Will I Ever Get This? Therapist Shame Learning Emotionally Focused Couples Therapy

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Abstract

Introduction: *There is a growing body of literature on the impact of client shame in psychotherapy, but little exploration of the construct in the clinicians who provide these services. The authors have consistently witnessed the process of acquiring new clinical skills in Emotionally Focused Couples Therapy result in feelings of intense self-doubt, failure and even withdrawal in their supervisees. Given the importance of ongoing skill acquisition to meet the fluid and demanding needs of clients, understanding the impact of therapist shame could prove beneficial to the field of psychotherapy.*

Objectives: *The purpose of this mixed methods study was to explicitly name shame, determine whether and how it impacted therapists learning Emotionally Focused Couples Therapy (EFCT) and identify factors that mitigated the shame.*

Methods: *A survey was completed anonymously by 71 licensed therapists from North America who had registered for an advanced EFCT training. Quantitative analyses were conducted to determine factors associated with therapist shame. Qualitative analyses were conducted to learn what participants found helpful in ameliorating shame.*

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Results: *Results revealed that shame was experienced by the majority of participants to some degree during the process of learning EFCT. Support from colleagues and supervisors, self-compassion and normalization of shame helped ameliorate it. Shame was associated with negative self-beliefs and a lower likelihood of sharing video recordings in supervision.*

Conclusions: *Therapists who recognize the impact of shame on their ability to learn and implement new skills may be more likely to employ protective measures such as participation in group or individual supervision and support from colleagues. For teachers of experiential models such as EFCT, this information could be used to improve the training process. Normalizing the struggle, acknowledging the long learning curve, and privileging self-compassion could all be included in training workshops to allow new learners to better focus on skill acquisition.*

Keywords: shame, emotionally focused couples therapy (EFCT), professional development, therapist experience, supervision

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I. Introduction

Interpretations of shame

The construct of shame as it relates to client psychopathology has been widely researched over the past five decades. Lewis's 1971 seminal treatise on shame made a case for its inclusion in psychotherapy treatment planning. Using transcripts of therapy sessions as data, Lewis noted that shame was highly prevalent among patients who did not respond well to traditional treatment, yet mostly unidentified by the psychoanalysts who were treating them. Conceiving shame as a complex amalgam of painful feelings that people are more or less prone to, and which can be triggered both internally and externally, Lewis suggested that therapist behavior could exacerbate or ameliorate client shame.

More recently, shame has been conceptualized as either transient or enduring in nature. State shame relates to specific situations and could therefore be experienced as temporary or short-lived. Trait shame originates internally and is likely to be experienced as pervasive and persistent. As such, state and trait shame could occur contemporaneously (Lear et al., 2022; del Rosario & White, 2006). Shame experienced by therapists and other healthcare providers during the process of professional development could be categorized as state shame. In a study of the impact of shame on medical residents, the authors suggested that shame triggers were largely related to interactions with others along four categories: supervisors' negative comments, peer rejection, revealing something that left participants feeling exposed or vulnerable, and challenging interactions with patients. Common coping strategies included avoidance, hiding, defensiveness and self-blame (Bynum et al., 2020).

Recognizing the significant impact that therapist shame could have on client outcomes, Ladany et al. (2011) proposed a model of supervision designed to address the ruptures that occur in the therapeutic alliance when a therapist fails to correctly attune to their client. They defined therapist shame as "an intense and enduring reaction to a threat to the therapist's sense of identity that consist of an exposure of the therapist's physical, emotional, or intellectual defects that occurs in the context of psychotherapy" (2011, p. 308). While this study considered therapist shame arising from uncomfortable client exchanges, therapists could experience a different kind of state shame or threat to their professional identity when being evaluated by supervisors and peers.

Learning a new therapy model can be challenging, particularly for seasoned clinicians whose theoretical orientations are well established. Some models require new learners to take professional risks; these can include experiential exercises, role-plays, and videotaping of emerging clinical skills. In these situations, competence can be challenged by feelings of self-doubt or shame, depending on how readily the skills are integrated.

