I interview people for intern applicants and I always ask for a case that’s a little messy...I think we all can have success, but it’s important to talk about the things that you can learn from and grow from. Being able to talk about many other kinds of negative things like the fuckups and the mistakes, it can lay the foundation.” (P7)</td>
<td></td>
</tr>
<tr>
<td>Superordinate Themes</td>
<td>Emergent Themes</td>
<td>Example Quote</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Developing Voices and the Professional Self (N=7)</td>
<td>“I know that they’re finding their voices as clinicians and I’m not looking to have people mimic or emulate my style, but to find their own voice.” (P3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“My role was to convey that knowledge, that practical knowledge, about: here we are with all this training and now you are trying to find your voice and really get into applying what you’ve been taught in a high tempo situation where there's a big volume of work to do.” (P4)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“But I feel like my role is to help students find their way of working with clients their way of conceptualizing their way of intervening and their way of working. So, I feel like I’m part teacher, but I’m also part mentor in trying to help them connect to their own style.” (P5)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“…my biggest goal is to help students connect with their own confidence in their own ways of being with people.” (P5)</td>
<td></td>
</tr>
<tr>
<td>Superordinate Themes</td>
<td>Emergent Themes</td>
<td>Example Quote</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------</td>
<td>---------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I really want people to kind of develop their own voice in their clinical work. So, I definitely don’t like to smother people, but I think because I do tend to supervise a lot of people who are learning DBT, there are just like some fundamental hard skills they got to get...So I think that there’s a lot of mentoring involved and there’s a lot of room to really see people gain new areas of growth and competence.” (P7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I feel like my role is to help students find their way of working with clients, their way of conceptualizing, their way of intervening, and their way of working. So, I feel like I’m part teacher, but I’m also part mentor in trying to help them.” (P2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Obviously I’d like to believe I have some knowledge to offer, but it’s collaborative. I mean, who the hell wants to do what I do? Don’t do it my way. It might sound funny to call it collaborative, but it is...So I feel strongly that my role as a supervisor is to be available, to support the students growth, to not force my views on them, but more to reinforce their development and their own views…” (P5)</td>
</tr>
<tr>
<td>Factors that Lead to Shame in and Out of The Supervision Room (N=8)</td>
<td>Countertransference (N= 6)</td>
<td>“I also feel like sometimes students are having a countertransference reaction to a client that they’re shutting that down, they’re shaming that, and not using it as the clinical tool it can be.” (P2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Especially with kids and teens, being angry and being hurt. Really, any kind of emotional reaction to a client can trigger shame. Clients can react negatively, you know. There are clients who get angry at the therapist or like my student when the kid in group was rude to her. I think that it really hurt her feelings and threw her off. She lost some objectivity there and went to ‘What did I do wrong?’” (P2)</td>
</tr>
</tbody>
</table>
|                      |                  | “Certainly, there is projection and there is countertransference and transference. Not all supervisors and supervisees may be willing to look at this because it’s not a therapeutic relationship, but that can certainly come into play and certainly can
<table>
<thead>
<tr>
<th>Superordinate Themes</th>
<th>Emergent Themes</th>
<th>Example Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>cause shame responses in either supervisor or supervisee.” (P3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“It can come in in a lot of different ways. It might come in if you’re working with a population that has issues that you’re struggling with.” (P3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“People’s whole history has been brought to the present with a client. They, like the supervisee, are figuring out ‘do they talk about it or not?’ If they talk about it and they reveal certain things about themselves that are still not completely resolved, how does that have an impact on them. So, that’s one piece that I think comes up: your own parts of your life that are so raw that get evoked in countertransference.” (P6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“... At the time, I couldn’t access that and articulate it well enough to my supervisee. And I know I frustrated my trainee within that interaction, well, disagreement about that topic. You know, I imagine her shame was up, because of my responses, but that’s where my countertransference came from.” (P4)</td>
</tr>
<tr>
<td></td>
<td>Sensitivity to Shame (N=5)</td>
