Counseling and Family Therapy Scholarship Review

Volume 4 | Issue 2 Article 2

November 2022

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Recommended Citation

Karris, Mark and Kim, Angela B. Ph.D. (2022) "MFT Trainee Experiences of Shame, Self-Criticism, and Self-Compassion in Their First Practicum," *Counseling and Family Therapy Scholarship Review*: Vol. 4: Iss. 2, Article 2.
DOI: https://doi.org/10.53309/2576-926X.1048
Available at: https://epublications.regis.edu/cftsr/vol4/iss2/2

MFT Trainee Experiences of Shame, Self-Criticism, and Self-Compassion in Their First Practicum

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The purpose of this transcendental phenomenological study was to explore the lived experiences of MFT trainee shame, self-criticism, and self-compassion. Additionally, this study also sought to understand how those experiences may affect a trainee's clinical work as a first-time practicum student. Interviews were conducted with 15 trainees in a graduate program who were performing therapy at a practicum site. Utilizing Moustakas' transcendental phenomenology, six essential themes emerged: (1) shame and self-criticism are interrelated and can affect therapeutic presence**;** (2) self-criticism can have a positive impact on clinical work; (3) trainees use metaphors to describe shame and self-criticism (4) self-compassion is an antidote to shame and self-criticism; (5) support from others is helpful to manage shame and self-criticism; and (6) graduate training on shame, self-criticism, and self-compassion was more implicit than explicit. A discussion of these findings, including recommendations for future research, training, and limitations are explored.

KEYWORDS: MFT trainee, shame, self-criticism, self-compassion, transcendental phenomenological analysis, supervision

MFT Trainee Experiences

Therapy trainees in graduate schools who have started their practicums and are providing therapy for the first time can experience intense stress and feel emotionally overwhelmed (Hill et al., 2007). Trainees need to absorb an inordinate amount of information in graduate school and learning the experiential intricacies of becoming an effective therapist can increase their doubts about their capability to reach a high standard (Cartwright & Gardner, 2016). Trainees often have a difficult time managing the emotions, insecurities, and anxieties that accompany navigating through the complex and newly acquired relationships, roles, and responsibilities involved in becoming therapists (Skovholt & Rønnestad, 2003).

Providing individual therapy for the first time can be difficult for trainees, and providing marriage and family therapy (MFT) can be even more challenging due to the complexity of the relationship dynamics between family members and between family members and the therapist (Edwards & Patterson, 2012). For example, MFT trainees can feel overwhelmed when they have to simultaneously build rapport with all members of the client system and manage their emotional dysregulation when it arises, on top of feeling overwhelmed in needing to learn and become effective in an evidence-based model of couple therapy (Sandberg & Knestel, 2011). Additionally, because there are multiple individuals present in the therapy room during MFT sessions, countertransference issues are highly complex and potentially difficult to handle for trainees (Gehlert et al., 2014; Kaslow, 2001).

Shame and self-criticism are two intrapsychic experiences that can impede the work of trainees and are seldom shared by trainees in supervision (Allan et al., 2016; Hauser, 2016; Kannan

& Levitt, 2017). Shame and self-criticism can stifle the effectiveness of trainees because those emotional experiences can trigger fight-or-flight responses and constrict their ability to be present and attuned to their clients (Gilbert, 2005). Because shame and self-criticism tend to make trainees direct their energy and attention toward themselves as opposed to their clients, they can miss opportunities to hear a client's concerns and repair ruptures in the therapeutic alliance, and this often impedes the efficacy of their therapeutic work (Karam et al., 2015; Longe et al., 2010).

Rather than experiencing shame and self-criticism when undergoing difficult and challenging events, some therapy trainees experience self-compassion, which, as operationalized by researcher Kristin Neff (2003a), is associated with a host of intrapersonal and interpersonal benefits (Bluth & Neff, 2018; Neff, 2003a; Neff et al., 2007; Yarnell & Neff, 2013). Self-compassion can be a buffer against trainee self-criticism (Richardson et al., 2018) and trainee shame (Bell et al., 2017). Shame and self-criticism can trigger a trainee's amygdala and threat system, thereby reducing access to the prefrontal cortex and ability to be present and mindful (Gilbert, 2010). Conversely, self-compassion can enable a trainee's affiliative system to be triggered, which can, in turn, enable the trainee to be fully present with clients (Gilbert, 2010; Leary et al., 2007; Longe et al., 2010). Because a decrease in shame and self-criticism and an increase in self-compassion during a trainee's stressful graduate school training and practicum experiences may increase their potential for clinical effectiveness, it may be beneficial to explore those dynamics on a phenomenological level.

The Gap in the Literature

Quantitative studies have been conducted on trainee shame (Hauser, 2016), self-criticism (Richardson et al., 2018), and self-compassion (Bell et al., 2017; Boellinghaus et al., 2013). A couple of qualitative studies have also been conducted on the lived experiences of trainee shame (Allan et al., 2016) and self-criticism (Kannan & Levitt, 2017). However, to date, no qualitative research studies have been conducted that specifically explore MFT trainees' threefold lived experiences of shame, self-criticism, and self-compassion when they are beginning their practicums in graduate school. Because couple and family work can be more complex and challenging than other types of therapy work, research is needed to understand the lived experiences of current MFT trainees to help inform the work of both future trainees and supervisors. The purpose of this study, which is based on Moustakas' (1994) transcendental phenomenological research method, was to explore the lived experiences of MFT trainee shame, self-criticism, and self-compassion. This study also sought to understand how those experiences may affect a trainee's clinical work as a first-time practicum student.

