**Abstract**

Couple and family therapists are rarely the focus of research yet are critical for positive outcomes in therapy. The attempts to integrate evidence-based approaches into the practice of couple and family therapy have been controversial resulting in passionate and at times divisive dialogue. The aims of this research project were to explore what do couple and family therapists experience when learning an evidence-based approach to working with couples and families. A total of 14 couple and family therapists were interviewed about their experience with learning an evidence-based approach. The research was guided methodologically by interpretive phenomenological analysis. Three themes emerged from the participants’ experiences including: the supports and challenges in learning; the embodiment of a therapy practice; and the experience of shame while learning.

*Keywords:* qualitative research; evidence based practice; couple therapy; supervision; family therapy

Evidence-based practices in couple and family therapy are increasingly recognized as critical for the growth and development of the field (Sexton et al., 2011; Stratton et al., 2015). This study reports on the experiences of couple and family therapists (CFT) learning about and using evidence-based couple and family therapy practices. While there have been studies that explore the experience of self of the therapist (Aponte et al., 2009), little research has investigated the experience of students or trainees learning couple and family therapy. For example, Nel (2006) did an extensive literature review of qualitative research about students' views of family therapy training and identified only two studies (Dowling, Cade, Breunlin, Frude, & Seligman, 1982; Green and Kirby-Turner, 1990). Other reviews of research that explores the training of couple and family therapists have been few and repeat the refrain of the limitation of the research in this area (e.g. Avis & Sprenkle, 1990; Knistern & Gurman, 1979, 1988; Sori & Sprenkle, 2004). Sandberg, Knestel, and Schade (2013) suggest the limited focus on therapists is because of the long held belief that change in therapy outcomes is a result of specific therapy techniques. Similar shortcomings have been identified in the research literature about supervisors as well (McCandless & Eatough, 2010, 2012). Given the focus of this research it is both important to mention why a focus on the therapist in training is needed and curious at the same time that there is a need to mention it at all.

Orlinsky, Rønnestad, and Willutzki (2004) note that over 1,000 research findings demonstrate a positive therapeutic alliance is one of the best predictors of outcome. The person of the therapist is a critical factor for therapy outcomes regardless of their theoretical orientation. As Skovholt and Starkey (2010) write, "just as carpenters have their hammers, screwdrivers, and other tools, therapists need to rely – almost exclusively – on one tool: the self" (p. 126). Yet little is known about the professional development of therapists and how that influences client

change both in and outside of the therapy room (Angus & Kagan, 2007; Obegi, 2008). While some research regarding models of training that focus on the self of the therapist identify the need for further clarification about both personal and professional development of therapists (Owen et al., 2014; Orlinsky & Ronnestad, 2005), there is varied integration across professions and countries. Some graduate programs may retain a strong focus on the therapist's proficient application of a particular clinical model and not the individual factors that influence the therapist during the learning process. In other programs, family therapists would have that integrated throughout their training. Across jurisdictions, there is limited attention in the search literature to the emotional experiences of trainees (Nel, 2006). While the issue of why there is limited research about trainees' experiences is not the focus of this research it is one of the questions that emerged for these researchers, why is there not a greater research focus on therapists' learning and development? More specific to this research are evidence-based practices (EBP) and what follows is a brief discussion of the benefits and challenges of the EBP project.

The use of and reference to EBPs has grown substantially in recent years (Nelson et al., 2012). EBPs offer a systematized and replicable approach to the training and use of therapeutic interventions with couples and families. The randomized control trials (RCT) used to develop the evidence bases for new therapies enable the measurement of fidelity to the treatment being studied and comparisons of different treatments (Stratton et al.,, 2015). Developing evidence-based practices is seen as a natural progression for the field of couple and family therapy, a maturing of sorts from anecdotal clinical reports to "conceptual and methodological sophistication" of CFT research and clinical practices (Sexton & Alexander, 2002). Challenges associated with EBP, however, include: overselling and promoting a one size fits all approach

(Coulter, 2011; Staller, 2006); limitations of the epistemological orientation of the research needed to establish EBP (e.g. Elliott, 1998; Seligman, 1996; Slife, Wiggins, & Graham, 2005; Wendt, Jr., 2006); and the heuristic limitations of EBP (Elliott, 1998; Rohrbaugh, 2014).

Given these problems with EBP, we used a qualitative approach to research called interpretative phenomenological analysis (IPA) to explore the following questions: What do couple and family therapists experience when learning an evidence-based CFT practice? What do couple and family therapists experience when adapting and using an evidence-based practice in their day-to-day clinical work?

## Methods

IPA was chosen for this research project because of the detailed and layered analytical process. The key elements of IPA are that: it is an inductive approach; participants are experts on their own experience and are recruited because of their expertise in the phenomenon being explored; researchers analyze data to identify what is distinct (idiographic study of persons) while balancing that with what is shared across the sample; and the analysis is interpretive, grounded in examples from the data, and plausible to the participants, supervisors, and general public (Smith, Flowers, and Larkin, 2009). Shaw (2001) explains that the focus on individuals' experiences in IPA and the exploration of meaning making processes that are situated in participants' many cultural roles provides rich and diverse data that can be explored in depth making it appropriate for CFT research (Allan & Eatough, 2016).

Participants were CFTs with at least a Masters degree in a mental health field, such as counselling, psychology, social work, or marriage and family therapy, and who have, or were in the process of learning and using an evidence-based couple or family therapy practice. For inclusion, the EBP they were learning or using had to have a treatment manual, CFTs had to

have received training and supervision specific to the EBP they discussed, and the EBP had to have a theory of change to which participants showed fidelity. Participants were recruited via professional listservs, snowball sampling, email, and direct requests from the research team.

In total, 14 CFTs were interviewed ranging in age from 32 to 65 years old. Details of the research participants (made anonymous here with pseudonyms) are summarized in Table 1 below. The therapy approaches used by participants included Emotionally Focused Therapy (EFT; Johnson, 2004), Attachment-Based Family Therapy (Diamond, Diamond, & Levy, 2013), Gottman Couples Therapy (Gottman, 1999), Imago Couple Therapy (Hendrix, 1988), and the Social Ecological Approach (Ungar, 2011). A number of programs have been set up to train and certify CFTs in a specific therapeutic approach (for examples see http://www.iceeft.com or https://www.gottman.com). Each program involves didactic training with an expert in the approach, additional experiential workshops, approved supervision specific to the therapeutic approach, and a review of live or video/audio therapy sessions by an approved supervisor. All of the participants in this research project had extensive training in the approach they discussed which included more than five days of didactic and experiential training and one-on-one as well as group supervision specific to the EBP they were learning. Eight of the 14 participants were "certified" in the approach they discussed.