The need for competent couples therapists

News reports from around the globe have described an increased demand for couples therapy since the beginning of the COVID 19 pandemic. In a recent Practitioner Impact Survey (American Psychological Association, 2022), psychologists reported increases in demand for treatment, longer waitlists, and low capacity for new patients. Perhaps more than ever, training in empirically validated models like Emotionally Focused Couples Therapy (EFCT) could prove beneficial to a therapy practice and a community. But gaining competence in this model is no easy task. The experiential nature of EFCT can result in learners becoming aware of their own attachment injuries and triggers; these are useful tools that are not learned through reading or conceptualizing. The certification process requires practitioners to videotape their work, seek corrective feedback through paid supervision and participate in role- plays during workshops.

These requirements are all associated with greater adherence to Evidence Based Practices and positive client outcomes (Frank, Becker-Haimes & Kendall, 2020). However, these activities can also highlight perceived therapist deficits relative to their peers, and negatively impact a sense of belonging to a professional community, leaving clinicians vulnerable to feelings of self-doubt and shame.

Emotionally Focused Couples Therapy

Emotionally Focused Therapy (EFT) is a humanistic model of short-term therapy based in attachment theory that can be used with individuals (EFIT), couples (EFCT), and families (EFFT). Previously published research has been primarily conducted and empirically validated with EFCT for couples (Johnson et al., 1999; Byrne, Carr, & Clark, 2004; Wood et al., 2005). EFCT therapists are considered process consultants (Furrow et al., 2019) who work experientially with emotion and choreograph transformative bonding moments that address attachment needs and longings. Research supports the long-lasting impact of these powerful experiences (Beasley & Ager, 2019).

Gaining competence in EFCT impacts therapists as well, strengthening emotional self-awareness, which is associated with greater authenticity in therapy (Kennedy & Moore, 2020). A short-term and longitudinal study concluded that training in EFCT reduced therapist avoidance behavior and increased the ability to process emotions (Montagno, Svatovic, & Levenson, 2011). An early study identified four areas that were particularly challenging for therapists learning EFCT: focusing on the interactions between couples rather than intrapsychic issues, staying with the emotion rather than cognitive processes, remaining non-judgmental and empathic to each partner, and learning to structure sessions (Greenberg & Johnson, 1988). More recent studies have noted that relinquishing previously employed techniques, shifting one's theoretical orientation, and the therapist's own comfort level working with emotion also posed obstacles to some new learners of EFCT (Palmer-Olsen, Gold & Woolley, 2011).

A therapist's attachment style may play a role in the successful implementation of EFCT. One study observed that novice therapists with a dismissive attachment style were more likely to discount or change the subject when their client's displayed emotion in session. Researchers concluded that the therapist's understanding of their own attachment style was reflected in their work with couples. Newer clinicians who had initially been rated as avoidant over time became less avoidant as they gained competence with the model (Wittenborn, 2012).

Several studies have been conducted to understand how therapists learn EFCT. One study identified specific factors as being helpful: talking with peers, watching tapes of sessions, and utilizing internal resources (Duplassie, Macknee & Williams, 2008). Factors that negatively impacted learning included anxiety/ pressure to get the skills right, lack of discussion about the model and process, as well as difficulty tolerating strong emotions. In a longitudinal EFCT study that included four therapists over a period of eight years, the authors noted that therapist feelings of stress, fear, frustration, and being stuck made learning difficult (Bell et al., 2018). The support of supervision was identified as helpful to working through issues like countertransference.

In two separate articles stemming from a study of 122 EFCT clinicians who responded to a survey, the authors examined the impact of learning EFCT on both therapist relationships and personal insight. Respondents described their discouragement while struggling to gain proficiency, e.g. "I am not very good at EFCT" (Sandberg, Knestle & Schad, 2013; Sandberg & Knestel, 2011). While several studies of the therapist experience of learning EFCT seemed to describe shame, none of them has explicitly named it: "...no one, including the therapist, is seeing or comforting the therapist's underlying fears of rejection and failure" (Woolley et al., 2016, p. 137) and "...the following commonly reported signature themes: fear of vulnerability, fear of rejection, fear of not being good enough, fear of not being in control, and fear of not being seen" (Zeytinoglu-Saydam & Nino, 2019, p. 236-237).