Research Methods

The specific qualitative approach utilized in this study is a variation on Moustakas' (1994) transcendental phenomenological methodology. Phenomenology is the study of the essence of individuals' everyday lived experiences (Qutoshi, 2018). The lived experiences that this study sought to understand and describe are the experiences of trainees who are in their first practicum—particularly their experiences of shame, self-criticism, and self-compassion and how those dynamics may affect their clinical effectiveness. One of the goals of a transcendental phenomenologist is to empathically understand the participants' experiences at a deep level and describe these experiences through the participants' eyes (Sheperis et al., 2017).

Participants

For this study, 15 participants were recruited in a graduate program in three different universities in the United States who were providing therapy at a practicum site, regardless of gender, religion, ethnicity, sexual orientation, race, or social class. There were four cisgender men, ten cisgender women, and one non-binary participant. Pseudonyms were used for the participants for confidentiality purposes and to honor a desire for anonymity.

Procedure

After the Institutional Review Board (IRB) approved the study, clinical directors of several universities in the United States were contacted. The directors forwarded the recruitment email to eligible participants. To be included in this study, participants had to be a graduate student trainee in a counseling program with an emphasis in MFT and with no previous experience conducting therapy. Participants took part in semi-structured interviews that lasted approximately 35-60 minutes. The participant interviews were audio and video recorded and then transcribed. Through email, the participants were compensated with a $20 Amazon gift card at the end of the study.

Data Analysis

A synthesis of Moustakas' (1994) and Vagle's (2018) steps for data analysis was performed. Epoché was the first step to be employed in this study to manage bias and judgment (Moustakas, 1994). While the epoché process cannot guarantee the interpreter will be completely free from bias and preconceptions, the goal is to describe the experiences of the participants without the impact of the preconceived notions of the interpreters as much as possible (Moustakas, 1994). Keeping biases and preconceptions of the researcher in check was important to enable participants to describe their experiences so the researcher could analyze them authentically.

The second data analysis step was a holistic reading of all the interviews (Vagle, 2018). This involved reading the interview transcripts from start to finish as a means of becoming reacquainted with them (Vagle, 2018). The third step was performing a sentence-by-sentence reading, which is a modified version of Vagle's (2018) first line-by-line reading. The third step was horizontalization, a procedure in which all statements were given equal value, and the researcher underlined pertinent statements related to the main research question (Moustakas, 1994). The fourth step was the creation of textural descriptions to illustrate the "what" of their experience of the phenomenon (Moustakas, 1994). This step involves the synthesis of meanings and essences, which groups important statements together into meaning units or coherent themes (Moustakas, 1994). The fifth step was the creation of structural descriptions (Moustakas, 1994) and "how" the participants experienced the phenomenon. This step involves the exploration of the relationships, features, and context of each theme. The final step was interweaving the textural and structural descriptions of all the participants in a way that captures the essence and essential themes of the phenomena described by the trainees (Moustakas, 1994).

Methods of Validation

Qualitative validity is based on whether the descriptions of participants' experiences are authentic and accurately described from the perspectives of the researcher, the readers, and most importantly, the participants (Creswell & Poth, 2017). Transcendental phenomenology includes methodologies that help researchers reduce their biases and preconceptions when describing participants' experiences (Moustakas, 1994). In this study, reflexivity (epoché), journaling, member checking, and triangulation as strategies to increase the validity of the study were utilized.

Epoché

When conducting a phenomenological study, researchers are encouraged to "bracket" or set aside their judgments, biases, and assumptions about the documented phenomenon (Moustakas, 1994). I, the first author of this article, considered myself a participant along with the interviewees (Creswell & Poth, 2017). I identify as a White, American, cisgender, heterosexual, spiritual, and educated male. I am a licensed marriage and family therapist. As a White male who carries a position of privilege, I wanted to be sensitive to my power when sitting across trainees, many of whom were female, and asking them to reveal information about vulnerable struggles they may have felt while providing therapy. It was also important to journal my relevant experiences before I began my study so as not to allow those experiences to take precedent over the participants' lived experiences of shame, self-criticism, and self-compassion.

Journaling

One of the ways I was mindful of my biases and preconceptions was to consistently journal my mental and emotional processes before, after, and throughout the study, so that they did not profoundly influence the final analysis (Vagle, 2018). Journaling was used as a way to reduce bias, suspend judgment, and bracket preconceived notions of shame, self-criticism, and self-compassion (Vagle, 2018). Journaling was a helpful tool to increase intentional self-reflection and, hopefully, decrease unconscious biases and preconceptions that could hinder my ability to capture the essence of the participants' lived experiences.

Member Checking

Member checking was used to increase the accuracy of the participants' experiences and the overall validity of the data (Creswell & Poth, 2017; Varpio et al., 2017). After capturing the essential themes and sub-themes from the textural and structural descriptions, they were sent to the participants. The participants were asked to offer any comments or feedback about the themes and subthemes if they felt comfortable.

Triangulation

Triangulation is a common strategy used to test the validity of qualitative research (Creswell & Poth, 2017). Triangulation is a way to strengthen the validity of a study by obtaining different insights and using various methods to deepen one's awareness of the phenomena being explored (Carter et al., 2014). Triangulation was used in the form of peer debriefing by enlisting

colleagues who were PsyD students to read the proposed interview questions, perform mock interviews, and then elicit feedback, which helped shape and strengthen the interview questions, and, in turn, helped to answer the main research question. Additionally, after receiving a non-disclosure agreement from a peer, their support as a peer debriefer was received. The peer debriefer reviewed the data's significant statements and provided feedback about the themes that were proposed.

Results

Significant Themes

Utilizing Moustakas' (1994) transcendental phenomenology, six essential themes emerged: (1) shame and self-criticism are interrelated and can affect therapeutic presence; (2) self-criticism can have a positive impact on clinical work; (3) trainees use metaphors to describe shame and self-criticism (4) self-compassion is an antidote to shame and self-criticism; (5) support from others is helpful to manage shame and self-criticism; (6) graduate training on shame, self-criticism, and self-compassion was more implicit than explicit. Additionally, the analysis of data associated with theme "5"—support from others is helpful to manage shame and self-criticism—also revealed subthemes of support from supervisors and support from peers and family.

