AN EXPLORATION OF COUNSELLING PSYCHOLOGY

TRAINEES’ PERCEPTIONS OF THERAPEUTIC COMPETENCE

A Thesis submitted to the University of Manchester for the degree of Doctor in Counselling Psychology (DCounsPsych)

by

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ABSTRACT
UNIVERSITY OF MANCHESTER
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Introduction: This is a study that explores how U.K.-based counselling psychology trainees perceive that they acquire the skills and abilities required for competent practice and their understanding of what it means to be competent practitioners. It outlines some of the factors that have influenced how therapeutic competence is defined in the current climate of NHS healthcare. It indicates that the training curriculum and the professional culture of their clinical placements influenced trainees’ perceptions and definitions of therapeutic competence. Literature Review: The literature review for the thesis covers two major areas. Firstly the sources for discovering how therapeutic competence is defined in counselling and psychotherapy are presented before considering the standards for competent practice in counselling psychology. Secondly the literature on trainees’ experiences in training and the qualitative studies related to trainees’ experiences of developing competence in training. Key themes from this review indicate that the field of counselling psychology has a commitment to its philosophical roots in humanism, personal development, and evidence-based practice. Methodology: A philosophy of qualitative analysis which introduces the grounded theory method is outlined. The assumptions, values and epistemology of the researcher are stated. The phases of the study which include: 1, Recruitment, 2. Pilot Interviews, 3. Data Collection, 4. Data Analysis, and 5. Developing the Theoretical Framework are described. A qualitative research approach based on constructionist assumptions was utilised in this study. Eleven trainee counselling psychologists were interviewed. The interviews were analysed using grounded theory analysis. Findings: This section includes a summary of two analytical phases which produced focused codes and a coding hierarchy. The results were two core categories: Perceptions of Competence and Defining Competence. Seven subcategories were also developed. Three of these subcategories, Coursework, Observer Feedback and Self-Reflections on Competence, were associated with the core category, Perceptions of Competence. Four subcategories – Clinical Experience, Reflexive Thinking/Self-Awareness, Theories and Models, and Supervision – were linked with the core category, Defining Competence. Discussion: Methods were discussed by which trainees perceive, acquire, and define therapeutic competence. The themes of self-perception of competence and self-confidence were identified as being relevant to therapeutic competence. Some of the vehicles for developing competence were highlighted including the idea that participants reflect on their experiences in training and clinical practice to develop competence. Some surprising results included a lack of evidence to suggest that trainees were thinking about the influence of pharmacology on treatment and some key professional issues (like multicultural competence and the social justice agenda) did not garner very much attention in the interviews. My contribution to knowledge is to inform training and therapist development by illuminating these processes in the context of U.K. based training programmes and representing the trainees’ voice in the literature on developing competence in counselling psychology.
DECLARATION

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INTRODUCTION

1.0 Background and Introduction to the Study
1.1 Defining Key Terms and Subjects
1.2 Personal Interest in the Topic
1.3 Overview of the Structure of the Thesis
1.4 Chapter Summary

1.0 BACKGROUND AND INTRODUCTION

This study is focused on counselling psychology trainees’ experience of developing a sense of their own competence. Researchers have acknowledged that the impact of training on counselling and counselling psychology trainees is an important but under researched area. (Grafanaki, 2010; Gross, 2005; Kamen, Veilleux, Bangen, VanderVeen, & Klonoff, 2010; Ridley & Mollen, 2011). Moreover, it has been observed that the trainees’ voice is under-represented in this literature (Gross, 2005; Kamen et al., 2010). Much of the published training literature is written for the benefit of educators and it employs a “top down” approach. Some of this “top down” literature will be reviewed in the next chapter.

McLeod (2001a) argues that counselling psychology practice is informed by a “bottom up” approach to research that is focused on the interpretation of subjective experience. This study purposes to add to the literature that informs training practice in counselling psychology by adopting a qualitative approach to examining the trainees’ experience of training to develop therapeutic competence. Although there is potential crossover between the literature that informs training practice in counselling and psychotherapy and counselling psychology, I would argue that it is important that counselling psychology continues to develop its own distinct body of training literature. I think this is especially true for the U.K. because much of the literature on training in counselling psychology is international literature – and most of that literature comes from the U.S.A., where professional psychology educators have published prolifically on the topic of developing competence in professional psychology (Fouad et al., 2009; Kaslow et al., 2007). This is important because counselling psychology in the U.K. is a distinct profession with its own professional identity, its own standards for professional training, and its own competency
requirements that have been established by the British Psychological Society (BPS) and the Health Care and Professions Council (HCPC).