<td>“There may be a fairly low threshold for emotions of shame and guilt to be evoked and I understand why it is...There are some people I’ve supervised where it’s not something they struggle with a lot and that for other supervisees they do suffer.” (P1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Other people, sometimes they may dip into shame in the sense that maybe they felt shameful, but I don’t know, maybe it’s management. Maybe they manage it better, but I don’t feel the same heaviness and they move quickly to the next topic. I don’t hear a lot of like, ‘I feel like I’m an imposter,’ so maybe they’re better at hiding. I’m not sure.” (P6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Some of us have stronger shame responses. So, it comes from childhood. How much is that going to come into the supervisory process or not? That’s probably based on how much trust you can engender, and how quickly you can do it.” (P6)</td>
</tr>
<tr>
<td>Superordinate Themes</td>
<td>Emergent Themes</td>
<td>Example Quote</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Mistakes, Feeling Like a Failure, and Wanting to be Competent (N=5)</td>
<td>“Also, certain people are more prone to feeling shame. The supervisees own psychological experience, personality, and experience matter.” (P7)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“I was just sensitive to that. I was sensitive knowing that this could come up again where she’s embarrassed because the last [supervision] experience she had. And not just embarrassed, but embarrassed and making her feel really miserable about it.” (P8)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“I do believe it was out of shame not just you know feeling guilty about disregarding policy or making an error, but as if I was attacking all their clinical work. And attacking him broadly, you know suggesting that he was not competent, which was not my intent.” (P1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“I think it is relatively common, natural, and understandable emotion, especially for anybody who might be doing clinical work because the motivation is, presumably, for that individual to help make a difference in someone's life. I believe that especially after years of advanced training, we all want to feel like we’re competent in some basic way.” (P1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“I think they have this mistaken assumption that therapy is a linear progression toward health and improvement. That we start to work with people, and they get better, and they don’t get worse along the way. I think there’s shame around ‘my client is not improving and so that means I am not doing it right’ because in the book, in the vignette, it worked right.” (P2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“…the feeling that students have probably gotten into sort of a right or wrong mentality that there’s a right way to do the to do whatever they’re trying to accomplish. There’s a right way and a wrong way and that they’ve deviated from the right way.” (P2)</td>
<td></td>
</tr>
</tbody>
</table>
|                      | “…And a lot of times shame was around what they weren’t doing or what I wanted them to do. Or they were feeling like I wasn’t listening to them…I was being disaffirmative [sic] and not letting them do
<table>
<thead>
<tr>
<th>Superordinate Themes</th>
<th>Emergent Themes</th>
<th>Example Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>things or affirming that they had something in mind that was worthy.” (P4)</td>
<td>“I think if someone felt that they had let us down, then they would feel shame. I think that we are good to people in our internship or training, and we value the relationship part of it. So, if something wasn’t working, I could see that embarking some shame.” (P5)</td>
</tr>
<tr>
<td></td>
<td>“...we are used to and want success. If something doesn’t work, you'd feel shame too.” (P5)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“...They feel like they’re bad or they feel like they failed them [the client].” (P6)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“I think there are clinical issues people are ashamed of, and administrative ones.” (P7)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“I think sometimes it implies a lack of confidence in themselves. I mean, you can be shameful and still be confident, I suspect. But, in my experience, there’s a lot of times that’s where that comes from.” (P8)</td>
<td></td>
</tr>
<tr>
<td>Power Differential and Being Evaluated (N=6)</td>
<td>“And there’s also the difference in power in the room for the supervisor and the supervisor. So again, I think that would lead quite naturally to the feelings of shame…” (P1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“If we’re not supervised appropriately, you know, obviously on a cognitive level I don’t know that students are walking around saying, ‘I’m a bad person because my supervisors don’t give me time,’ but on a deeper level that’s what it’s instilling in the student.” (P2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“I think that there is a lot of hesitancy maybe to point out to a supervisor something that doesn’t feel good or the manner in which it’s delivered. There’s the power differential and if you don't agree, I mean, sometimes you get the supervisor that is, maybe a lot more cognitive behavioral and your psychodynamic and you just want to discuss maybe a different way of working it. It’s not, it’s not allowed…” (P3)</td>
<td></td>
</tr>
</tbody>
</table>
Superordinate Themes | Emergent Themes | Example Quote
--- | --- | ---
Recognizing Shame through Nonverbal and Verbal Cues (N=8) | Negative and Critical Statements (N=7) | “There’s a sense of I’m showing up for this, I’m being judged, being critiqued, and literally they are. They are being evaluated. And I have to...I have to know what I’m doing.” (P3)