*(Insert Table 1 here)*

Semi-structured interviews were carried out according to guidelines provided by Smith and colleagues (2009). Individual interviews conducted by the first author (RA) with the therapists occurred either face-to-face or online via Blackboard Collaborate. Sample questions included: Can you tell me about a CFT evidence-based approach that you have learned about? What influenced your decision to learn about that CFT approach? Were there clinical issues that

you were dealing with that led you to explore that approach specifically? What was your experience of learning that CFT approach? Can you tell me about what you enjoyed/ found challenging about learning that new CFT approach? What metaphor would you use to describe the process of learning that EBP? Has learning that new approach affected your clinical practice? What do you see as the role of evidence-based CFT approaches in the future of your clinical practice?

The interviews lasted 60-100 minutes and were audio-recorded and transcribed verbatim, then reviewed by the researchers to ensure the transcripts captured the specific text of the interview as well as the intonation, utterance and other components of speech which might lend themselves to further interpretation. The interview data were supplemented by the researchers' reflexive engagement with the participants and related research literature (Willig, 2008). Approval for this study was granted by the research ethics board at the host institution [name removed for blind review].

Data were analyzed using the six step process outlined by Smith and colleagues (2009). These six steps included first reading and re-reading the transcripts and noting anything of interest. Next was initial noting of the participant's content, linguistic interpretations, and conceptual comments. In the third step we developed emergent themes. Fourth, we searched for connections across emergent themes and identified the purpose a theme may play in a therapist's life. For the fifth step we moved to the next interview and repeated the same analytical process. The sixth and final step was to begin to look for patterns across transcripts. The three themes identified here are derived from the data and are the outcome of an inductive iterative process which synthesizes the participants' own meanings with those of the researchers to arrive at a thematic structure which captures the most salient aspects of the experience.

**Researchers' Locations**

Bronfenbrenner (1979) suggests that meaningful analysis of research findings is easier when researchers participate in similar roles and if they are members of the subculture from which the research participants come. The first author, a Canadian, came to this research as a licensed Marriage and Family Therapist and is someone who is trained and certified in evidence-based approaches to working with couples and families. He also trains and supervises others who are learning an evidence-based couple or family therapy approach, and he teaches couple and family therapy courses in a graduate program. This paper is based on his doctoral dissertation which was completed at a Canadian university. The second and third authors are both university-based researchers who supervised and were part of the dissertation committee. The second author is also a CFT while the third author has extensive experience with phenomenological approaches to research, particularly IPA. The data was collected and analyzed by the first author and the second and third authors reviewed the analysis and offered feedback and direction then guided the development of the themes.

## Results

Our analysis produced three superordinate themes of increasing depth (see Figure 1 below): the factors that support and challenge the learning of an EBP; the role of embodiment while learning an EBP; and the experience of shame while learning an evidence-based practice. The visual representation in Figure 1 both reflects the number of participants who provided substantive discussion about each theme and the impact that each described it having on their lives as they discussed the theme (from broad and unfocused at the top of the inverted pyramid, to profound and personal at the bottom). The most representative theme, the challenges and supports while learning an EBP, incorporates extracts from the all of the participants and

addressed each of the research questions. A second theme, the role of the body in learning an EBP, reflects the deep meaning that some of the participants made of their experiences and how they spoke of that meaning making process. The experience of shame while learning an EBP was the third theme identified and represents what Smith (2011b) refers to as a gem in the research findings. The titles of each theme combine quotes from the research participants and a note by the researchers about the participants' experiences in an effort to reflect the interpretative and ideographic nature of IPA.

*(Insert Figure 1 here)*

**Challenges and Supports while Learning an Evidence-Based Practice**

This is the most prevalent theme and best represents Smith's (2011a) notion of "capturing of similarity and difference, convergence and divergence" (p. 24) that are good hallmarks of IPA research. The participants discussed their experiences of learning and adapting an EBP to their clinical work including what supported that process and what they found hindered or made it more challenging. These supports and challenges included specific factors such as their experience of their trainer, the role of supervision, and what resources the participants drew on when they felt challenged. This theme speaks to each of the research questions as all of the participants mentioned that they pursued training to improve their work with couples or families.

Cassandra for example, discussed how she engaged cognitively while learning a new approach primarily through reading and noted that "I find that really helpful, the intellectual piece of it and kind of that guidance". She did not, though, perceive at first the need for a trainer or supervisor, believing she had the capacity to learn the techniques on her own. She went on, however, to discuss the challenges she experienced in learning EFT and the limitation of approaching it using her cognitive strengths:

> Well do you have five hours? It's a hard, you know it's really funny that at the time, back in 2009, I was about a year and a half into the clinical psychology program and I'd really gotten good at the program that I'm in. There's a lot of independent learning, so I thought I can learn anything, I can learn this, it's not going to be that hard, so I go the books, I got the videos. I even thought well I probably won't even need training, I can just train myself and I pulled down articles and I was reading everything and I was watching the videos. And then you get into a room with a couple and even if I felt like I had a decent idea of what I wanted to do you know I thought I did. At this point I realized that like what it looks like on paper and what it looks like in the room and what you're really trying to do, that translation in and of itself takes a lot of the time.

While skilled at integrating the reading she did into her clinical work, Cassandra was also painfully aware of the limitation of this approach to adopting an EBP

Louise also talked about the cognitive aspects of her learning. She reported that she is always reading about clinical innovations and how that contributes to her thinking, case conceptualization, and treatment planning. She talked about focusing in on particular aspects of her current caseload while reviewing research about therapy:

> It's a very, very rich way to learn because it is like doing lab work right. I mean ah, you know you read an article, anything I read, like I said I'm constantly reading, and anything I read, I have three or four cases in my mind as I'm reading it going oh right, so that's what's happening here you know.

Louise went on to describe the value of learning about her therapy in this way; describing how "…it's very rich. So you're, you know I'm very engaged because I have live people who I'm going to see [laughter] within 24 hours often, you know so talk about something coming alive".

The strong desire to learn reported by Cassandra and Louise fits well with the category of cognitive characteristics noted by Skovholt and Starkey (2010) as contributing to therapists' learning. Research participants similarly discussed the role of attending to emotional awareness in their development.

A number of research participants mentioned the role of supervisors, peers, or just moments in their learning where they developed a new emotional awareness and began to see the learning as incorporating a means to explore the emotional aspects of their learning. Kathy mentioned that:

> One of the things I value very highly is supervision in my own therapy to do the work that I do, so ah this was just another piece of it, really helping me to understand relationships better and the struggles that we have.

For Kathy, the opportunity to explore her own relationships, as well as those of her clients, was an important aspect of supervision and one that she saw as contributing to her emotional awareness of herself and the couples she worked with. Likewise, Cassandra took the initiative to form a peer support group specifically for the means of exploring the emotional material that arose for her and colleagues while learning:

> So I actually ended up organizing for a period of time, a support group kind of for therapists themselves and to really deal with our personal feelings related to what it's like to learn this model and to do this model. So I ended up finding a bunch of kind of compadres.

This focus on self-awareness noted by Kathy and Cassandra was an integral part of their learning process. The relational domain was also addressed by the research participants.