Theme 1: Shame and self-criticism are interrelated and can affect therapeutic presence. All 15 participants (100%) reported that shame and self-criticism are interrelated and can affect therapeutic presence. A few of the participants used the word "cycle" to describe the interrelatedness of shame and self-criticism. Participant Susan stated, "It's a vicious cycle because if you shame, then you start to self-criticize and the more you self-criticize yourself then the more you feel shame."

Florence shared the following about the interrelatedness of shame and self-criticism:

> I feel like they just kind of one up each other. The more self-criticism I have of my work of myself as a therapist, as a trainee, the more shame I have of, you know, what's going on, what I'm thinking. So, they kind of definitely are, um, together in a relationship.

Barbara stated, "They intensify each other. For sure, when I have more self-criticism, I experience more shame. When I'm feeling more shame, then the self-criticism either intensifies or it grows in quantity or frequency."

Over two-thirds of the participants shared how shame and self-criticism narrow their perspective, keep them in their own heads, and affect their ability to stay present with their clients. The narrowing of perspective is related to causality since the constriction of awareness is caused by the self-criticism and shame. Mary stated:

> I think shame it turns me towards myself quite a bit. Like it narrows my perspective I think, like it just takes the scope of what I'm doing, and it really makes it thin. Um, I think shame puts like hyper-focus on not the full picture and so it seems like I'm narrowing on ways to just be hard on myself at that point.

Sandra described her experience of self-criticism in session. She stated, "I think I also sometimes get like stuck in my head like just being like, 'Okay, what should I say, what should I do? What if I mess up? What's the client thinking?'" It is apparent that self-criticism has a ruminative quality to it that keeps participants thinking about their own work, rather than focusing on the client.

Alejandra shared:

> If I'm in therapy and I start hearing those self-critical thoughts, and if I focus on those while I'm in the therapeutic setting, I'm not going to be thinking about really what my patient is saying. I think if I get too focused, which you know I have experienced that in the moment, I'm thinking too much about what's going on with me. Then you miss what the client is saying, and then… and I think they can probably tell when you're not fully present with them.

Jennifer also shared a time when self-criticism affected her effectiveness as a therapist. She stated, "I don't think I'm centering the client anymore because I'm so in my head about thinking the questions, that I'm more focused on my own experience."

Vanessa shared how self-criticism could be "crippling" and is "a limitation to therapy because I can't get out of my own head."

Lastly, Tamara described shame as a "visceral primal sensation" that keeps her from trusting herself and that affects her ability "to be a good therapist." Tamara also shared that shame can spiral into "oh my god, I did so bad, and then you're not present with the client because you're in your own head about stuff."

Theme 2: Self-criticism can positively help their clinical work. In the previous theme, the data indicated that self-criticism can hinder clinical effectiveness by negatively affecting therapeutic presence. The data analysis also showed that self-criticism can paradoxically aid clinical effectiveness. Twelve out of 15 participants (80%) described self-criticism as potentially positive and believed it could aid clinical effectiveness. Jason shared how self-criticism helped him reflect on his performance as a therapist in session, see where he could have done things differently, and "serve as a motivation to prepare for the next sessions."

Marlene stated, "I would describe self-criticism as something that is on a spectrum and isn't necessarily negatively-oriented. But self-criticism. . . Like a self-evaluation, I think… Self-evaluation or like examining of… examining of myself."

Sandra shared:

> For me, sometimes self-criticism is good because I think it makes me more intentional and thoughtful. But like to a certain extent, I think when it's happening like too much or I'm getting too stuck in my head, or just like it becomes over-thinking, I think that's another problem. It makes me lose confidence when I'm… when I'm like doing too much self-criticism, but I think some of it is helpful.

Patricia stated, "Self-criticism does help me 'cause it pushes me to be the best that I can be."

Barbara stated that self-criticism helps her "see where I can improve and be very growth-oriented."

Lastly, Florence shared, "It is looking at ways to improve or I guess finding what's not working, finding what needs more help, needs more support in me."

Theme 3: Trainees use metaphors to describe shame and self-criticism. Twelve participants (80%) described their experience of shame and self-criticism through the use of metaphors. Mary used the word "bully" for self-criticism and "monster" for shame. Vanessa used the word "currency" to describe shame. According to Vanessa, shame can either go up or down depending on whether self-criticism or self-compassion is influencing it. Max used the word "force" to describe shame. Sean used the phrases "measuring stick" to describe self-criticism and "sledge-hammer" to describe both shame and self-criticism. Jordan used the phrase "swamp state" to describe what occurs if shame is front and center in his experience. Lastly, Patricia described her experience of shame as a plugged and "overflowing" bathtub.

Eight out of 15 (53%) participants described their experience of shame and self-compassion as consisting of a "fight," "battle," or needing to "combat" them. Mary stated, "Shame for me is battling wanting to provide services effectively and then also trying to stay true to how I want to show up in a room."

George stated, "Shame and self-criticism? I guess they fight to see who gets the most attention."

Alejandra shared, "It's just hard to combat those thoughts because you're so stuck in feeling shame about something and then just feeling bad about yourself because of how you know. . . 'cause you're being critical of how you performed."

Lastly, Max shared:

> I don't think that I would have as potent an experience of self-compassion as I do now if I hadn't spent time like really dwelling in and being paralyzed by shame. Because I know where it can take me, I know how strong my self-compassion needs to be to combat it.