II. Objectives

In our roles as clinical supervisors of Emotionally Focused Couples Therapy, we have worked with many seasoned clinicians who have expressed intense feelings of self-doubt and failure and coped with these feelings by withdrawing from peers or avoiding challenging professional learning opportunities. Given the importance of ongoing skill acquisition to meet the fluid and demanding needs of clients, the authors believe that understanding the impact of therapist shame on learning new experiential treatment models could prove beneficial to the field. The purpose of this mixed methods study was to name shame explicitly and determine whether and how it impacted seasoned clinicians learning Emotionally Focused Couples Therapy.

III. Methods

Participants

Participants were recruited from an international body of EFCT trained clinicians who had registered for a specialty workshop focused on helping couples navigate shame in their relationships (February 12-13, 2021). Clinicians who registered for the workshop (n = 107) were located either in the USA or Canada. A direct online link was sent to participants that brought them to an anonymous survey where data were collected and sent to a digital third party. The data collected through the online survey had no identifying information; the authors did not have the ability to match surveys to respondents.

From this pool of 107 therapists, 71 participants (66%) completed the anonymous survey and gave permission for their answers to be included in the research. Participants were largely experienced, with more than 50% licensed for 15 years or more, and fewer than 10% licensed 4 years or less. When asked about their level of EFCT training, 2.8% had completed only

an online course, 11.3% had completed an EFCT externship only, 8.5% had also completed core skills, and 46.5% had completed core skills plus additional EFCT training or supervision. Regarding certification, 16.9% identified as certified EFCT therapists and 8.5% identified as certified EFCT supervisors. A small percentage of participants (5.6%) reported being between categories; either awaiting news on their certification applications or waiting to begin further training. Regarding their EFCT training, most had completed this 5-10 years ago (39.1%), followed by 1-4 years ago (32.8%), less than one year ago (21.9%), and 11+ years ago (6.3%).

The 2-day, online EFCT Shame workshop was delivered on the Zoom platform by a senior ICEEFT trainer and was organized by one of this study's authors (NR). The workshop was marketed to the international EFCT community using listservs and was open to any licensed mental health clinician. The format included lectures, observation of taped EFCT therapy sessions, and small group exercises in virtual breakout rooms. Some of the learning objectives of this workshop were to increase understanding of client shame through an attachment lens, identify markers for shame, and develop skills for working with shame in a clinical setting. Workshop participants were also encouraged to reflect on their own experiences of shame.

Procedure

In constructing the survey to be used for this study, we examined the literature for existing definitions of shame and psychometric measures. Though there is overlap among the many descriptions of shame, there is no universally accepted definition. Therefore, we chose to simply use the term shame, thus allowing participants to decide whether and to what degree they experienced it. We distinguished between the shame participants might have initially felt when first learning EFCT ("inaugural shame") and shame they currently felt ("current shame"), which could have been years later.

In a systematic review of 19 psychometric measures of shame, issues were found with most of them. The authors suggested "As the main advantage of the concept of shame is its granularity and situational specificity, it makes sense that measures focused on shame in response to particular cues, self-concepts, or situations may also have more utility in clinical practice." (Lear et al., 2022, p. 1325). Following this reasoning, we used a Likert scale to ask whether and to what degree participants experienced shame in the process of learning EFCT. Open-ended questions were offered after the Likert questions to discover what, if anything, participants found useful in ameliorating shame for those who identified as having experienced it. The open-ended questions included: how shame showed up initially, how it showed up currently, how shame impacted their work with clients, and how it impacted the process of pursuing EFCT certification. Participants were also asked what they had found most helpful in dealing with shame while learning or implementing the EFCT model.

To examine whether therapist shame was unique to learning EFCT or present in other experiential models, and whether therapist attachment style might be involved, additional Likert-scale questions about training-associated shame were asked, including: experiences with advanced training in other therapeutic models that required videotaping, self-reported attachment style in interpersonal relationships, self-description in EFCT terms regarding their significant relationships and self-perceptions regarding use of the EFCT model (e.g., negative beliefs about ability to learn and implement model, etc.). Self-perceptions were rated on a Likert scale from *1 = never* to *5 = always*.

Exploratory quantitative analyses were conducted to better understand the association of shame during the training process with some socio-demographic variables, including attachment style and video-recording sharing, among other factors. Exploratory qualitative analyses were conducted to understand how shame manifested and what therapists found helpful in ameliorating its impact.