Although there is a paucity of research on trainees’ experiences in training a handful of qualitative and mixed methods studies have been done (e.g. Fitzpatrick, Kovalak, & Weaver, 2010; Stahl et al., 2009). These studies are reviewed in the following chapter. Studies show that trainees perceive that they improve their skills and abilities during training (Hill et al., 2015). Few studies approach this topic with the specific intent to discover how trainees experience a sense of their own competence. I was only able to identify one U.K. based study that purposed to examine how trainees perceive that they develop a sense of therapeutic competence (Bennett-Levy & Beedie, 2007). This study focused on trainees’ perceptions of their experiences of developing skills in cognitive and behaviour therapy (CBT).

I would argue that there is a need to study therapeutic competence in counselling psychology from a much broader perspective that takes into account more than simply the acquisition of skills in a particular model of therapy. This is because training in counselling psychology has certain elements that distinguish it from training in other applied psychology disciplines. Counselling psychology in the U.K. is distinguished by philosophical and ethical principles that are rooted in humanism (Cooper, 2009; Martin, 2010; Strawbridge & Woolfe, 2010). Humanistic psychology is driven by a set of clearly defined ethics around valuing the clients’ primary experience and supporting the principles of client agency in therapy (Gillon, 2007; Warmoth, 1998). Counselling and psychotherapy practiced from a humanistic perspective eschew a directive, “therapist-as-expert” approach (Gillon, 2007; Mearns & Thorne, 2007). It is important to distinguish this philosophy of practice from other, more recent approaches to counselling and psychotherapy training and practice which prize a therapist’s technical knowledge of theory and their fidelity to manualised protocols for the implementation of empirically supported treatments (Beidas, Edmunds, Marcus, & Kendall, 2011; Polkinghorne, 1999).

The aim of this research is to fill a gap in the literature by exploring U.K.- based counselling psychology trainees’ understanding of therapeutic competence. This study uses data gathered from trainees’ self reports to suggest some of the factors that influence trainees’ perceptions of therapeutic competence and some of the ways they define therapeutic competence. It illuminates how a group of eleven counselling
psychology trainees understands therapeutic competence and the skills and abilities required to develop it.

This research has the potential to inform education and training in counselling psychology in several ways. Firstly, it illuminates the experiences of eleven participant trainees who are undergoing training to develop competence in counselling psychology within one of two training routes – one that is established by the British Psychological Society (BPS) as a professional qualification (Q-COP) and the other a university doctorate in counselling psychology. Two university-based training programmes were represented in this study and several trainee participants were enroute to gaining a professional qualification in counselling psychology through the BPS. This study offers a perspective on the experiences of a broad cross section of counselling psychology trainees. To my knowledge there are no other published studies that have taken this approach. Thus this research has the potential to lay the groundwork for further study on the context of training in counselling psychology in the U.K.

This study may help to improve training practice in counselling psychology because it may lead to an improved understanding of trainees’ experiences, laying a foundation for empathy between counselling psychology trainees and those who train and supervise them. Smith (2011) found that counselling students valued empathic tutors and supervisors, and they reported that the quality of these relationships enhanced their learning experiences. I suggest that the data from trainees’ self-reports may help to improve the student-tutor and supervisor-supervisee alliance, making trainees more willing to take academic and personal risks that deepen their experiences in training and further their professional development (Smith, 2011). I think this is important for counselling psychology trainees in the U.K. who have to negotiate a number of challenges in training including those already identified by Ronnestad and Skovholt (2003).

My study illuminates the unique processes by which these eleven trainees perceive that they acquire therapeutic competence, how they define it, and how they understand the significance of that learning. One of the benefits of this study might be that it highlights how trainees reflect on practice to develop competence. An enhanced understanding of this process may help to improve the quality of practice in counselling psychology. Quality assurance in counselling and therapy is predicated on the assumption that practitioners can reflect on practice to accurately assess their
competence, develop their competence and remain within the limits of their training and experience (Brosan, Reynolds, & Moore, 2008).