Theme 4: Self-compassion is an antidote to shame and self-criticism. All 15 participants (100%) described self-compassion as an antidote to shame and negative self-criticism. Sandra described self-compassion as those times she is able to "be kind to myself and just give myself the benefit of the doubt." When Sandra experienced the challenges of being a trainee providing therapy and started "the negative self-talk," she was able to calm herself, engage in self-compassion, and say to herself, "You're just a baby therapist. You'll get there one day. You know, it's not the end of the world if you feel like you messed up."

Barbara shared her experience of self-compassion and stated that "when practicing self-compassion, it does mediate that relationship, it definitely prevents self-criticism from happening or it makes it more manageable."

Discussing self-criticism, Mary shared, "Self-compassion is definitely like just taking that inner bully and trying to shut that voice off and like quiet it and not let it be too powerful and not let it take over."

Lastly, Max stated, "Self-compassion combined with compassion from other people is a really powerful defender against shame."

In combating shame and self-criticism, Mary stated, "Self-compassion feels very honest. It feels very gentle. It feels very much like maybe that wasn't your best experience, maybe you would've done that very differently, but you don't have to act like it's the end of the world."

Theme 5: Support from others is helpful to manage shame and self-criticism. All participants found support from others to be helpful in managing the shame and self-criticism that arose from their experience as a trainee providing therapy at their practicum site. Below are the subthemes from the data analysis that show supportive others are helpful to manage shame and self-criticism.

***Subtheme 4. 1: Support from supervisors*.** All 15 participants found their supervisors to be helpful to manage and work through their shame and self-criticism, even if on an implicit level. Vanessa shared about her supervisor, "She's been really helpful, identifying my self-criticism and validating and normalizing my experience as a trainee."

In regard to sharing her experiences of shame in supervision, Sandra stated, "I think it's helpful to just talk about it and like he'll ask me questions like, what's your history with that or what's coming up for you." Sandra also indicated, "I think that's been helpful and making me feel like this experience isn't something that I'm in just alone."

Patricia shared about her experience with her supervisor:

> It has been helpful for me when she has told me you could try to be less critical of yourself because we're not as critical of you as your being of yourself. So, I think that's been helpful just to know that she does see growth in me and just seeing the potential of you know where I'll be at the end of practicum.

Many participants stated that their supervisors did not necessarily use the words of shame, self-criticism, or self-compassion; however, participants indicated that their shame and self-criticism subsided through the encouraging words provided by their supervisors. Sean stated, "I don't know if we've talked about shame as much in the word of shame. . . but we've addressed the concept in a round-about way."

Patricia shared:

> There have been times where I show up and I'm crying, and I'm like, I can't do this. And it's just like, you're doing fine, you're doing great. Or, when I exit my Zoom with my client, I'm like, I did this all wrong. And she's like, what does wrong mean to you? What does that look like?. . . I think that self-doubt can sometimes over-power and she's like nope. Let's redirect. Let's talk through this. So, yeah, she's an amazing help.

Subtheme 4. 2: Support from peers and family. All 15 participants (100%) found peer relationships inside and outside of group supervision to be helpful to manage and work through their shame and self-criticism. There were five participants (33%) who found either spousal or parental support helpful in managing their shame and self-criticism. Patricia, reflecting on the benefits of her peer support on self-criticism and shame, shared, "I think it kind of dwindles it and tells it just to shut up… I feel like those group sessions boost that confidence and change that perspective."

George shared about his peer experience and stated:

> I think that was the biggest surprise for me. I thought that it would not be helpful that I would be kind of disclosed or in a sense exposed or shamed even more because of my weaknesses or certain ways that I perform. I think that was one of the biggest life-savers. They were my self-compassion in the sense of reminding me that I don't have it all.

Florence, who does not find a significant benefit from group supervision when it comes to her shame and self-criticism, shared about the support she receives from her partner:

> "My partner… kind of knows what it's like to work with clients, he's in graduate school now… he's been a really great support… he helps a lot just kind of bringing me back and grounding me to like centering me."

Theme 6: Graduate training on shame, self-criticism, and self-compassion was more implicit than explicit. All participants (100%) discussed their appreciation for their graduate training. The participants also appreciated their supervision experiences and stated supervision helped them manage their shame and self-criticism. The trainees also experienced their supervision to be helpful in increasing their self-compassion. However, for a majority of the participants, they received no formal teaching or training on shame, self-criticism, and self-compassion. Additionally, the participants reported that the terms "shame," "self-criticism," and "self-compassion" were rarely mentioned in their graduate training and supervision, even within supervisor conversations focused on self of the therapist concerns. The participants also reported that the training they received to manage their self-criticism and shame and grow in their self-compassion came from more implicit education and training, rather than explicit.

Vanessa shared, "I can't think of any professor that's really discussed shame in terms of the individual. Um, shame from the clients. . . Sure, cause of the stigma. I don't know if shame from the therapist perspective really been touched on."

Susan stated, “I don't think anyone has said anything explicitly about shame and self-criticism.” Susan went on to say, “It's more like emphasizing the importance of self-compassion, but even then, they haven't mentioned self-compassion.”

Max shared:

> I'm gonna go out on a limb and say like probably every single one of our clients ever is going to have experiences of shame and self-criticism. Not only would it make us more effective as therapists if we've had explicit training on those… on those topics, but I do think also for our ability to care for ourselves to have explicit training or explicit conversation is helpful.

George stated, “I think it's implicit in a sense. . . Like for example, I would take the politics of imperfection, kind of like self-compassion or connected with that so I would say it's done implicitly.”

Tamara said, “I don't think that there were too many workshops or much teaching about shame and self-compassion, to be honest.”

Jason stated:

> And it would be nice if at school provided a class in which, okay, let's specifically target shame and self-criticism and self-compassion and looking at it from a therapist point of view. I think that would have been really helpful.