The aspects of the relational domain that participants most spoke of were the demands placed on the therapist by clients. While working with more than one person in the room, thinking relationally and systemically, and considering the impact on self of the therapist left participants seeking specific supports related to the development of proficiency in an EBP to aid them in their practice. For example, Cassandra said that what she needed was:

> Either people who are further down the path or at the same place with me. That you know that I could talk to other colleagues who weren't learning EFT about some of those struggles, but they couldn't quite relate because I think the model itself demands so much of the therapist.

Cassandra is aware of the demand on the self-of-the-therapist in her learning and sought out people who would have been on the leading edge of her experience with the EBP she was integrating into her practice.

Overall, participants reported an evolution of their work from novice to expert. During the novice phase of learning, learners are judged and judge themselves by how their skills follow the rules (Flyvberg, 2001). This phase of learning begins with the "instructor decomposing the task environment into context-free features that the beginner can recognize without the desired skill" (Dreyfus, 2004, p. 577). One important element for learning an evidence-based practice is the treatment manual. At the novice stage of learning, it becomes a rule book, the description of what the practice is, how it is done right, what the skills are, and so on. Jessica talked about referring back to the treatment manual as her source of what was the right thing to do with her clients:

> So I feel like I'm getting it and then sometimes I think OK, no I'm not, I need to refer back to it to find out where I'm at. Because it is a very directive type approach and so, you want to make sure that you are following the intent of the theory so I refer back a lot.

Constantly wondering if she was following the rules as laid out in the treatment manual, Jessica was reassured by having the resource as a guide.

For those participants who became more proficient in their use of an EBP, they described more of an intuitive sense of how to work with couples and families. Dreyfus and Dreyfus (1986) refer to intuition as the "understanding that effortlessly occurs upon seeing similarities with previous experiences" (p. 28). They use intuition and know-how interchangeably, adding to their description that intuition is "the product of deep situational involvement and recognition of similarity" (p. 29). One research participant captured this notion of intuition well. Raylene described her process of feeling more proficient with EFT as "I've got it, it's like I got it…I have that map now, it's not just a cognitive concept. I have a direct experience of it in my body, and so now I know the terrain". This experience of embodying an EBP is explored further in the next theme.

**A Role for the Body in Learning an EBP**

Participants' experiences with embodying an EBP and the struggles they had with embodiment was the second most frequently occurring super-ordinate theme. Participants discussed the experience of being "pushed", "drawn to", or compelled to explore something "deep inside" them. Possibly two of the bigger influences on participants' willingness to discuss how they embodied a practice would be the particular therapy approach they discussed and their professional background and training. Research participants came from a variety of professions (Table 1) and each of these professions has a different understanding of whether exploration and

understanding of one's self or exploring felt senses is part of the training. Within each profession there are different schools of thought about how students should be prepared for the profession.

Therapists who came out of graduate training where self-of-the-therapist exploration was central to their learning tended to have a greater capacity to discuss their experiences with learning an EBP. For example, it seemed that MFTs in this sample had showed greatest ease with discussing these experiences. Likewise, the therapy approach discussed was another factor that influenced research participants' experiences with embodying a therapeutic approach. Not surprisingly, the research participants who discussed EBPs that were influenced by attachment theory were more likely to discuss the experience of embodying a practice. Though this was not an issue that was explored in this research project until later phases of the analysis (and after interviews were completed), we are able to speculate why some of these participants were more likely to explore the experience of embodying a therapy practice. It is possible that, as Louise suggested, attachment is a "primal theme" and the primacy of this experience evokes more from someone learning a therapy approach informed by attachment theory. Another possible consideration is whether participants were encouraged to embody a practice as they were learning it. For example, whether they were encouraged to explore how different aspects of the new model felt for them or how they experienced the model in their own relationships as they were learning a new therapeutic approach to working with couples or families.

For this theme, the body is understood as a form of consciousness (Merleau-Ponty, 2002); our bodies are the mechanism for perception, both objective and subjective. Merleau-Ponty offers an epistemological means to explore participants' experiences as a form of embodiment. He writes of the body as "the vehicle of being in the world, and having a body is, for a living creature, to be intervolved in a definite environment, to identify oneself with certain

projects and be continually committed to them" (Merleau-Ponty, 2002, p. 94). While Merleau-Ponty offers an epistemological framework for understanding the body as a way to make meaning of participants' experiences, Gendlin (1978) offers a means to explore what that process involved step by step.

Gendlin (1978) notes this process as a "change [that] begins but seems oddly, mysteriously incomplete. It gives you the start of a shift, but you know (your body knows) a more complete shift is possible" (p. 15). Our research participants reported their experiences with resonating with that felt sense and making meaning of it. This included discussion about their challenges with that process both individually and in the environments they worked in. Ken noted it as an individual experience saying that it was "by far the most difficult training and learning process that I've ever been in" while George spoke to the challenges he experienced in his work environment and how he managed those. He described how "more and more" of his colleagues were "doing things that can be programmed" as a means to respond to "government" and the "paymasters". George went on to describe his colleagues' efforts to address how government funding was spent by looking to "evidence-based practice". For George this meant a "move" that would allow him to retain and attend to his felt sense about what was effective in his work with families. He described it as follows:

> In some ways I have actually moved a little bit outside of mainstream because I'm getting increasingly concerned by that, fiscal restraints on health care and the exclusion of therapies that can't be proven to be effective and the shortness of treatment lengths now which are really driven by cost implications.

George's "move" is a means to understand and make sense of the cost-pressures of his environment. The opportunity for research participants to explore something "deep" or "inside" also led to some of the research participants to describing a powerful shift in their bodies.

Ken, for example, described this powerful shift as feeling like he had "reached Everest on this issue" with regards to integrating a new approach to working with couples. Therapists who exercise skill with a sense of competence will "manifest [an] understanding of both their surroundings and themselves" (Romdenh-Romluc, 2011, p. 90). Ken not only experiences himself as competent but relays a sense of exhilaration in accomplishing a long sought after goal. Gendlin (1978) describes this change process as "natural to the body" (p. 8) with the crucial move that "goes beneath the usual painful places to a bodily sensing that is at first unclear" (p. 8). Much as Ken described, this experience "of something emerging from there feels like a relief and a coming alive" (p. 8). Ken's excitement and physical exhilaration leads to a significant point in Merleau-Ponty's work on embodiment.

Merleau-Ponty (1964) suggests that the body is integral to the understanding of the human situation. He writes, "I perceive in a total way with my whole being; I grasp a unique structure of the thing, a unique way of being, which speaks to all my senses at once" (p. 50). Raylene reflected this way of knowing by stating that "that's what you have to be able to do with clients, and if you can't do that with yourself, you're not going to be able to do that with clients". The research participants who felt the exhilaration of knowing "from the inside out" also spoke at length about the pain they experienced along the way to integrating a new EBP. In the end though, it left them with a sense of confidence and knowing, that they felt "in" them. Ken reported that "I feel so much more confident, than I ever have been". Reaching the peak of Everest will leave one with confidence and an understanding of one self, as Gendlin (1978)

writes, "there is a kind of bodily awareness that profoundly influences our lives" (p. 32). This shift is what Gendlin referred to as a felt sense. This same felt sense is also a part of the third major theme that emerged from this research, the therapists' experience of shame while learning.