Belar (2009) has argued that self-assessment of competence is the foundation for individual development and lifelong learning in professional psychology. Belar’s argument suggests that self-assessment skills are fundamental to ethical practice and professional development in psychology. This is not a study about self-assessment but I would argue that there is some overlap between the skills required to accurately assess one’s own competence and those required to reflect on practice. Trainees’ capacity for reflecting on practice is a key skill that is developed during training and one benefit of this research is that it suggests a framework for how these skills might be developing in this group of counselling psychology trainees.

Schon (1987) (1983) and Thompson and Thompson (2008) have successfully argued that reflection on practice is a key process for developing professional competence. Reflexivity in therapeutic practice demands, among other things, that the practitioner understands their role in the therapeutic process. Reflexivity or reflective practice is a key outcome for training in counselling psychology (Martin, 2010). McLeod (1992) argues that advanced training in counselling should produce students who have developed the skills to accurately assess their competence. This thesis argues that an enhanced understanding of how a developing practitioner uses reflexivity to reflect on his or her therapeutic practice to enhance competence helps to inform education, training and professional development in counselling psychology. This research is the study of the process that is supposed to produce the outcome: a well-trained, competent counselling psychologist who has developed the relevant knowledge, therapeutic competencies, and ethical attitudes needed to distinguish the practice of counselling psychology from other applied disciplines and to make a unique contribution to the treatment of clients.

Some previous studies of trainees’ experiences in training have examined therapist development and the development of expertise in therapy (e.g. Orlinsky et al., 1999; Ronnestad & Skovholt, 2003; Skovholt, Ronnestad, & Jennings, 1997). A few large scale studies have looked at trainees’ perceptions of their own development (Bennett-Levy & Beedie, 2007; Hill et al., 2015; Kamen et al., 2010). Some small scale studies have focused on trainees’ experiences in training (e.g. Hill, Sullivan, Knox, & Schlosser, 2007; Pascual-Leone, Rodriguez-Rubio, & Metler, 2013). Those studies that study trainees’ specific experiences of developing competence are few in
number. One such study, Bennett-Levy and Beedie (2007), focused on trainees’ experiences of acquiring skills in CBT. This study is different to my study because my primary aim has been to identify trainee counselling psychologists’ perceptions of acquiring the full range of competencies needed for effective practice in counselling psychology.

Because trainee competence is an under-researched topic that is not easily defined, I sought a methodology to explore meaning and interpret dynamic processes. I chose to employ the grounded theory method, a qualitative methodology that is uniquely suited to building theory from the ground up (Morrow, 2007). My purpose in this study is to represent the trainees’ voice in the literature and to discover how trainee counselling psychologists perceive that they develop competence and how they understand it. Because this is a grounded theory study, I did not do a specific literature review prior to the study. Some engagement with the literature was unavoidable, however, because of my role as a research student. I sought to keep an open mind throughout data collection and analysis and took measures to enhance the transparency of this study. These measures are outlined in Chapter Three.

Martin (2010) observes that counselling psychology has adopted the scientist practitioner and the reflective practitioner model of training. He further asserts that counselling psychologists are trained to be evidence-based practitioners. Belar (2009) maintains that scientific practice has historically been the standard in the psychology profession. The current standards for psychological treatment in the United States and the United Kingdom are based on evidence from controlled clinical trials from which treatment guidelines for specific psychological disorders have been established (e.g., NICE, 2009). These therapies are commonly referred to as empirically supported treatments (Chambless et al., 1998; Chambless & Ollendick, 2001).

**Historical Factors**

Research in therapy outcomes proliferated in response to growing demands from third-party payers in mental health services for evidence that psychotherapy works (Strupp, 1986). Pressure was brought to bear on the profession of psychology to validate psychological treatments using research evidence from controlled clinical trials. The English Department of Health commissioned a review of the evidence to determine what psychotherapies are effective for which patients (Roth & Fonagy, 1996). The American Psychological Association (APA) commissioned the Division
12 task force to evaluate the evidence for empirically supported psychological treatments. A list of empirically supported treatments was collated and published (Chambless et al., 1998; Chambless & Hollon, 1998). The decision to formulate this list sparked controversy in the profession of psychology. A number of articles were written supporting both sides of the argument. Elliott (1998) has summarized and presented those arguments in his introduction to the controversy. For example, opinions differ as to the quality of that evidence and the relevance of empirically supported treatments to clinical practice. It was noted that almost all of the treatments on the list were forms of cognitive and behaviour therapy (CBT). Some have argued that because the criteria for inclusion were based on evidence from controlled clinical trials, other therapies were marginalized (Bohart, O'Hara, & Leitner, 1998; Westen, Novotny, & Thompson-Brenner, 2004). Garfield (1996) further argues that evidence-based guidelines ignore decades of clinical research on the role of the common factors in psychotherapy. Despite the controversy, on the strength of evidence from controlled clinical trials, cognitive and behaviour therapy (CBT) became the treatment of choice for many forms of psychological disorders in the United States and the United Kingdom.