Discussion

Within this phenomenological study, the researchers sought to understand trainees’ lived experiences of shame, self-criticism, and self-compassion. Additionally, within this study the research explored trainees’ perspectives on how their experiences of shame, self-criticism, and self-compassion impacted their clinical work. There are a few quantitative studies that focused on trainee shame (Hauser, 2016), self-criticism (Richardson et al., 2018), and self-compassion (Bell et al., 2017; Boellinghaus et al., 2013). A couple of qualitative studies have also been conducted on the lived experiences of trainee shame (Allan et al., 2016) and self-criticism (Kannan & Levitt, 2017). This research is unique in that it is the first qualitative study to explore MFT trainees’ threefold lived experiences of shame, self-criticism, and self-compassion when they are beginning their practicums in graduate school. Using Moustakas’ (1994) transcendental phenomenological research method, six core themes and two subthemes were summarized from participant interviews.

All participants described their experiences of shame and self-criticism and reported that they are often interrelated, which is consistent with previous research (Gilbert, 2010; Pinto et al., 2013). This is the first study to explore trainees’ lived experiences of the connections between the two intrapsychic dynamics. For the participants, where shame lingered, self-criticism was not too far behind. One participant called self-criticism “the language of shame,” and others noted the “vicious cycle” of shame and self-criticism. However, shame and self-criticism are not always connected. A few participants mentioned being triggered by trainee challenges, such as not feeling confident in the model of therapy they were using and struggling with self-criticism. However, they reported feeling no shame while experiencing their self-criticism. A trainee experiencing self-criticism does not mean they will automatically experience shame. Nevertheless, every participant who described feeling shame had some form of self-criticism. It could be that when trainees feel badly due to shame, they tend to think bad thoughts about themselves and their work.

All participants shared that shame and self-criticism could affect their clinical work negatively. One of the clearest consequences of shame and self-criticism, described by the participants, is that shame and self-criticism affected trainees' ability to be compassionately present and attuned to their clients. Shame and self-criticism constricted trainee awareness and caused trainees to focus on themselves. Getting "stuck in my head" was a common sentiment among participants, which meant they were more focused on their perceived failings and shortcomings than on the client and the important tasks of therapy. Consistent with previous research, negative self-criticism and lack of confidence negatively affect the therapist-patient alliance and restrict the trainee capacity to attend to the tasks, goals, and bonds necessary for effective therapy (Karam et al., 2015).

Twelve participants (80%) described their experience of shame and self-criticism through the use of metaphors. According to Wagener (2017), "Metaphors are not simply a linguistic or literary device; they play an important role in learning and cognitively organizing an understanding of the world" (p. 144). Research findings support the claim that metaphors are common verbal strategies used to communicate visceral emotional experiences (Lakoff, 2016). Therefore, it is not surprising that participants used metaphors such as "bully," "monster," "swamp state," and "sledgehammer" to communicate their experiences of shame and self-criticism, and to a far lesser extent self-compassion. Educators and supervisors are invited to pay special attention to each trainee's experiential and metaphorical knowledge of shame, self-criticism, and self-criticism as a way to understand their unique situations, challenges and emotional landscapes (Wagener, 2017).

The results of this study also confirmed prior research (Bluth & Neff, 2018; Gilbert, 2010; Ortega, 2007; Richardson et al., 2018) that showed self-compassion can reduce shame and self-criticism. The findings in this study were also consistent with Richardson et al.'s study, where self-compassion could benefit trainees' self-critical perfectionism and potentially benefit clinical effectiveness. All participants described the benefits of self-compassion to not only mitigate the experiences of shame and self-criticism but also to increase their effectiveness as trainees providing therapy at their first practicum site. Many of the participants' facial expressions softened, and they smiled after transitioning from the topic of shame and self-criticism to the topic of self-compassion. Participants stated that self-compassion enabled them to "be kind," "extend grace," "be nurturing" and be their own "cheerleader" and "parent" after being triggered by challenging events. Some of the challenging events faced by participants were not knowing theory, worrying about their age, being consumed by shame or self-criticism rather than being present with their clients, and comparing themselves to other peers and their clinical work. When it came to describing how self-compassion impacted their clinical work, one participant succinctly summed up many other participants' experiences: "self-compassion allows me to put my own stuff to rest so that I can come to my client as present, and attuned, and compassionate, and kind."

Many of the participants found that self-criticism was on a spectrum and could be considered positive and beneficial for their growth and effectiveness as a trainee. Their experience of self-criticism was that it told them what they were doing wrong, or what they could do better, and they found in the absence of shame that it helped them see where they needed to grow and develop as trainees. The participants' view that self-criticism could be beneficial to their work aligned prior research (Duek et al., 2018; Kannan & Levitt, 2017) that showed self-criticism could be positive and beneficial. Kannan and Levitt (2017) demonstrated that when trainees had safe spaces to process their self-criticism, they were more likely to be authentic, curious, and learn from their self-criticism. Because the trainees' self-criticism showed them exactly what they needed to

do to perform more effectively, they were able to see their self-criticism as "helpful," "effective," and "motivating" to move them "forward" to being a more "effective" therapist.

A unique contribution of this study was the discovery that participants were not explicitly taught about shame, self-criticism, or self-compassion in their graduate training. Additionally, shame, self-criticism, and self-compassion were rarely explicitly mentioned in the trainees' individual and group supervision. A majority (93%) of the participants found their graduate training and supervision helpful in reducing their shame and self-criticism while increasing their self-compassion. However, a majority (87%) would have appreciated more specific and explicit education and training on those topics. There are no previous research studies exploring MFT graduate schools that have included shame, self-criticism, and self-compassion in their curriculums. Additionally, there are no previous studies exploring specific practices supervisors utilize to help trainees explore shame and self-criticism. Shame and self-criticism are seldom discussed by trainees, including those in supervision (Allan et al., 2016; Hauser, 2016; Kannan & Levitt, 2017). This researcher found just one study that explored supervisors' use of self-compassion principles and practices in their supervision (Coaston, 2019). Self-compassion training has been shown to reduce self-criticism and shame among therapy trainees (Bell et al., 2017; Boellinghaus et al., 2013). Trainees may benefit from more explicit graduate instruction on shame, self-criticism, and self-compassion and more candid conversations on those dynamics in individual and group supervision.