**The Experience of Shame While Learning an EBP**

The methodological commitment in IPA to an ideographic perspective can lead to a focus on a particular passage from a research participant. Smith (2011b) reflected on his own experience of conducting IPA-based research and noted that he is "aware of the pivotal role played by single utterances and small passages of the analysis of a research corpus" (p. 6). It is this recognition of the significance of a passage that is disproportionate and that he refers to as a "gem" in the research. A question arises as to how to assess the value of these kinds of findings in IPA research and Smith points to a greater focus on the particulars. He outlines (2011b), it has "to do with the utterance that stands out and has added value to the analysis as a whole" (p. 7). One such example that we encountered was when Raylene noted the following:

> And I'm just like oh my god, that's it, that's it, and then I begin to tell them the story about how I had put this together through my supervision, the shame piece, my sister's suicide and me feeling responsible and this is what I was hitting inside myself and having that line-up with the emotion was incredibly powerful and it was very dysregulating. I was actually pretty disassociated there.

Raylene used the words "shame piece" to describe an aspect of her experience of learning a new EBP five times during our interview. She also used various other descriptors such as describing herself as "ashamed", "shameful", "my shame", "filled with shame", and "my shame experience" 18 times during the interview. The evocative passage from Raylene noted above was an entry into an experience shared with other research participants. This, for us, was a gem,

a pearl in the midst of the sea of data and an important opportunity to explore further as a means to illuminate this issue for the group of participants as a whole.

In the early stages of learning an EBP, participants experienced a strong sense of risk and of being a novice again, despite some being very experienced therapists. At face value, the participant's use of shame may seem unusual and in spirit with IPA's hermeneutic emphasis, when one looks beyond the face value to reflect on what the use might mean, it is possible that being put in this new learning environment triggers earlier training and other related life experiences before participants' got used to being exposed. Shame is often infused with other emotions (Mills, 2005) and participants in this research discussed factors from the learning and their own lives that contributed to the experience of shame.

George, for example, described an aspect of family therapy training that he experienced as someone who has been training for a few decades now:

> We had a lot of problems with residents in training, not just residents but whoever, who come up against their own personal difficulties quite quickly, I think there's nothing like family practice to push people into a bit of a corner.

The ways we are personally confronted in couple and family therapy training seem to evoke this sense of shame. Shame is negatively related to perspective taking and the focus of cognitive and emotional energy when shame is directed inwards. "Shame often produces overwhelming and painful feelings of confusion, fear, anger, judgment, and/or the need to hide" (Brown, 2006, p. 46). Half of the participants spoke to such experiences of shame in some way.

One example is Helen who spoke about the challenge of sitting with colleagues while learning a new evidence-based approach to working with families:

> I guess I would say when it's taught, so it's challenging when there are professionals from other agencies. As much as I want to be collaborative…But to me that can be challenging, particularly if you're just learning, be a little hesitant, I'm thinking in my head there's this person, this is a psychologist and has x number of years' experience, or people, you know, in a program that work with families all the time.

Helen had a sense of herself as somehow inferior to that of her colleagues during her training. This felt sense does not have to be known to this participant to affect her experience. In contexts like this, shame can have three functions: to reduce exposure to evaluation by withdrawing or disengaging us from embarrassing situations, to focus attention on social standards and use of self in that context, and to communicate deference to others (Mills, 2005).

Each function was evident in the stories told by the participants. For example, Raylene talked about one way that she hid during her training:

> A whole group of people that were getting together and studying and you had to videotape your sessions and I was very resistant to that at the time, thinking that I wanted to protect my client confidentiality, but really later, as the years went on, I realized I didn't want to have my own work exposed and be scrutinized.

Raylene also spoke to the social standards and expectations for marriage and family therapists in her context:

> I ended with [founder of the EBP] in the car that time, we were going to lunch or something, a bunch of us were going to lunch. And I mentioned to her because I'm sure I felt ashamed about it, it was always shameful for a marriage/family therapist to get a divorce, so I felt ashamed and she must have picked up on it cause I was mentioning it and she said to me, this is the most significant thing I remember from her, she turned to

me and she said…oh yah I was married before and divorced.

Finally, Beth spoke of the deference she experienced with her supervisor who was responsible for helping her to develop skills related to the EBP she was learning. It was a deference by silence experience where she described being "very intimidated. Ah, I think because I really admired my supervisor so much I really thought 'O my gosh' I was very nervous to say anything".

For other participants, shame manifested as a cognitive attribution. As Mills (2005) explains, "Overt shame involves a *feeling* of being ashamed, i.e., an awareness of autonomic reactions (e.g. rapid heart rate, blushing, sweating) with a subjective feeling (e.g., feeling small, helpless, unable to control the situation)" (p. 29-30). For example, Raylene discussed an incident with her supervisor:

> In that moment, I had this like experience in my body, where I, it's like this pain going into my gut, and all I can think of is [name of supervisor] that wasn't my experience and then I tell him, I look like a deer in the headlights o.k. and finally he looks at me, and says what's happening to you?

Raylene clearly conveys her sense of feeling helpless in that moment of supervision combined with an awareness of pain in her body and being physically frozen ("deer in the headlights"). From the cognitive perspective, shame is believed to be activated by negative attributions that are internal and global. A person believes they are bad, not that they have done something bad. The entire self is viewed as undesirable, unworthy, or flawed (Tangney & Dearing, 2002).

Typical of participants who struggled with these negative attributions, Cassandra discussed how, in the process of learning an evidence-based approach to working with couples,

she had to stop seeing couples because she was aware that her work did not match the intent of the model she was learning:

> And at some point I just kind of stopped seeing couples because it was so difficult to manage the dynamic. I didn't really feel like I was helping in the way that I wanted to help. I really wanted to, you know I felt like I could create superficial change, but to really create that systemic change, wasn't happening.

Cassandra went on to describe repeated moments of pain in her work, like a paper cut in the one spot on her finger that she used for several tasks throughout the day. She was constantly reminded as she was learning and using this new approach, of experiencing herself as incompetent. "There's tremendous amounts of conscience incompetent moments in the work and that for me as somebody who's…really kind of arrived at a point where I felt very confident with individuals, it was just painful." Another important perspective brought forward to further interrogate participants' experiences of shame while learning an EBP was Sartre's conceptualization of shame.

Sartre (1956) writes the following about the experience of shame, "I recognize that I *am* as the other sees me" (p. 222). The process of learning an evidence-based practice for the research participants required one to constantly submit to the gaze of an "other". For some participants, this was integral to their learning. Mary was a therapist in a clinical trial of an approach to working with families, the constant review and supervision required for clinical trials afforded her important developmental opportunities. She described the benefits of supervision for her practice as follows:

> But it is about having live supervision, continuous live supervision, and having had so much attention that I think I am really improving my clinical skills. I'm getting a lot of

feedback about how I'm doing in the therapy room. I get the opportunity to discuss with my supervisor, very thoroughly the cases and the strategies, and to plan for each case.