In the U.K., the National Institute for Health and Clinical Excellence (NICE) issued guidelines between 2004 and 2011 that strongly supports the use of CBT for depression and anxiety (Clark, 2011). The U.K. government’s initiative for Improving Access to Psychological Therapies (IAPT) was commissioned in 2007. Clark (2011) explains that a massive programme for recruitment and training of psychological practitioners was undertaken between 2007 and 2014 to implement the NICE Guidelines. These recruits were initially trained to deliver CBT interventions but the initiative has been widened to include other therapies (Pearce, Sewell, Hill, & Cole, 2012).

1.1 DEFINING KEY TERMS AND SUBJECTS

Counselling and Psychotherapy
In this thesis I use the terms “counselling” and “psychotherapy” interchangeably to refer to “a range of talking therapies delivered by trained practitioners” (BACP, 2015).

Competencies of the Practitioner
For the purpose of this research there is no practical difference between the competencies for counsellors and counselling psychologists. I draw equally from the bodies of literature on competence in counselling and counselling psychology. However, there are different theoretical traditions within counselling and psychotherapy. The therapeutic competencies required within these theoretical traditions are distinct.

Research in competence in counselling and psychotherapy may focus on a therapist’s ability to facilitate traditional insight-oriented therapies such as psychodynamic or humanistic therapies, or it may focus on therapists’ knowledge of the protocol required to competently deliver empirically supported therapies, most of which are cognitive and behavioural therapies. For the purpose of clarity, I differentiate between “traditional counselling and psychotherapy” research and research that validates “empirically supported treatments”.

Professional Psychologist
The term “professional psychologist” is used mainly in the North American literature, some of which was reviewed for this thesis. My reading of this literature indicates that the term “professional psychologist” may refer to any psychologist who is a licensed and working professional. A “professionally trained” psychologist is a graduate of a professional school of psychology and this is the usual education pathway for practitioner psychologists in the U.S.A.

Therapeutic Competence
Research that determines “what works for whom” has changed the landscape for the delivery of mental health services (Roth & Fonagy, 1996). Evidence-based practice establishes the standards for quality in the psychology profession. Corrie and Calanan (2001) state: “Therapeutic decision making has moved from intuition and precedent towards the use of research findings and empirical evaluation” (p. 135) In a research context, therapist competence is part of a fidelity package for internal validity (Santacroce, Maccarelli, & Grey, 2004). Here therapeutic competence is defined as the ability of the therapist to deliver an empirically supported treatment in the manner in which it is intended to produce maximum effect. Thus Brown, Craske, Glenn, Stein, and Sullivan (2013) and Shaw and Dobson (1988) argue that in the therapy situation, the therapist acts as an agent of psychological change. The assumption here
is that if the therapist is competent to deliver the treatment in the way in which it was intended then, all other things being equal, constructive psychological change will occur (Fairburn & Cooper, 2011).

Research into competence in counselling and psychotherapy suggests that competence is a developmental construct that is difficult to define. Shaw and Dobson (1988) and Milne, Baker, Blackburn, James, and Reichelt (1999) observe that there is a long-standing sense of uncertainty about the interactions that facilitate psychological change. Margison et al. (2000) and Shaw and Dobson (1988) have observed that therapeutic competence is also difficult to measure.

Schon (1987) identifies a sphere of competence that encompasses the ability of the professional to systematically apply technical knowledge (theory and technique) to the solving of problems. Schon’s definition could be applied to the notion of intervention competence in psychotherapy, which relies on the therapist’s technical knowledge of the model (Sharpless & Barber, 2009). Intervention competence is based on the technical knowledge of the therapist, which means that he or she adequately understands the theory and has the necessary skills to implement the appropriate interventions (Barber, Sharpless, Klosterman, & McCarthey, 2007). General therapeutic skills such as the ability to engage in relationships and communicate with clients are implicit within this definition of competence (Roth & Pilling, 2007). Knowledge of theory is a key element of intervention competence. For example, in CBT the therapist is supposed to be able to structure a CBT session and formulate the client’s concerns within a CBT framework (Roth & Pilling, 2007). Intervention competence is assessed to an external standard, ideally a validated measure of therapists’ facilitative behaviours such as the Cognitive Therapy Scale-Revised (Blackburn, James, Milne, & Reichelt, 2001).