Limitations

Although the results in this study increased our understanding of trainee shame, self-criticism, and self-compassion, this study presented with potential limitations. All participants came from graduate schools in southern California. More than half of the participants came from one school in particular. Therefore, while the study may reveal important themes that expand the conversation around trainee shame, self-criticism, and self-compassion, the themes from the qualitative analysis may differ depending on the program in which the trainees are enrolled. For example, perhaps the experiences of shame, self-criticism, and self-compassion of trainees who were enrolled in a program oriented around narrative therapy, with a supervision focus on externalizing, deconstructing narratives, and unique outcomes, may differ from trainees who were enrolled in an emotionally focused oriented program where supervision focused more in depth on trainees' emotional experiences. It is possible that trainees in an emotionally focused oriented program may be more aware of their experiences of shame and self-criticism and may be able to self-regulate more effectively and be less impacted by them. Additionally, the length of time performing therapy could have an impact on the interpretive findings. Most of the participants in this study were performing therapy at their practicum site between one to six months. There could potentially be a difference in the phenomenological experience of those who just started their practicum compared to those who have been performing therapy at their practicum site for a longer period of time. It is possible that those who have been performing therapy for a longer period of time have more confidence and self-compassion and less shame and self-criticism.

Additionally, the study may be limited due to the researcher's biases. Although an epoché was engaged in throughout the study, it is impossible to completely rid oneself of biases, beliefs, and attitudes. Therefore, the findings and conclusions in this study could have been influenced and interpreted in unforeseen ways. Lastly, the majority of the participants were self-identified as Caucasian. While in this study, the demographics did not demonstrate any significant findings, a

study that included a more racially and ethnically diverse participants might have provided a wider breadth of experiences and diverse themes.

Future Recommendations

Research

Future research could include a quantitative research study of a year-long practicum experience that would include a larger trainee sample size. The proposed study should involve the measurement of shame, self-criticism, and self-compassion at the start of their practicum, at the six-month mark, and after their completion as a means to identify any changes in these measures over time. There are various measures that could be used in the study. The Shame and Resilience Among Mental Health Trainees Scale (SRMHT; Hauser, 2016) could be used to measure trainee shame before and after their practicum. The Forms of Self-Criticizing/Attacking & Self-Reassuring Scale (FSCRS; Baião et al., 2015) could be used to measure self-criticism before the start of the practicum and upon its completion. The Self-Compassion Scale (SCS; Neff, 2003) could be used to measure self-compassion before and after their practicum. The completion of the measures would provide quantitative data regarding possible relationships between shame, self-criticism, and self-compassion. Additionally, the measures would provide data regarding the progression of time on the three variables as trainees progress through their practicums.

Training

Within this study, all participants indicated that their supervisors were helpful in reducing shame and self-criticism. This suggests that supervisors could use their influence by modeling and teaching trainees specific principles, skills, and interventions designed to reduce shame and self-criticism. To this point, one of the most powerful interventions supervisors can employ in reducing trainee shame and self-criticism—while simultaneously increasing self-compassion—is the use of themselves. As research has suggested, the quality of attachment between a supervisor and trainee is crucial in improving the experience of supervision as well as supporting and enhancing trainees' relationships with their clients (White & Queener, 2003). Fitch, Pistole and Gunn (2010) indicated in their research that the more secure a trainee's attachment to their supervisor is, the safer they feel to explore their internal experiences and learn from them. On the other hand, an insecure attachment between a supervisor and supervisee is a potent predictor of intentional non-disclosure (Cook & Welfare, 2018). Supervisee non-disclosure negatively affects both the supervisee and their clients as a result of the supervisor being unaware of information key to navigating the supervisory relationship, such as factors for nurturing supervisee trust and client welfare (Cook & Welfare, 2018). Since shame and self-criticism are often neglected areas of discussion in supervision (Weatherford et al., 2008), supervisors are invited to provide a secure attachment relationship with their trainees and provide a safe space for trainees to share those often-neglected intrapsychic dynamics.

Supervisors can also help trainees create an "internal compassionate supervisor" (Bell et al., 2017) as a way of increasing self-compassion and reducing shame and self-criticism. In the beginning of trainee's practicum experience, supervisors can assist trainees in creating an image of a wise and nurturing supervisor who could offer them compassionate support as they navigate the complexities and challenges of learning and performing therapy. When challenges arise, trainees could take a moment and practice imagining what the internal supervisor would say to

them, along with their warm posture, compassionate tone of voice, and kind relational qualities (Bell et al., 2017). Bell et al. (2017) found that trainees who engaged in the internal compassionate supervisor imaginal activity for a four-week period experienced "reductions in self-criticism, shame, and feelings of threat, as well as perceived increases in resilience and positive capabilities" (p. 645).

The findings in this current study suggest that it would be beneficial for graduate training programs to explicitly include psychoeducation about shame, self-criticism, and self-compassion to help trainees increase self-compassion and reduce shame and self-criticism that may arise inside and outside the therapy room. Since trainees in graduate programs are enrolled in practicum classes, practicum instructors are encouraged to explicitly address the dynamics of shame, self-criticism, and self-compassion. Graduate programs are recommended to have a specific self-of-the-therapist or therapist formation class that would intentionally explore the dynamics of shame, self-criticism, and self-compassion. The researchers envision the therapist formation class addressing family of origin issues that could potentially affect their clinical work (Timm & Blow, 1999) and assisting trainees with reflecting on their biases in the context of "gender, race, ethnicity, culture, sexual orientation, socioeconomic class, and disability" (Hee-Sun & Murphy, 2007, p.11). Invariably, the class material could trigger the experiences of shame and self-criticism, prompting professors to normalize discussions around those experiences and provide self-compassion principles and practices that best address them. Graduate programs intentionally and explicitly facilitating trainee's awareness of shame and self-criticism, while increasing their self-compassion, may positively affect their clinical work.