IV. Results

Quantitative Results

Regarding descriptive statistics, some degree of therapist shame in the process of learning EFCT was reported by 90% of participants, with nearly 55% reporting feeling shame often. Bivariate correlation revealed significant associations between inaugural shame regarding ability to learn and implement EFCT and current shame ($r = .545$, $p < .00005$, $n = 70$), current sharing of EFCT videotapes with peers and/ or supervisors ($r = -.333$, $p = .005$, $n = 70$), as well as various negative self-beliefs (coded as 0 = no, 1 = yes):

"I'll never get this" ($r = .547$, $p < .00005$, $n = 69$),

"Other people would do a better job with my clients" ($r = .583$, $p < .00005$, $n = 70$),

"I'm not good enough working with present process" ($r = .407$, $p < .0005$, $n = 71$),

"I'm not good enough working with emotion" (r = .325, p = .006, n = 71).

ANOVA revealed no significant differences in attachment style or significant relationships in EFCT terms regarding inaugural shame. No other variables were significantly related with inaugural shame. A multiple regression model with these six significant covariates, and inaugural shame as the dependent variable (Table 1), was significant: F (6, 61) = 9.91, p < .00005 (adjusted r^2 = .444). Only two covariates were significant in this model, including current sharing of videotapes (standardized B = -.224, p = .02) and the belief *"Other people would do a better job with my clients"* (standardized B = .329, p = .011).

Table 1

Multiple Regression Predictors of Past Shame Regarding EFT Learning and Implementation

	R^2	*F (df)*	*p*
	.44	9.91 (6, 61)	< .0005
Predictors	*b* (s_b)	*t*	*p*
Current Shame	0.24 (0.21)	1.65	.104
Current videotape sharing	-0.41 (-0.22)	-2.39	.020
"I'll never get this"	0.20 (0.23)	1.90	.062
"Other people would do a better job with my clients"	0.30 (0.33)	2.63	.011
"I'm not good enough working with present process"	-0.004 (-0.005)	-0.03	.979
"I'm not good enough working with emotion"	-0.03 (-0.04)	-0.26	.794

Note. EFT = Emotion Focused Therapy. R^2 = adjusted R square.

Bivariate correlation also revealed significant associations between *current shame regarding ability to learn and implement EFT* and level of EFT expertise (r = -.274, p = .025, n = 67), inaugural shame (r = .545, p < .00005, n = 70), "I'll never get this" (r = .578, p < .00005, n = 68), "Other people would do a better job with my clients" (r = .567, p < .00005, n = 69), "I'm not good enough working with present process" (r = .603, p < .00005, n = 70), "I'm not good enough working with emotion" (r = .423, p < .0005, n = 70), and "I do too much teaching/ explaining" (r = .492, p < .00005, n = 70). ANOVA revealed no significant differences in attachment style or significant relationships in EFT terms regarding current shame. No other variables were significantly related with current shame. A multiple regression model with these seven significant covariates, and current shame as the dependent variable (Table 2), was significant: F (7, 58) = 12.95, p < .00005 (adjusted r^2 = .563). Three covariates were significant in this model, including inaugural shame (standardized B = .302, p = .013), the belief that "I'm not good enough working with present process" (standardized B = .353, p = .023), and the belief that "I do too much teaching/ explaining" (standardized B = .239, p = .021).

Table 2

Multiple Regression Predictors of Current Shame Regarding EFT Learning and Implementation

	R^2	*F (df)*	*p*
	.56	12.95 (7, 58)	<.0005
Predictors	*b* (s_b)	*t*	*p*
Past Shame	0.27 (0.30)	2.57	.013
"I'll never get this"	0.13 (0.16)	1.39	.170
"Other people would do a better job with my clients"	0.11 (0.13)	1.10	.274
"I'm not good enough working with present process"	0.29 (0.35)	2.34	.023
"I'm not good enough working with emotion"	-0.18 (-0.24)	-1.80	.076
"I do too much teaching/explaining"	0.20 (0.24)	2.38	.021

Note. EFT = Emotion Focused Therapy. R^2 = adjusted R square.

Qualitative Results

Regarding the first theme (inaugural shame), responses fell into four categories: feelings, thoughts, actions, and miscellaneous. Most participants (n = 22)

reported feelings, such as "self-doubt", "fear", "dread", and "panic". For example, participants noted:

"I felt like a complete beginner as a therapist despite decades of experience."