Several researchers have suggested that there is more to therapeutic competence than adherence and technical skill (Cross & West, 2011; Margison et al., 2000; Sharpless & Barber, 2009). There is also an element of therapist competence that requires a set of complex cognitive skills and an ability to use those skills to reflect on practice (Stoltenberg, 2005). Roth and Pilling (2007) suggest that there are certain cognitive schemas or meta-competencies that are essential to competent practice. These authors describe meta-competence as understanding “when and when not to apply the model”. Ridley, Mollen, and Kelly (2011) argue that meta-competence is a complex cognitive skill that involves reflecting on one’s thoughts,
Skills, and experience. These authors suggest that self-reflection helps to develop therapist expertise. Skovholt and Jennings (2005) make a similar argument. It may be that one of the ways practitioners develop meta-competence is by reflecting on practice.

Schon (1987) identified a second sphere of professional competence that represents the professional’s ability to respond to unique and uncertain situations in practice where the “problems” are not clearly structured or easily defined. Schon argues that this second sphere of competence is the purview of professional artistry and an indispensable component of professional competence. In my view, Schon’s second sphere of influence can be compared to a dimension of competence in counselling and psychotherapy that Barber et al. (2007) call global competence. Sharpless and Barber (2009) define global competence as a form of therapeutic competence that incorporates practical wisdom. Global competence presupposes the therapists’ ability to integrate knowledge, skills, and attitudes to engage in judicious clinical decision-making (Epstein & Hundert, 2002). Global competence requires skillfulness, which is a multi-dimensional concept that involves therapists’ ability to attend to and integrate relevant information to conceptualize a client and use that understanding to inform a course of treatment (Schaffer, 1982; Shaw & Dobson, 1988).

Technical competence includes discrete skills, such as therapist behaviours, which can be measured using external criteria, and a more complex set of skills such as those that help the therapist to conceptualize a client or to decide whether to use an intervention during a course of therapy (Margison, 2000; Shaw & Dobson, 1988). Margison (2000) defines skillfulness as “the ability to adapt so as to stay broadly within a treatment paradigm even under unfavorable conditions” (p. 125) She calls this realm of practice clinical judgment. She further observes that skilled performance and clinical judgment is even more difficult to measure than adherence or competence.

Another dimension of competence includes the therapist’s ability to cultivate a growth-facilitating relationship with a client (Mearns & Thorne, 2007). Such competencies involve the therapist’s understanding of theory and the therapeutic process, and also the ability to be genuine, empathic and to demonstrate positive regard towards the client (Mearns & Thorne, 2007; Rogers, 1957). These relational competencies are especially important for the practice of insight-oriented therapies.
where the therapist enters into a relationship with the client to help the client facilitate psychological change (Mearns & Thorne, 2007).

Counselling Psychology

Counselling psychology got its start in the U.K. in 1982 as a special interest group within the British Psychological Society; it attained divisional status in 1994 (BPS, 2014). The discipline of counselling psychology emphasizes its philosophical roots in humanism (BPS, 2001; Orlando & Van Scoyoc, 2009; Strawbridge & Woolfe, 2010). Morrow (2007) Connolly et al. (2014) and Martin (2010) point out that humanistic philosophy and the ideals of social constructionism are embedded in counselling psychology training, research, and practice. Warmoth (1998) points out that humanistic psychology advanced two key principles:

1. All knowledge represents an interpretation of human experience and so individual experience is counted as valid data.
2. Appreciation of an individual’s uniqueness and the value of completely understanding that person, especially in clinical and growth facilitating relationships.

Warmoth (1998) further asserts that humanistic psychology advocated the tenets of self-actualization, which attended to the possibility of individual self-realization, and synergy, which focused on the potential for human fulfillment within organizations and communities.