## Discussion

Research participants discussed a number of factors that supported and challenged their learning an EBP. Some of these factors were the need to learn from the "inside out", to have opportunities for trial and error learning, the role of context, and the need for supervision and support to deal with personal issues that arise. In terms of research participants' experiences with learning and using an EBP and what influenced their decision to learn a new therapeutic approach, the intent to improve their work with couples and families was central while the process of learning and using an EBP provided a focus and an intent that organized these experiences.

The way our own families and relationships are evoked in couple and family training added to the complexity of the learning and integrating of an EBP. This knowing from the "inside out" was also painful at times for research participants as previously noted. A few of the research participants even had a visceral reaction to the EBP project in general. George for example noted how EBPs are "becoming the new religion, people want to, I see more and more of us doing things that can be programmed". George reports this programming as if he is becoming automated, a machine calibrated to respond in specific ways. He went on to say that "we're talking about the way that the soul has been left out of therapy". George suggests that learning and integrating a new EBP is not only a personal challenge but a spiritual challenge as well. In some ways, the challenges - personal, spiritual, and otherwise - are a necessary ingredient for learning an EBP.

The experience of shame while learning an EBP was described as a gem of a theme evoked by the experiences of one of the research participants (Raylene) which helped to illuminate the experience as discussed by other participants. Talbot (1995) noted that possible sources of shame for a CFT include: the relationship between therapist and clients**,** the therapist's fears or experience of not being approved by a supervisor**,** and discussing personal material in a supervisory session. The options for exploring the impact of shame for a therapist are further complicated by the cultural norms and action tendencies when in shame. For example, Dearing and Tangney (2011) report that the word "shame" is often avoided, that the action tendency of shame is to hide, and that therapists inadvertently avoid discussing shame related issues. The focus of therapists' experience of shame to date has been while they are providing therapy, not while they are learning. The research literature has noted that the progression that therapists go through in their development may expose a therapist to the experience of shame.

Ward and House (1998) for example, report that supervisees progress "through a sequence of definitive stages while experiencing increased levels of emotional and cognitive dissonance" (p. 23). This dissonance can lead some to feelings of guilt while others experience shame. Guilt however leads to a reparative action while shame does not (Smith, Webster, Parrott & Eyre, 2002). Talbot (1995) noted that "interpersonally, shame is the emotion associated with the humiliating revelation of personal failure to another" (p. 339). It is difficult to imagine a learner or supervisee who experiences shame finding a means to explore that experience. As Chao, Cheng, and Chio (2011) report, "one's self-image is questioned in a state of shame" (p. 203). An important goal for a therapist learning a new EBP while experiencing shame is "to seek an effective means of buttressing a threatened social self or bolstering self-esteem" (p. 203).

Evidence-based approaches to working with couples and families tell us how to work with typical cases, not a particular case or cases in general. EBPs provide lists of rules for how to work with couples and families. Examples of rules familiar to many CFTs are how a parent who involves a child in an argument with his or her spouse is triangulating (Bowen, 1978); a spouse who goes silent or removes him- or her-self from meaningful discussion with his or her partner in an attempt to reduce conflict is using an avoidant attachment strategy (Johnson, 2004); a child or adult who struggles with emotion and emotion regulation likely has a mood disorder (American Psychiatric Association, 2013); and from a structural perspective that the parental hierarchy is out of order if a child is ruling the household with his or her bad behavior (Minuchin, 1974). Each model gives us a map to interpret clinical material. Rules are implicit in our interpretations.

We know these rules because of clinical experience and the research that has been conducted over the years and the range of evidence developed to help understand these patterns. EBPs are about "learning a lot of facts and rules for relating them" (Dreyfus & Dreyfus, 1986, p. 4). If we are to attune and be helpful with the couples and families that we work with however, couple and family therapy is a skill akin to knowing how to find one's way about a couple or family, what it is like to be in those relationships. That kind of attunement requires a "basic understanding…a knowing how rather than a knowing that" (p. 4). "Knowing that" is learning the rules as outlined in an empirically supported treatment manual while "knowing how" incorporates a variety of other ways of knowing such as embodying a therapy practice and attending to the experiences that emerge in our learning an EBP such as shame. Empirically supported treatment lists are about "knowing that" and not a "knowing how".

Another way to understand "knowing how" is Merleau-Ponty's proposal "that perception and understanding are based in our capacity for picking up, not rules, but flexible styles of behavior" (Dreyfus & Dreyfus, 1986, p. 5). To embody a new approach, our participants tell us they must employ a different use of self that avoids shame and other challenges. Here then is the tension in our findings. Participants must both accept and learn the rules while remaining confident that they will eventually be proficient enough in an EBP to ignore the rulebook when needed. This is a complicated emotional terrain to navigate as reported by our participants. The complexity of couple and family therapy tasks and the complexity of couples and families that present for therapy is what Dreyfus and Dreyfus refer to as unstructured tasks. These tasks present a "potentially unlimited number of possibly relevant facts and features and the ways these elements interrelate and determine other events is unclear" (p. 20). Unstructured tasks require a high level of skill and the kind of intent and focus that the research participants discussed. Incorporating a new EBP into their clinical practices can help them succeed, but not without temporary discomfort. Merleau-Ponty (1964, 2002) noted that we have a view from somewhere, a personal intent to be a more effective therapist with couples and families was an essential view for the participants in this research project.

The research participants' view or position was also essential for dealing with the learning challenges and more importantly helped to navigate the paradox of learning an EBP. That is, that it is an important step but not the final step because EBP "are fixed and explicit"; however, they do not "mirror the uncertain, nonstationary, unstructured world in which we live" (Dreyfus & Dreyfus, 1986, p. 44). The complexity of the tasks that couple and family therapists perform requires intent, a focus, and the accumulation and understanding of a lot of rules or skills. As Sprenkle and co-authors (2009) note, "therapists need models to give their work

coherence and direction" (p. 5) but a model is only a direction, not an end point. Therapists require the substantial skill development that EBP offers. Learning about an empirically supported treatment or common factors are both research-based ways to accumulate skills as a CFT but neither can sustain the ongoing development of a therapist. The question of whether to explore and learn an EBP is not as relevant as deciding what our view is, where we view from, and what our intent is for our work with couples and families. Learning an evidence-based practice can be an important means to support the development of couple and family therapists though cannot be the only resource that therapists use in their development.

As previously noted, much of the research about evidence-based CFT approaches have focused on the outcome of an intervention and occasionally on the experience of the patients themselves. There are a number of potential implications for this research, not the least of which is that CFTs "must attend to the results of RCTs for clinical, ethical, and legal reasons" (Persons & Silberschatz, 1998, p. 126). While historically driven by the empirical sciences, the focus on evidence-based practice is growing across all fields. Public funding and consumer interest is often influenced by what is deemed as an evidence-based practice at any given moment. CFTs may increasingly be asked to link their approach to evidence-based practices as a means to account for their work from an ethical and legal perspective, minimizing risk to themselves, their practice, and their employer. Understanding what the experience is of learning an evidence-based practice may provide insights to that process that are helpful for the training, development, and supervision of CFTs.