“I think as a supervisor it’s very important to me to be aware of the power that you have and the effect that you have on the people that you’re working with. So, yeah, it’s a tricky tricky situation. There’s a sense of: I’m showing up for this, I’m being judged and being critiqued. Literally, they are being evaluated. Also, there’s this sense of: I have to know what I’m doing.” (P3)

“And you’re trying to attend to the power differential you know...” (P4)

“So, it’s just a strange phenomenon where people treat me differently because I’m a director, especially if they don’t know me…” (P6)

“...and acknowledging the power differential in the beginning.” (P8)

“...whatever sort of like protective or defensive comments that they might make...For instance, they may say, ‘You know, you’re right, I really should have caught that’ or ‘I can’t believe I missed that’ or ‘I’m just you know I was really off my game. I can’t believe...’” (P1)

“...he was very defensive throughout the whole interaction. I asked him to tell me more about it to...to see if there was anything I was unintentionally communicating... that made it harder for him to receive feedback and to be engaged and learning and growing.” (P1)

“Sometimes they’ll talk a lot and they’ll do a lot of setup on the video and say, ‘Well, this day, I know this was going on and this happened, etc.’ It sort of cues to me that they’re anxious about showing the video.” (P2)
Superordinate Themes | Emergent Themes | Example Quote
--- | --- | ---
Avoidance: Withdrawing and Shutting Down (N=7)

“I think that, obviously shame around ‘This client is hard to work with’, ‘They don’t like me’, or ‘I don’t feel like it’s going well’. You know, they could be saying things like that, too. I’ve actually had students come in and they’ll preface a video with ‘this was an awful session’ or present a client with, ‘I had a terrible session with so-and-so the other day.’” (P2)

“This person told me about feeling like, ‘I’m not good enough. I am an imposter so...’ Just telling me by using stronger type feeling words, ‘imposter’ or ‘I don’t know what I’m doing’ that would tend to reflect a feeling of shame to me.” (P6)

“Another part where shame can get evoked is that just people feel or they project on to you mastery or they idealize you and then they devalue themselves.” (P6)

“I think of the tendency when you feel shame to be withdrawn and to not be forthcoming or able to receive feedback easily it really does undermine the ability for good supervision to occur you know because it’s hard for the supervisee and then it’s hard for the supervisor to have a real sense of what's going on.” (P1)

“The shame can shut the student down and cause them to retreat within themselves, not get the help they need, not get the guidance they need. And also, not understand the dynamic that’s going on between them and the client and missing an opportunity to read what their reaction is to the client and use that.” (P2)

“That’s an example of someone who can retreat into themselves and really almost sabotage themselves with shame” (P2)

“Shame is a very disintegrating experience. It feels very primitive. And it causes people to withdraw and react and get triggered in ways that they may not be conscious of.” (P3)
<table>
<thead>
<tr>
<th>Superordinate Themes</th>
<th>Emergent Themes</th>
<th>Example Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Superordinate Themes</strong></td>
<td><strong>Emergent Themes</strong></td>
<td><strong>Example Quote</strong></td>
</tr>
<tr>
<td>“So, there can be things that go on that aren’t talked about in supervision. I mean both volitionally kind of hidden and kind of unintentionally just like ‘oh we didn't get to that’...They tend to try and hide. So, whether it’s not talking about something or minimizing it or trying to avoid it, avoiding talking about certain things seems to be one of the signs.” (P7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“I think nonverbal communication can tell you a lot. So, there’s a kind of lack of eye contact or they’re blushing or they’re anxious.” (P8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“I think shame is going beyond embarrassment...You’re feeling like there’s something about yourself that’s not right or defunct, rather than this is a skill set you can work on. It’s more personal and feels more un-liveable... to me supervisory shame would be a heavier feeling it’s something more personal. Like there’s something wrong with me and the way I’m practicing or doing things.” (P6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“I probably tend to be more directive with my second-year student—my beginning psychotherapy student—than I am with my you know my third and fourth year students.” (P2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“I work differently with each student to some degree because their needs are different. They are different in the room.” (P3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“My intent depended on what people’s needs were coming in, because people would come in with a variety of experience in our particular population. Depending on what they had in their toolbox and where they were starting, there might be a lot more instruction in the initial part of the year.” (P4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“I would say in group and individual supervision I always think about: What is the person asking? Are they really asking because they are out of their league and need me to step in? Do they want me to reflect a bit with them? How much should I bring myself into the room in a more directive versus non-directive way?” (N=8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Intervening with Shame: “We Need to Talk About it””</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meeting Supervisees Where They are At (N=5)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Intervening with Shame:** “We Need to Talk About it” (N=8)
<table>
<thead>
<tr>
<th>Superordinate Themes</th>
<th>Emergent Themes</th>
<th>Example Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Normalizing Shame and Creating Clarity (N= 8)</td>
<td>“The emotion compels us to draw inward and to keep things to ourselves where upsetting experiences dwell. So, I invite individuals to come forward with their concerns or questions so that it’s less upsetting to them. Also, to help them draw a parallel between being a supervisee and being a client. To come forward with their concerns because in the light of the day, it tends to be easier to manage than one might fear.” (P1)</td>
</tr>
</tbody>
</table>