Conclusion

Trainees who are in graduate school learning to be therapists have to deal with a number of challenges and stressors. While they are engaged in intense studies and experience large learning curves, the last thing they need is debilitating shame and constricting self-criticism decreasing their effectiveness as students and clinicians. The participants in this phenomenological study demonstrated that shame and self-criticism negatively impacted their clinical work by constricting their attention on themselves, as opposed to attuning to and focusing their presence upon the clients with whom they were working. Thankfully, the findings of this study also point to a constructive way forward. Self-compassion and compassion from others in the midst of trainee shame and self-criticism have the potential to decrease constricting negative emotional experiences and increase a greater sense of well-being and clinical effectiveness. Supervisors can glean insights from this study and be proactive in talking about, normalizing, and educating their trainees about shame and self-criticism, as well as emphasizing principles and practices of self-compassion. Supervisors are also invited to compassionately inquire about trainees' experiences of shame and self-criticism, especially being intentional about exploring the visceral metaphors trainees use. Lastly, graduate schools can also be intentional about incorporating lesson plans about shame, self-criticism, and self-compassion for the sake of therapists in training and those they work with.

References

Allan, R., Eatough, V., & Ungar, M. (2016). "I had no idea this shame piece was in me": Couple and family therapists' experience with learning an evidence-based practice. *Cogent Psychology, 3*(1). https://doi.org/10.1080/23311908.2015.1129120

Bell, T., Dixon, A., & Kolts, R. (2017). Developing a compassionate internal supervisor: Compassion-focused therapy for trainee therapists. *Clinical Psychology & Psychotherapy*, *24*(3), 632–648. https://doi.org/10.1002/cpp.2031

Bluth, K., & Neff, K. D. (2018). New frontiers in understanding the benefits of self-compassion. *Self & Identity*, *17*(6), 605–608. https://doi.org/10.1080/15298868.2018.1508494

Boellinghaus, I., Jones, F. W., & Hutton, J. (2013). Cultivating self-care and compassion in psychological therapists in training: The experience of practicing loving-kindness meditation. *Training and Education in Professional Psychology*, *7*(4), 267-277. https://doi.org/10.1037/a0033092

Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J., & Neville, A. J. (2014). The use of triangulation in qualitative research. *Oncology Nursing Forum*, *41*(5), 545–547. https://doi.org/10.1188/14.onf.545-547

Cartwright, D., & Gardner, M. (2016). Trainee difficulties with therapeutic engagement: A qualitative study of in-session critical incidents. *South African Journal of Psychology*, *46*(2), 254-265. https://doi.org/10.1177/0081246315605679

Coaston, S. C. (2019). Cultivating self-compassion within the supervision relationship. *Clinical Supervisor, 38*(1), 79–96. https://doi.org/10.1080/07325223.2018.1525596

Cook, R. M., Welfare, L. E., & Jones, C. T. (2020). Incidence of intentional nondisclosure in clinical supervision by prelicensed counselors. *Professional Counselor*, 10(1), 25–38. https://doi.org/10.15241/rmc.10.1.25

Creswell, J. W., & Poth, C. N. (2017). *Qualitative inquiry & research design: Choosing among five approaches* (4th ed.). SAGE Publications, Inc.

Duek, O., Shahar, G., Osher, Y., & Kofman, O. (2018). Role of self-criticism in reward and punishment probabilistic learning. *Personality and Individual Differences, 134*, 155–163. https://doi.org/10.1016/j.paid.2018.06.007

Edwards, T. M., & Patterson, J. E. (2012). The daily events and emotions of master's-level family therapy trainees in off-campus practicum settings. *Journal of Marital and Family Therapy*, *38*(4), 688–696. https://doi.org/10.1111/j.1752-0606.2012.00263.x

Fitch, J. C., Pistole, M. C., & Gunn, J. E. (2010). The bonds of development: An attachment-caregiving model of supervision. *Clinical Supervisor*, 29(1), 20–34. https://doi.org/10.1080/07325221003730319

Gehlert, K. M., Pinke, J., & Segal, R. (2014). A trainee's guide to conceptualizing countertransference in marriage and family therapy supervision. *The Family Journal*, *22(*1), 7–16. https://doi.org/10.1177/1066480713504894

Gilbert, P. (2005). Social mentalities: A biopsychosocial and evolutionary reflection on social relationships. In M. W. Baldwin (Ed.), *Interpersonal cognition* (299–335). Guilford.

Gilbert, P. (2010). *Compassion focused therapy*: *Distinctive features*. Routledge.

Hauser, C. T. (2017). Shame and resilience among mental health trainees: A scale construction study [ProQuest Information & Learning]. In *Dissertation Abstracts International Section A: Humanities and Social Sciences* (Vol. 78, Issue 1–A(E)).