Couple and family therapists themselves may be seeking a better understanding of the process of learning an evidence-based approach. Evidence-based approaches may provide us with hints about how to proceed, be a guide or knowledge base for our practice, and engage us

with research in general. The present study promotes a research culture by engaging CFTs who are interested in and exploring the results of research in their own practice. This would contrast the research-practice gap that "plagues all clinical fields... (and is) particularly prevalent in [CFT]" (Sprenkle, 2002, p. 11). This gap has been noted as a combination of clinicians' interest in a "charismatic individual" (Crane, Wampler, Sprenkle, Sandberg, & Hovestadt, 2002, p. 76) who develops a model with little evidence to support it becoming popular on the workshop circuit and researchers who "sometimes disdain clinicians, fail to listen to the wisdom of good clinicians, and typically do not work hard at making their work clinically accessible" (Sprenkle, 2002, p. 11). This research directly engaged CFTs about their experience with research-based approaches to working couples and families. Therapists may see the results of this research as relevant to their practice and researchers may better understand engaging CFTs as central to their research.

**Limitations of this Study and Opportunities for Further Research**

This study has identified important links between therapists learning an EBP, the role of embodiment, experiences of shame, and the limitations of EBP. The small scale of the research, however, does not permit more general conclusions about couple and family therapists' experiences of EBP. A variety of methodological approaches is best to approach each of the experiences outlined in this paper. Kvale and Brinkman (2009) for example, discuss how survey techniques can be used to link with qualitative methods. A multi-pronged approach would further enhance the understanding of experiences of shame while learning an EBP, the strengths and limitations of EBPs for couple and family therapists, and further develop an understanding of the role of embodiment as a therapist is learning and using an EBP in their practice.

The use of IPA to conduct this research can be seen as both its limitation and its strength. Exploring therapists' experiences has developed an understanding of what happens when learning an EBP. The process of integrating an EBP, however, can be considered ongoing and long term. While challenging, it may be useful to examine and build on other longitudinal research about the development of therapists (e.g. Ronnestad & Skovholt, 2003), contrasting our results with those from methodologically different studies.

Our findings have also been affected by the characteristics of the participants. It is possible that volunteers differ their peers (Yancey, Ortega, & Kumanyika, 2006). Volunteers may be drawn to discuss a particular aspect of their experience, positive or negative. Of note for this research is the diversity of the experiences discussed; the sample did not repeat a singular experience but spoke about learning different therapies in different contexts with different (but thematically linked) experiences of similar processes.

Finally, there are characteristics of the research sample not outlined for reasons of confidentiality. These are important to consider and include but are not limited to socio-economic status, ethnic and racial identity, and sexual orientation. These limitations suggest the need for further research if the process of learning and EBP are to be better understood.

## Conclusion

While there is limited research about the experiences of therapists learning and using an EBP, the present study touches on a small part of what could potentially be a vast and growing area of academic research. It is surprising to see to what degree therapists are ignored in the research literature on practice especially that concerned with EBP. Exceptions are the research about Self-of-the-Therapist models (e,g, Aponte et al., 2009). Considering therapists as central to the success of training, supervision, and research requires epistemological approaches that

have the agility to construct more than one reality at a time and meaningfully engage with lived experiences. Evidence-based practices privilege technique over other dimensions of therapy (Fruggeri, 2011), which can be helpful for training but leaves both couples/families and therapists in a context-free void. The politics around EBP are complex and evolving as couple and family therapy continues as a field to justify systemic approaches to working with clinical issues (Sexton et al., 2011). EBPs can be useful tools for training, developing the field of couple and family therapy, engaging researchers and practitioners across health and mental health fields, and creating clinical effectiveness. We believe the efficacy of EBP will be determined by the degree to which therapists themselves are engaged in the application of manualized approaches and their personal challenges addressed.

## References

Allan, R., & Eatough, V. (2016). The use of Interpretive Phenomenological Analysis in couple and family therapy research. *The Family Journal, 4*(4), 406-414. doi: 10.1177/1066480716662652

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5*. Washington, D.C: American Psychiatric Association.

Angus, L., & Kagan, F. (2007). Empathic relational bonds and personal agency in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, *44*, 371–377. doi:10.1037/0033-3204.44.4.371

Aponte, H. J., Powell, F., Brooks, S., Watson, M. F., Litzke, C., Lawless, J., & Johnson, E. (2009). Training the person of the therapist in an academic setting. *Journal of Marital & Family Therapy*, *35*(4), 381-394. doi:10.1111/j.1752-0606.2009.00123.x

Avis, J. M., & Sprenkle, D. H. (1990). Outcome research on family therapy training: A substantive and methodological review. *Journal of Marital and Family Therapy, 16*(3), 241–264. doi: 10.1111/j.1752-0606.1990.tb00846.x

Bowen, M. (1978). *Family therapy in clinical practice.* New York, NY: Jason Aronson.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Cambridge, MA: Harvard University Press.

Brown, B. (2006). Shame resilience theory: A grounded theory study on women and shame. *Families in Society, 87*(1), 43-52.

Chao, Y.-H., Cheng, Y.-Y., & Chiou, W.-B. (2011). The psychological consequence of experiencing shame: Self-sufficiency and mood-repair. *Motivation and Emotion, 3*(2), 202-210. doi: 10.1007/s11031-011-9208-y

Coulter, S. (2011). Systemic family therapy for families who have experienced trauma: A randomised controlled trial. *British Journal of Social Work, 41*(3), 502-519. doi: 10.1093/bjsw/bcq132

Crane, D. R., Wampler, K. S., Sprenkle, D. H., Sandberg, J. G., & Hovestadt, A. J. (2002). The scientist-practitioner model in marriage and family therapy doctoral programs: Current status. *Journal of Marital and Family Therapy, 28*(1), 75-83. doi: 10.1111/j.1752-0606.2002.tb01175.x

Dearing, R. L., & Tangney, J. P. (2011) Introduction: Putting shame in context. In R. L. Dearing & J. P. Tangney (Eds.), *Shame in the therapy hour* (pp. 3-19). Washington, DC: American Psychological Association.

Diamond, G.S., Diamond, G., M., & Levy, S. A. (2013). *Attachment-based family therapy for depressed adolescents*. Washington, DC: American Psychological Association.

Dowling, E., Cade, B., Breunlin, D. C., Frude, N., & Seligman, P. (1982). A retrospective survey of students' views on a family therapy training programme. *Journal of Family Therapy, 4*(1), 61-72. doi: 10.1046/j..1982.00577.x

Dreyfus, H. L., & Dreyfus, S. E. (1986). *Mind over machine: The power of human intuition and expertise in the era of the computer*. New York, NY: Free Press.