"Feeling overwhelmed and unable to help."

"Feeling like I wasn't good at this, didn't understand it well enough, like I wasn't able to help clients as much as I would have liked."

Thoughts (*n* = 14) included one positive and multiple negative self-perceptions and perceptions of others, such as:

"Anxious thoughts. Am I doing it right? If couples saw an experienced EFCT therapist, they would be doing much better or improving more quickly."

"I don't have what it takes. I'm not healthy enough myself."

"I was worried about holding everything at the same time, the model, my feelings and the couples' feelings."

"Why can't I get this?"

Lastly, actions (*n* = 17) included negative behaviors:

"An inability to watch my tapes... Wanting to hide – not speak up/ ask question."

"Hiding, not speaking."

"Going into psychoeducation mode".

For the second theme (how shame shows up currently), various feelings, thoughts, and actions were also identified (*n* = 9):

"I get very anxious, tension and tightness in my chest."

"A bad session turns into negative thoughts about myself, my lack of finesse, my own issues impeding effective work, the conviction that I deserve to be locked in a dungeon for the rest of time. You know, the usual."

"Defensiveness – when I stray from the model, I make excuses. I hide... sometimes decide not to share my failures in my peer group."

For the third theme, how feelings of shame have impacted the process of pursuing certification (*n* = 21), several sub-themes emerged, including positive, negative, and neutral impact:

"I think shame sometimes motivates me to prove my worthiness to myself and others."

"My feelings of shame and inadequacy have absolutely ground my supervision and certification process to a halt. I have completely withdrawn from supervision and pursuing certification."

"It hasn't."

The fourth and final theme (what has been most helpful in dealing with shame while implementing and learning EFCT) revealed the importance of support (*n* = 45), normalization (*n* = 14), and self-compassion (*n* = 6) (see Figure 1).

"Warm empathic supervisor, the support of the community."

"Camaraderie at trainings, peer supervision."

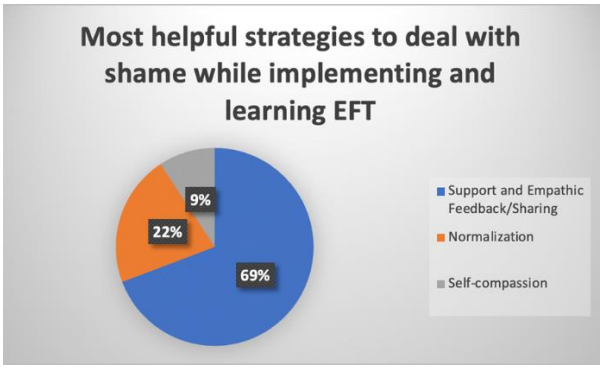
"Hearing others sharing about their experiences of it."

"I remember I'm human with my own history and hurts and realizing we are all on a journey."

"Everything is made okay when the person in charge is willing to put a big pile of emotional dog poop in the middle of the floor and then shows us all how they too can step right in it. I love that kind of authenticity."

Figure 1

Most helpful in dealing with shame



V. Discussion

Results from this study were similar to previous inquiries on novice therapists learning EFCT, indicating that seasoned clinicians also struggle to gain competence and confidence in EFCT (Palmer & Johnson, 2002; Wittenborn, 2012). This is significant because it is common for EFCT trainees to be older, experienced clinicians (Montagno, Statovic & Levenson, 2011). These practitioners may struggle in different ways than their beginner counterparts. Acquiring new skills may involve the "unlearning" of techniques that older clinicians have employed for years or decades (Palmer-Olsen, 2009). Before competence is achieved, the feeling of not being able to help couples may be particularly difficult for more experienced clinicians who have previously felt successful. A correlation between therapist ability to identify and regulate internal distress and fidelity to the model has been identified (Wittenborn, 2012). Similarly, an early study of the process of learning EFCT concluded that therapists who understood both their strengths and triggers were more equipped to

effectively implement EFCT (Palmer & Johnson, 2002). We believe that shame is perhaps one of the most limiting responses to distress; without a safe space to acknowledge and process it, clinical work is likely to suffer. Therapists can only show up for our clients as we show up for ourselves.