The BPS guidelines for the practice of counselling psychology emphasize a distinct philosophical perspective that is rooted in the primacy of the therapeutic relationship (BPS, 2009b). The philosophy of counselling psychology has much in common with Rogers’s (1951, 1957) person-centred framework. In accordance with the tenets of humanistic psychology and philosophy, the discipline of counselling psychology prioritizes the subjective and intersubjective experiences of the client and the therapist in the context of the therapeutic relationship (Warmoth, 1998). The principle of client agency is a key value in counselling psychology. The counselling psychologist seeks to cultivate egalitarianism in their practice along with the attitude that clients are the experts in their own change processes (Gillon, 2007).

Counselling Psychology Trainees
Walsh, Frankland, and Cross (2004) summarize the requirements for education and training for U.K. counselling psychologists. These authors say that counselling psychologists working in the U.K. are required to have at least three years of postgraduate training. Qualifications for entry into the profession can be obtained through the BPS independent route or through graduate training courses in professional psychology at BPS and HCPC accredited training sites. Training in counselling psychology includes coursework that teaches theory, principles of scientific research and practice in counselling psychology (UOM, 2011).

Handelsman, Gottlieb, and Knapp (2005) suggest that trainees are socialized into a professional culture through the training process as key philosophical principles and cultural traditions are transmitted. Knowledge of humanistic principles and traditions is a hallmark of counselling psychology practice and an expectation for competence in the discipline (HCPC, 2012b). Counselling psychologists are also expected to demonstrate a commitment to counselling psychology ethics and values (BPS, 2001; HCPC, 2012a). Connolly et al. (2014) suggest that these values and ethics distinguish the practice of counselling psychology in the U.K.

Martin (2010) lists five common features of counselling psychology training. These include:

1. Psychological knowledge (study of mind and behavior)
2. Social and developmental psychology (focus on being informed by the client’s context)
3. The philosophy of values and ethics (emphasis on subjectivity and intersubjectivity)
4. Holistic training and practice
5. The scientific method and critical evaluation of research

Cooper (2009) summarizes some of the key principles and traditions relevant to counselling psychology. These include:

1. A focus on the therapeutic relationship
2. Prioritization of the client’s subjective and intersubjective experience over the therapist’s observations or a diagnostic label
3. A commitment to empower clients and avoid establishing hierarchical relationships with them
4. A commitment to anti-discriminatory practice

To achieve these competences counselling psychologists require well-developed interpersonal skills, an understanding of diversity, knowledge of humanistic psychology, high levels of self-awareness, and skills in relating personal and interpersonal dynamics to the therapeutic context (BPS, 2001, 2009b).

**Evidence-Based Practice**

The BPS (2009a) states that counselling psychologists are expected to be competent evidence-based practitioners. Therapeutic competence in this context requires therapists to be capable scientist-practitioners, having combined their abilities to engage in and to evaluate research with their skills in clinical decision-making (Shapiro, 1985; Spring, 2007).

The definition of evidence-based practice in psychology is derived from the practice of evidence-based medicine (Collins, Leffingwell, & Belar, 2007). Spring (2007) defines evidence-based practice as a “three legged stool” that ties together the best possible research evidence, the therapists’ clinical expertise, and patient values, preferences, characteristics and circumstances. Collins, Leffingwell and Belar (2007) define the best research evidence as the most recent and most efficacious treatment. These authors define clinical expertise as accuracy in diagnosis, and patients’ values as the beliefs, expectations and concerns they bring to the clinical encounter. Shaw and Dobson (1988) and Fairburn and Cooper (2011) define the term “skillfulness” as therapist adherence and therapist competence. Spring (2007) explains that the primary skill in the evidence-based practice framework is clinical decision-making or clinical reasoning which is the means by which the therapist brings together all three of the defining elements to produce the best possible outcomes for clients.

**1.2 PERSONAL INTEREST IN THE TOPIC**

My interest in this topic began when I performed a case study reflecting on my own practice using a videoed fitness to practice evaluation. This was an assessment conducted during my training programme that required a trainee to deliver a person-centred counselling session before undertaking work with clients. The fitness to
practice evaluation is conducted with a videoed piece of work of a trainee in the role of a therapist with a colleague in the role of a client. The class evaluated one another’s competence using the Person-Centred and Experiential Psychotherapy Scales (PCEPS) that were designed to measure a therapist’s skill in delivering a counselling session that is consistent with person-centred and experiential practice (Freire, Elliot & Westwell, 2011). This videoed assessment is ultimately evaluated by one of the tutors before a trainee can begin their work with clients.