Dreyfus, S. E. (2004). The five-stage model of adult skill acquisition. *Bulletin of Science, Technology and Society, 24*(3), 177-181.

Elliott, R. (1998). Editor's introduction: A guide to the empirically supported treatments controversy. *Psychotherapy Research, 8*(2), 115-125. doi: 10.1080/10503309812331332257

Flyvbjerg, B. (2001). *Making social science matter: Why social inquiry fails and how it can succeed again*. Oxford, UK: Cambridge University Press.

Fruggeri, L. (2011). Different levels of psychotherapeutic competence. *Journal of Family Therapy*, 34 91–105. doi: 10.1111/j.1467-6427.2011.00564.x

Gendlin, E. T. (1978). *Focusing*. New York: Everest House.

Gottman, J. M. (1999). *The marriage clinic: A scientifically-based marital therapy*. New York, NY: W. W. Norton.

Green, D., & Kirby-Turner, N. (1990). First steps in family therapy: A personal construct analysis. *Journal of Family Therapy, 12*(2) 139–154. doi: 10.1046/j..1990.00379.x

Hendrix, H. (1988). *Getting the love you want: A guide for couples*. New York, NY: H. Holt.

Johnson, S. M. (2004). *The practice of emotionally focused couple therapy: Creating connection*. New York: Brunner-Routledge.

Knistern, D., & Gurman, A. (1979). Research on training in marriage and family therapy: Status, issues and directions, *Journal of Marital and Family Therapy, 5*(3), 83-94.

Knistern, D., & Gurman, A. (1988). Research in family therapy training. In: H. Liddle, D, Breulin and R. Schwartz (eds.) *Handbook of Family Therapy Training and Supervision*, New York, NY: Guilford Press.

Kvale, S. & Brinkman, S. (2009). *InterViews: An introduction to qualitative research interviewing***.** Thousand Oaks, CA; Sage.

McCandless, R., & Eatough, V. (2010). "How can this person get me so wrong?": A qualitative study examining the self of the systemic training supervisor. *Human Systems, 21*(2), 208-236.

McCandless, R., & Eatough, V. (2012). 'Her energy kind of went into a different place': A qualitative study examining supervisors' experience of promoting reflexive learning in students. *Journal of Marital & Family Therapy, 38*(4), 621-638. doi: 10.1111/j.1752-0606.2011.00235.x

Merleau-Ponty, M. (1964). Sense and non-sense. Evanston, Ill: Northwestern University Press.

Merleau-Ponty, M. (2002). *Phenomenology of perception*. Hoboken: Routledge.

Mills, R. S. L. (2005). Taking stock of the developmental literature on shame. *Developmental Review, 25*(1), 26-63. doi: 10.1016/j.dr.2004.08.001

Minuchin, S. (1974). *Families and family therapy.* Cambridge, MA: Harvard University Press.

Nel, P. W. (2006). Trainee perspectives on their family therapy training. *Journal of Family Therapy, 28*(3), 307–328. doi: 10.1111/j.1467-6427.2006.00354.x

Nelson, M. M., Stanley, J. R., Funderburk, B. W., & Bard, E. (2012) Therapists' attitudes toward evidence-based practices and implementation of parent–child interaction therapy. *Child Maltreatment*, *17*(1), 47–55. doi:10.1177/1077559512436674

Obegi, J. H. (2008). The development of the client-therapist bond through the lens of attachment theory. *Psychotherapy Theory, Research, Practice, Training*, *45*, 431–446. doi:10.1037/a0014330

Orlinsky, D. E., & Ronnestad, M. H. (2005). *How psychotherapists develop: A study of therapeutic work and professional growth*. Washington, D.C.: American Psychological Association. doi:10.1037/11157-000

Orlinsky, D. E., Rønnestad, M. H., & Willutzki, U. (2004). Fifty years of process-outcome research: Continuity and change. In M. J. Lambert (Ed.), Bergin and Garfield's handbook of psychotherapy and behavior change (5th ed., pp. 307-390). New York, NY: Wiley.

Owen, J., Duncan, B. L., Reese, J., Anker, M. G., & Sparks, J. A. (2014). Accounting for therapist variability in couple therapy: What really matters? *Journal of Sex and Marital Therapy, 40*(6), 488-502. doi: 10.1080/0092623X.2013.772552

Persons, J. B., & Silberschatz, G. (1998). Are results of randomized controlled trials useful to psychotherapists?. *Journal of Consulting and Clinical Psychology, 66*(1), 126-135. doi: 10.1037/0022-006X.66.1.126

Rohrbaugh, M. J. (2014). Old wine in new bottles: Decanting systemic family process research in the era of evidence-based practice. *Family Process, 53*(3), 434–444. doi: 10.1111/famp.12079

Romdenh-Romluc, K. (2011). *Routledge philosophy guidebook to Merleau-Ponty and phenomenology of perception*. New York, NY: Routledge.

Ronnestad, M. H., & Skovholt, T. M. (2003). The journey of the counselor and therapist: Research findings and perspectives on professional development. *Journal of Career Development, 30*(1), 5-44. doi: 10.1177/089484530303000102

Sandberg, J. G., Knestel, A., & Schade, L. C. (2013). From head to heart: A report on clinicians' perceptions of the impact of learning Emotionally Focused Couple Therapy on their personal and professional lives. *Journal of Couple & Relationship Therapy, 12*(1), 38-57.doi: 10.1080/15332691.2013.750076

Sartre, J.-P. (1956). *Being and nothingness: An essay on phenomenological ontology*. New York: Philosophical Library.

Seligman, M. E. (1996). Science as an ally of practice. *American Psychologist, 51*(10), 1072-1079. doi: 10.1037/0003-066X.51.10.1072

Sexton, T. L., & Alexander, J. F. (2002). Family-based empirically supported intervention programs. *The Counseling Psychologist, 30*(2), 238-261. doi: 10.1177/0011000002302003

Sexton, T., Gordon, K. C., Gurman, A., Lebow, J., Holtzworth-Munroe, A., & Johnson, S. (2011). Guidelines for classifying evidence-based treatments in couple and family therapy. *Family Process, 50*(3), 377-92. doi: 10.1111/j.1545-5300.2011.01363.x

Shaw, R. L. (2001). Why use interpretative phenomenological analysis in health psychology? *Health Psychology Update, 10*(4), 48-52.

Skovholt, T. M., & Starkey, M. T. (2010). The three legs of the practitioner's learning stool: Practice, research/theory, and personal life. *Journal of Contemporary Psychotherapy, 40*(3), 125-130. doi: 10.1007/s10879-010-9137-1

Slife, B. D., Wiggins, B. J., & Graham, J. T. (2005). Avoiding an EST monopoly: Toward a pluralism of philosophies and methods. *Journal of Contemporary Psychotherapy, 35,* 83-97. doi: 10.1007/s10879-005-0805-5

Smith, J. A. (2011a) Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review, 5*, 9-27. doi: 10.1080/17437199.2010.510659

Smith, J. A. (2011b). "We could be diving for pearls": The value of the gem in experiential qualitative psychology. *Qualitative Methods in Psychology Bulletin, 12*, 6-15. The British Psychological Society.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretive phenomenological analysis: Theory, method, and research*. London: Sage.