These results also support previous research on the social aspect of shame, which appears to play a significant part in the level of experienced distress. Allan et al. have conceptualized shame as a social emotion with a relational basis (2016). For supervisors, understanding the impact that direct or off-hand comments can have on new learners, particularly throughout the process of certification, could counteract the insidious nature of shame and negative self-talk. For trainers, awareness of the hierarchical system of the wider EFCT community and their place in it, and the positive and powerful impact of disclosing their own struggles in learning the model could also serve to counteract therapist shame. Trainers could share their own early sessions to normalize the long learning curve of the model and demonstrate the gradual acquisition of skills.

The importance of supervisor attunement, particularly when teaching an attachment based and relational model such as EFCT, cannot be overstated. Supervisors who shared their own struggles and provided attuned support appeared to normalize and minimize the impact of therapist shame. Conversely, supervisors and trainers who made careless or dismissive comments were referenced as having a powerful negative impact on participants. Regarding shame, teachers who were non-responsive when shame was shared, or critical or dismissive of participant's videotapes seemed to confirm negative self-beliefs.

Many clinicians described the prospect of pursuing certification as intimidating, shame inducing, draining and unworthy of the effort. Several respondents mentioned that being told by supervisors that their tapes would not qualify for certification served as confirmation of their feelings of shame. Yet for other participants, the challenge of certification proved to be motivational. Using our original survey, we did not differentiate between trait shame and state shame, but such a distinction could potentially yield significant findings. We hypothesize that trait shame may impede such endeavors as pursuit of EFCT certification and exacerbate state shame. Exploration of a possible negative correlation between trait shame and resilience could be useful to future learners of EFCT and other experiential models.

Shame in the EFCT training process led some participants to avoid sharing their videotaped clinical work. Without feedback about emerging clinical skills, therapists have only their subjective experiences of sessions to gauge areas for improvement. Thus, participants who were ultimately unwilling to share recordings may have robbed themselves of the opportunity to increase their skill level. This could create a kind of shame-bound loop with negative self-beliefs and feelings of isolation persisting. These results did not correlate to other factors considered, including therapist self-reported attachment style, therapist identity as a withdrawer or pursuer, or length of time licensed. Because a reduction in client symptoms is associated with expert status in psychotherapists (Goodyear et al., 2017; Chow et al., 2015), and achieving expert status requires the sharing of videotaped work with supervisors, shame can impact clients as well as psychotherapists.

Future studies could reach a larger pool of participants, and include demographic questions about ethnicity, culture, gender, and sexuality to determine whether any correlations with shame emerge. Further, researchers may wish to employ standardized attachment measures rather than using self-report questions, given previous correlations between attachment style and fidelity to the model (e.g., Brennan, Clark & Shaver, 1998). Additionally, questions about trauma and other attachment injuries, experiences with systemic racism, marginalization, and other forms of oppression could yield a more complete picture of experiences with trait shame. It would be interesting to learn what allows participants who are not derailed by shame the ability to frame challenges more positively and develop resilience to it.

VI. Conclusion

It appears that state shame may be unavoidable in the process of learning EFCT. We propose that acknowledgment of therapist shame and its impact on clinical skill acquisition are long overdue in our field. With the increasing demand for psychotherapy services and pressure on clinicians to provide effective treatment, understanding factors that impact the acquisition of clinical skills can benefit therapists and also those who seek their services. We suggest that self-of-therapist work should include an examination of therapist shame; it is reasonable to conclude that therapists who recognize its impact on their ability to learn and implement new skills may be more likely to employ protective measures such as self-compassion, participation in group or individual supervision and support from colleagues.

For teachers of experiential models such as EFCT, this information could be used to shame-proof the training process from state shame. Normalizing the

struggle, acknowledging the long learning curve, and sharing stories of their own struggles could become training tools to level the playing field and allow learners to focus on skill acquisition. A teaching approach that privileges rehearsal over performance and purposefully focuses on areas of undeveloped clinical skills could also be effective at ameliorating shame. Supervisees who can isolate and rehearse specific skills may find the learning process less overwhelming and shame inducing. Evidence from this study suggests that this could result in more clinicians opting to pursue EFCT certification, thus developing expertise in the model. Lastly, future research on therapist shame could focus on trait shame. This has the potential to impact therapists in all professional stages, from graduate school to retirement, becoming another resource to heal the healers.

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