“...and I said, ‘Where else were you going to bring it in? Of course, you bring it in here. This is part of what we do. We are human beings being clinicians.’ You aren’t supposed to be perfect.” (P3)

“Sometimes I would just miss it, but sometimes I would try to inquire about it just to say, ‘So, how is this sitting with you?’ Or ‘How are you feeling about what's happening right now?’... Just ask facilitative questions.” (P4)

“...my whole goal if that had happened would be around trying to help them feel competent that mistakes happen, and that it doesn't define you... we’ve all made them.” (P5)

“So, a lot of what I tried to do is bring up the tension into the room, in the supervision, to talk about it just knowing that hopefully talking about it would make you feel a little bit better.” (P6)

“You know, part of what we do as therapists is talk about everything. My goal is that when people experience shame, we’re able to talk through it and leave in a less shameful place than they entered.” (P7)

“I consider it healthy when people are able to talk about it directly and shed light on things that they might...
<table>
<thead>
<tr>
<th>Superordinate Themes</th>
<th>Emergent Themes</th>
<th>Example Quote</th>
</tr>
</thead>
</table>

**Using Self-Disclosure:**

**Modeling Vulnerability and Making Mistakes (N=5)**

“I certainly used a lot of teaching stories that came from those previous experiences. You know I would share a lot... I have teaching stories, I have stuff that I self-disclose. There are certain things both in therapy and in supervision I disclose. I shared a lot about my own screw ups or my own perplexity or my own process with stuff.” (P4)

“I tell her, ‘I’m embarrassed that I have to go to these meetings and show them my reports after reading yours.’ And, I don’t say that to make her feel good. She does a great job and some days she can write a much better report than I do.” (P5)

“I think it’s a big responsibility in terms of trying to model how to be a professional, especially in a place that’s really difficult to work... You know, it doesn’t mean I’m doing everything right, but I think one of the big things is acknowledging when you make mistakes, especially if it’s a big one. Also, if you’re a little behind or if you got something not quite right in supervision. I had that recently where I think I was a little frustrated and it came out. I just followed up with the person the following supervision. It wasn’t big, but I think that's a model for therapy.” (P6)

“There are always things that we do that when you say it out loud you know you feel ashamed about any of it. It’s really important to be able to talk about that. Giving examples or saying things like, ‘Wow, after that patient told you you were a horrible therapist, I can imagine you really wanting to get the hell out of the room.’” (P7)

“I also try to use my own examples to get at it. To kind of show that I don’t expect perfection.” (P7)

“We both know up front what is the best way to talk about things. Also, making myself a little bit vulnerable too, if the opportunity presents itself, so...” (P7)

want to flip the switch off for. So, I think being able to talk about it in supervision is really key to growth as a therapist.” (P7)
### Superordinate Themes

<table>
<thead>
<tr>
<th><strong>Emergent Themes</strong></th>
<th><strong>Example Quote</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Challenging The Inner Critic (N=4)</td>
<td>“I said, ‘Here’s what we need, here’s why we need it. We are not trying to get rid of you. We’re trying to get our needs met and we want you to get your needs met because we need you. We need you here doing what you’re doing. You also need the capacity to adapt to settings.’ Reaffirming and reiterating and being very clear about my intent. It was exhausting, but it had a positive outcome. We worked up a plan and things improved.” (P4)</td>
</tr>
</tbody>
</table>

“"I will try to figure out what went wrong and why, and then figure out how to help you feel either better about the situation or feel less bad…So, my whole goal is to help the supervisee feel competent and that mistakes happen, and that it doesn’t define you. We’ve all made them. My whole focus outside of playing out what happened would be: How to make you feel better.” (P5) |

“"So, trying to validate them, but also help them look at: is there evidence that you feel this way? Is there evidence that you messed up or did something wrong, bad, or should feel ashamed about what you did? I’m kind of thinking of that model of, you know, brief cognitive restructuring. I think that’s important to do because sometimes a feeling is a feeling and you feel that way, but look and see.” (P8) |

| Shame Can Help and Hinder Growth (N=8) | Positive Aspects of Shame (N=4) | “And he was very appreciative actually. He said, ‘I have carried so much shame because there are basic things that I don’t know and I’m afraid that if I say I don’t know those things they’ll kick me out.’” (P2) |

“"It was more shame that they felt in their practical experience and were reticent to bring it in to the supervision, but did. What they shared with me was that they were happy to have it normalized.” (P3) |