Smith, R. H., Webster, J., Parrott, W., & Eyre, H. L. (2002). The role of public exposure in moral and nonmoral shame and guilt. *Journal of Personality and Social Psychology*, *83*(1), 138-159. doi:10.1037/0022-3514.83.1.138

Sori, C. F., & Sprenkle, D. H. (2004). Training family therapists to work with children and families: A modified Delphi study. *Journal of Marital and Family Therapy, 30*(4), 479-495. doi: 10.1111/j.1752-0606.2004.tb01257.x

Sprenkle, D. H. (2012). Intervention research in couple and family therapy: A methodological and substantive review and an introduction to the special issue. *Journal of Marital & Family Therapy*, *38*(1), 3-29. doi:10.1111/j.1752-0606.2011.00271.x

Sprenkle, D. H., Davis, S. D., & Lebow, J. (2009). *Common factors in couple and family therapy: The overlooked foundation for effective practice*. New York, NY: Guilford Press.

Staller, K. M. (2006). Railroads, runaways, & researchers: Returning evidence rhetoric to its practice base. *Qualitative Inquiry, 12*(3), 503-522. doi: 10.1177/1077800406286524

Stratton, P., Silver, E., Nascimento, N., McDonnell, L., Powell, G., & Nowotny, E. (2015). Couple and family therapy outcome research in the previous decade: What does the evidence tell us? *Contemporary Family Therapy*, *37*, 1–12. doi: 10.1007/s10591-014-9314-6

Talbot, N. L. (1995). Unearthing shame in the supervisory experience. *American Journal Of Psychotherapy*, *49*(3), 338-349.

Tangney, J. P., & Dearing, R. L. (2002). *Shame and guilt*. New York: Guilford Press.

Ungar, M. (2011). *Counseling in challenging contexts: Working with individuals and families across clinical and community settings*. Belmont, Calif: Brooks/Cole.

Ward, C. C., & House, R. M. (1998). Counseling supervision: A reflective model. *Counselor Education & Supervision*, *38*(1), 23-33. doi: 10.1002/j.1556-6978.1998.tb00554.x

Wendt, D. Jr. (2006). The unevaluated framework of APA's policy on evidence-based practice in psychology (EBPP). *The New School Psychology Bulletin, 4*(1), 89-99.

Willig, C. (2008). Introducing qualitative research in psychology: Adventures in theory and method. Maidenhead: McGraw-Hill Open University Press.

Yancey, A. K., Ortega, A. N., & Kumanyika, S. K. (2006). Effective recruitment and retention of minority research participants. *Annual Review of Public Health, 27*(1), 1-28. doi: 10.1146/annurev.publhealth.27.021405.102113

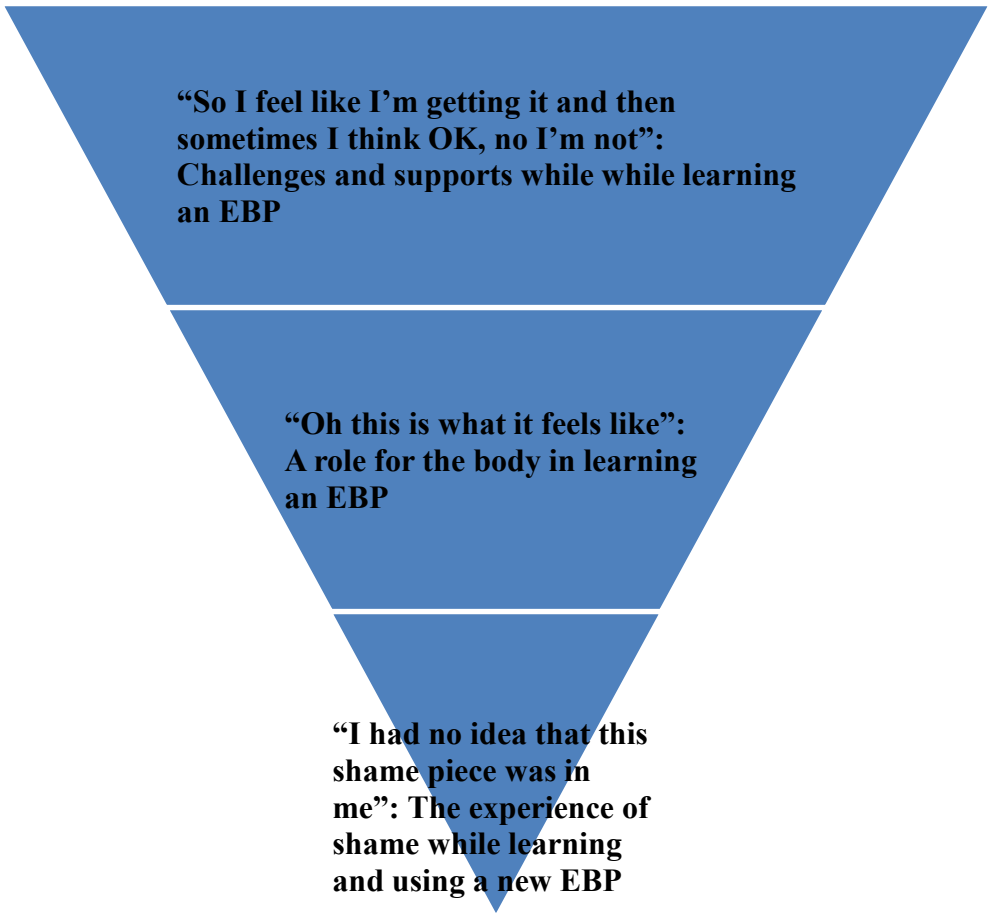


*Figure 1* Representation of Super-ordinate Themes

Table 1

*Description of research participants*

| Participant | Age | Gender | Location | Profession | Years in practic |
|---|---|---|---|---|---|
| Jessica | 40-49 | F | Canada | Counselling | 8 |
| Ken | 60-69 | M | Canada | Social Work | 40 |
| Cassandra | 40-49 | F | United States | Marriage and Family Therapy | 4 |
| George | 60-69 | M | Canada | Mental health professional | 33 |
| Kathy | 60-69 | F | Canada | Social Work | 20 |
| Louise | 40-49 | F | Canada | Counselling | 12 |
| Beth | 30-39 | F | Canada | Psychology | 10 |
| Helen | 40-49 | F | Canada | Social Work | 28 |
| Sally | 40-49 | F | Canada | Psychology | 20 |
| Raylene | 60-69 | F | United States | Marriage and Family Therapy | 25 |
| Mary | 30-39 | F | United States | Marriage and Family Therapy | 3 |
| Tina | 40-49 | F | Canada | Marriage and Family Therapy | 5 |
| Peter | 50-59 | M | United States | Marriage and Family Therapy | 25 |
| Eric | 30-39 | M | Canada | Counselling | 1 |