Hee-Sun, C., & Murphy, M. J. (2007). The self-of-the-therapist awakened: postmodern approaches to the use of self in marriage and family therapy. *Journal of Feminist Family Therapy*, 19(1), 1-16. https://doi.org/10.1300/J086v19n01_01

Hill, C. E., Sullivan, C., Knox, S., & Schlosser, L. Z. (2007). Becoming psychotherapists: Experiences of novice trainees in a beginning graduate class. *Psychotherapy: Theory, Research, Practice, Training*, *44*(4), 434–449. https://doi.org/10.1037/0033-3204.44.4.434

Kannan, D., & Levitt, H. M. (2017). Self-criticism in therapist training: A grounded theory analysis. Psychotherapy Research, 27(2), 201–214. https://doi.org/10.1080/10503307.2015.1090036

Karam, E. A., Sprenkle, D. H., & Davis, S. D. (2015). Targeting threats to the therapeutic alliance: A primer for marriage and family therapy training. *Journal of Marital and Family Therapy*, *41*(4), 389–400. https://doi.org/10.1111/jmft.12097

Kaslow, F. W. (2001). Whither countertransference in couples and family therapy: A systemic perspective. Journal of Clinical Psychology, 57(8), 1029–1040. https://doi.org/10.1002/jclp.1071

Lakoff, G. (2016). Language and emotion. *Emotion Review, 8*(3), 269–273. https://doi.org/10.1177/1754073915595097

Leary, M. R., Tate, E. B., Adams, C. E., Allen, A. B., & Hancock, J. (2007). Self-compassion and reactions to unpleasant self-relevant events: The implications of treating oneself kindly. *Journal of Personality & Social Psychology*, *92*(5), 887–904. https://doi.org/10.1037/0022-3514.92.5.887

Longe, O., Maratos, F. A., Gilbert, P., Evans, G., Volker, F., Rockliff, H., & Rippon, G. (2010). Having a word with yourself: Neural correlates of self-criticism and self-reassurance. *NeuroImage*, *49*(2), 1849–1856. https://doi.org/10.1016/j.neuroimage.2009.09.019

Moustakas, C. (1994). *Phenomenological research methods* (1st ed.). SAGE Publications, Inc.

Neff, K. D. (2003a). The development and validation of a scale to measure self-compassion. *Self and Identity*, *2*(3), 223–250. https://doi.org/10.1080/15298860309027

Neff, K. D. (2003b). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity*, *2*(2), 85–101. https://doi.org/10.1080/15298860309032

Neff, K. D. (2012). The science of self-compassion. In C. Germer & R. Siegel (Eds.), *Compassion and Wisdom in Psychotherapy* (79-92). Guilford Press.

Neff, K. D., Rude, S. S., & Kirkpatrick, K. (2007). An examination of self-compassion in relation to positive psychological functioning and personality traits. *Journal of Research in Personality*, *41*(4), 908–916. https://doi.org/10.1016/j.jrp.2006.08.002

Pinto, G. J., Castilho, P., Matos, M., & Xavier, A. (2013). Centrality of shame memories and psychopathology: The mediator effect of self-criticism. *Clinical Psychology: Science and Practice*, *20*(3), 323–334. https://doi.org/10.1111/cpsp.12044

Prenn, N. C., & Fosha, D. (2017). *Supervision essentials for accelerated experiential dynamic psychotherapy*. American Psychological Association.

Qutoshi, S. B. (2018). Phenomenology: A philosophy and method of inquiry. *Journal of Education and Educational Development*, *5*(1), 215–222. https://doi.org/10.22555/JOEED.V5I1.2154

Richardson, C. M. E., Trusty, W. T., & George, K. A. (2018). Trainee wellness: Self-critical perfectionism, self-compassion, depression, and burnout among doctoral trainees in psychology. *Counselling Psychology Quarterly*, *33*(2). https://doi.org/10.1080/09515070.2018.1509839

Sandberg, J. G., & Knestel, A. (2011). The experience of learning emotionally focused couples therapy. *Journal of Marital and Family T*herapy, *37*(4), 393–410. https://doi.org/10.1111/j.1752-0606.2011.00254.x

Sheperis, C., Young, J. S., & Daniels, M. H. (2017). *Counseling research: Quantitative, qualitative, and mixed methods*. Pearson.

Siegel, D. (2007). *The Mindful Brain: Reflection and Attunement in the Cultivation of Well-Being*. W.W. Norton.

Skovholt, T. M., & Rønnestad, M. H. (2003). Struggles of the novice counselor and therapist. *Journal of Career Development, 30*(1), 45–58. https://doi.org/10.1023/A:1025125624919

Timm, T. M., & Blow, A. J. (1999). Self-of-the-therapist work: A balance between removing restraints and identifying resources. Contemporary Family Therapy: An International Journal, 21(3), 331–351. https://doi.org/10.1023/A:1021960315503

Vagle, M. D. (2018). *Crafting phenomenological research*. Routledge/Taylor & Francis Group.

Varpio, L., Ajjawi, R., Monrouxe, L. V., O'Brien, B. C., & Rees, C. E. (2017). Shedding the cobra effect: Problematizing thematic emergence, triangulation, saturation and member checking. *Medical Education, 51*(1), 40–50. https://doi.org/10.1111/medu.13124

Wagener, A. E. (2017). Metaphor in professional counseling. *Professional Counselor, 7*(2), 144–154. https://doi.org/10.15241/aew.7.2.144

Weatherford, R., O'Shaughnessy, T., Mori, Y., & Kaduvettoor, A. (2008). The new supervisee: Order from chaos. In A. K. Hess, K. D. Hess, & T. H. Hess (Eds.), *Psychotherapy supervision: Theory, research, and practice* (2nd ed., pp. 40–54). John Wiley & Sons.

White, V. E., & Queener, J. (2003). Supervisor and supervisee attachments and social provisions related to the supervisory working alliance. *Counselor Education & Supervision*, 42(3), 203. https://doi.org/10.1002/j.1556-6978.2003.tb01812.x

Yarnell, L. M., & Neff, K. D. (2013). Self-compassion, interpersonal conflict resolutions, and well-being. *Self & Identity, 12*(2), 146–159. https://doi.org/10.1080/15298868.2011.649545