After passing the assessment I began to develop an interest in reflecting on my practice to assess my strengths and weaknesses as a therapist. For one of my assignments, I experimented with a method of self-supervision in which I reflected on my own fitness to practice video and scored my own performance as a therapist using the (PCEPS) (Freire, Elliott, & Westwell, 2011). Learning to use the scales helped me to understand the criteria for competence and scoring my own practice helped me to discover my strengths and weaknesses as a person-centred practitioner. In my estimation, this self-supervision exercise taught me more than the feedback I received from those who had observed my practice and remarked on my competence.

This experience deepened my interest in self-assessment and formative learning. Through further reading I became acquainted with the literature on therapist development and trainees’ experiences of training (e.g. Ronnestad & Skovholt, 2003). I learned from my reading and my own personal experience that competence develops with time and continues to develop over the span of one’s professional career.

I began to ask myself what it means to be competent at this stage of my training? I understood that competence measures such as the PCEPS were evaluating aspects of my skills and abilities, but I wondered how else competence might be understood? I became curious about other trainees’ perspectives on therapeutic competence in counselling psychology.

**Reflexive Statement**

Self-reflexive positioning requires that researchers demonstrate that their own assumptions are not unquestioned (Kobayashi, 2003). “Bracketing interviews” are one way of documenting the researchers’ prior beliefs that might influence the research. Before beginning to collect my data, I participated in a bracketing interview with a colleague who used my own questions to interview me. A review of my bracketing interview suggests the following assumptions, values, attitudes, and beliefs:
1. I place a priority on the therapeutic relationship. I assume the most important skill in counselling is the ability to establish rapport and create an alliance with a client.

2. My definition of therapeutic competence refers to the following skills and abilities: self-awareness, a caring attitude, attentiveness to the client, logic, and systematic, analytical thinking.

3. I believe that competence is a developmental concept. I accept my own developmental phase as a trainee therapist, but some of my comments are self-deprecating, which indicates that I have some doubt about my own competence.

4. I believe that I have learned the most from reading about theory, doing research, reflecting on practice, and developing a sense of identity as a therapist.

5. My formative learning needs include focusing more on what it is like to work as a psychologist, exploring what kind of specialties are out there, and training in how to do therapy – especially cognitive and behaviour therapy – and linking theory with practice.

6. My challenges in training include juggling research assignments and placements along with my personal responsibilities. I feel I do not have enough time to reflect on practice.

My assumptions, attitudes, and beliefs have no doubt affected this study. In my bracketing interview I describe my practice as relational. This means that during training I focused on building my interpersonal and communication skills. I knew I needed to learn skills to implement a model of therapy, but it seemed more fundamental to learn how to relate to my clients. This may be because one of the most important skills I had to develop in my previous employment with adolescent substance misusers was my ability to engage these clients who did not often self-refer.

My identity as a trainee counselling psychologist is affected by my age and life circumstances. I am a white, middle-aged woman who left higher education seventeen years prior to entering professional doctorate training. My learning curve has been a steep one. I perceive that my lack of confidence as a student and lack of experience as a therapist and a clinician has some influence over my choice of this
topic. I wanted to address my formative learning needs and to know how to become more competent in my practice.

I have a strong interest in personal development and spiritual practice. I had been in personal therapy for a number of years as part of my training for my first degree in psychology. It is my belief that cognitive and behaviour therapy can be very useful in relieving symptoms of psychological distress, but for me therapy was about more than just relieving symptoms. It was a personal journey in which I gained insight and developed myself both personally and professionally.

I suggest that my constructivist epistemology influenced my findings and my conclusions in two ways:

1. My constructivist orientation motivated me to code the data to discover basic processes such as the idea of being/becoming competent (Glaser, 2009). I think this orientation influenced how I developed the theory.

2. My constructivist orientation heightened my awareness to the influence of context. This perspective helped to enhance my core category, perceptions of competence.

I am aware that my early hunches about theory were influenced by my values as a social constructionist. One might also question whether these early hunches could have exerted an undue influence on my analysis. Maybe I was looking to impose social constructionist theories onto the data. This question is not easily answered and presents a challenge for every qualitative researcher.