“"It can be this really powerful force for good. It can be an opportunity to get people more to help us be more and more comfortable with our discomfort. To
<table>
<thead>
<tr>
<th>Superordinate Themes</th>
<th>Emergent Themes</th>
<th>Example Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>practice our facility of our healing curiosity with ourselves as well as with other people...” (P4)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“I think that she felt supported and it was beneficial. I was glad that she trusted me and I shared that with her. I think it furthered our work together.” (P8)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“Well luckily it went well (laughs) so it just strengthened our relationship. And I feel that she even feels more confident coming to me and less embarrassed about things.” (P8)</td>
<td></td>
</tr>
<tr>
<td>Preventing Growth</td>
<td>“It has over time affected the supervision of him and his ability to learn from supervision... it is a barrier to ongoing collaboration.” (P1)</td>
<td></td>
</tr>
<tr>
<td>(N=8)</td>
<td>“It’s probably particularly destructive to the supervisory relationship because not only does that leave supervisees potentially really struggling, but again because I think of the tendency when you feel shame to be withdrawn and to not be forthcoming or able to receive feedback easily.” (P1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“I’ve had students report, you know I would link this to shame, losing sleep over clients. I mean, I can remember losing some sleep over clients myself you know. But, that feeling that you didn’t do well enough or if you feel like you didn’t adequately serve a client where you ruptured a relationship somehow. That affects your own physical and emotional well-being.” (P2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“The shame can shut the student down and cause them to retreat within themselves, not get the help they need, not get the guidance they need. And also, not understand the dynamic that’s going on between them and the client and missing an opportunity to read what their reaction is to the client and utilize that in a clinical manner.” (P2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“My perception was that shame had the biggest deleterious impact when it was in the relationship between me and the supervisee.” (P4)</td>
<td></td>
</tr>
<tr>
<td>Superordinate Themes</td>
<td>Emergent Themes</td>
<td>Example Quote</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Feeling Stuck (N=7)</td>
<td>Uncertainty and Frustration (N=7)</td>
<td>“... it shuts people down and shuts the supervisor down. It did in my case at times.” (P4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I could see someone feeling ashamed and some learned helplessness.” (P6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“You know, not sleeping and things like that. So, I was watching for that because I wanted to address it right away so that she would be able to work past that and be there.” (P8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I do think, I do notice it. I hope that I would be able to pick up on that and address it directly.” (P1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“My efforts to sort of mitigate that had been ineffective...It’s very draining and I think it makes it hard for me to stay as invested in the process as I’d like to be because it’s draining and ultimately not so very rewarding. I also think it interferes with my effectiveness as a supervisor.” (P1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I feel like I was able to manage my frustration so that my interactions with him were civil, and not overly negative. All along I was firm and very direct with him about where he had not performed well, but I was also able to manage my own frustration with reports that just weren't up to minimum standards.” (P2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I mean, I don’t think I managed it well, but I didn’t know how to figure it out. I was really like constantly trying to figure out... I think that was part of the challenge and I probably needed more reflection. Like, ‘Why is this evoking so much frustration?’ Because, I think I got frustrated. I wonder if that would have been picked up in one way or another, just throughout the relationship...” (P6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I need to acknowledge that at times feel like ‘Oh man I don’t have the skills for this.’ This is pointing out to me a place where I don’t have on tap what I want to do to be able to do...” (P4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“So, it’s a little hard to parse sometimes. What is shame and what is something else?” (P4)</td>
</tr>
<tr>
<td>Superordinate Themes</td>
<td>Emergent Themes</td>
<td>Example Quote</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------</td>
<td>---------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“...the supervisee is usually embarrassed at some point... If they don’t say ‘I feel ashamed’... They may be avoiding something or... And you just kind of have to figure that out. So, it’s not as clear cut all the time.” (P8)</td>
</tr>
<tr>
<td></td>
<td>Seeking Support (N= 5)</td>
<td>“I had to process that with [my co-worker] and with another colleague, you know, just about ‘Hey, I’m really having some negative reactions to this student and his lack of follow through and lack of awareness of things and his knowledge’ and things like that. So, I felt that processing through that with people and that I had a decent relationship with him even through my frustration was helpful.” (P2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I think also just collaborating with colleagues I have. We’re very fortunate here to have a good network of professional psychologists.” (P2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“So, what we did was form this association, but it evolved out of an informal thing that was already running. We would meet together, we had a listserv, and we would call each other. I knew that if I was up against something, and I did on several times, I had enough emotional safety with my friends over the years that I could put out an email just to my subset of other people and get good supervision.” (P4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Oh, and I steal stuff from everyone. It’s totally true. I’m just stealing supervisory tricks from people. I asked one supervisor, ‘What are you doing with your supervisees?’ because they all love her.” (P6)</td>
</tr>
</tbody>
</table>