Grounded theorists are not permitted to simply apply pre-existing theory to the data (Fassinger, 2005; Glaser & Strauss, 1967). The prevailing view within grounded theory is that theoretical categories must always earn their way into the analysis (Charmaz, 2006). Two methodological procedures within grounded theory, delaying literature reviews until after the analysis is completed and applying constant comparative methods, guard against “forcing” the data into preconceived categories (Charmaz, 2006; Fassinger, 2005).

Grounded theory methods require the researcher to stay close to the data. Hunches are fine and even to be encouraged within a constructivist paradigm (as long as the researcher remains reflexive and transparent about them), but successful grounded theorists needs to be able to hold their guesses to one side to remain open to all of the theoretical possibilities until the coding process is completed (Charmaz, 2006; Cutcliffe, 2000; Fassinger, 2005).
1.3 THESIS OVERVIEW
This thesis consists of five chapters, including this introductory chapter. In this introduction I provide a context for the study by introducing myself to the reader and outlining some of the main themes in the research. The second chapter reviews definitions of psychotherapy and therapeutic competence, the literature on training to develop therapeutic competence and graduate trainees’ experiences of psychotherapy training. The third chapter begins by stating the research question that guides this study. It goes on to explain my methodology and gives details about my research design including procedures for data collection and analysis. It outlines the steps I took to conduct a transparent and ethical study. The fourth chapter reports my findings. The fifth chapter reflects on the findings to answer the research question. The sixth chapter concludes the thesis and contains recommendations for further research.

1.4 CHAPTER SUMMARY
This chapter has introduced the research by outlining some of the main themes including therapeutic competence, evidence-based practice, counselling psychology training, and practice. It provides a context for the study by outlining some of the factors that have influenced how therapeutic competence is defined in the current climate of NHS healthcare. It discusses themes that are relevant to the delivery of mental health services in the United States and the United Kingdom. It reflects on my personal interest in the topic and on my values and assumptions as a researcher.
2

LITERATURE REVIEW

2.0 Introduction
2.1 Defining Therapeutic Competence in the Counselling and Psychotherapy
2.2 Defining Competent Practice in Counselling Psychology
2.3 Trainees’ Experiences in Training
2.4 Chapter Summary

2.0 INTRODUCTION

Purpose
This study is informed by literature that explores the following issues:
1. How therapeutic competence in defined in counselling and psychotherapy
2. The understanding of competent practice in counselling psychology
3. The experiences of counselling and counselling psychology trainees in training

This chapter is structured in the following way. Section 2.1 reviews how therapeutic competence is defined in the literature in counselling and psychotherapy. Section 2.2 explores perspectives on competent practice in counselling psychology. Section 2.3 reviews the literature that explores trainees’ experiences in training. Section 2.4 contains a chapter summary.

Procedures
In keeping with the tenets of the grounded theory method, this review was conducted after data collection and analysis was completed. Thus the review identified published literature related to the themes trainees had already highlighted.

I began this review by looking at previously identified studies that were comparable to my own. I examined the bibliographies of these studies to identify some of the key themes. I widened the scope of the search by querying the databases PsychInfo and MEDLINE. I did not apply any date parameters in these searches. I investigated the databases using the following key terms: competence in counselling and psychotherapy, competence in counselling psychology, professional competence in psychology, training in counselling psychology, and assessment of competence in professional psychology. This search identified literature that pertains to how psychology is practiced in the United States and the United Kingdom. I draw from U.S.-based literature for this study because American authors have written extensively on professional competence in psychology. The US literature is relevant
to UK practice for two main reasons: counselling psychology in the two countries shares common historical and philosophical traditions, and the flurry of research on empirically supported treatments in psychology first gained momentum in the US (N.J.B. Kaslow et al., 2007; Strawbridge & Woolfe, 2010). This research has had an impact on best practice guidelines in the U.K. (Roth & Pilling, 2008).

**Background for the Literature**

There are key differences between the U.S.A. and the U.K. in terms of the structure and training of psychologists. Readers should be introduced to some of these differences to enhance their understanding of this literature. The following information on graduate training in the U.S.A. has been taken from Stein and Lambert (1995).

U.K. counselling psychology trainees are in a phase of training that is roughly equivalent to that phase of professional development in the U.S.A. known as the practicum. Practicum training in the U.S.A. refers to fieldwork (approximately 500 hours) that is completed alongside doctoral coursework. In the U.S.A. trainees who finish their coursework and complete practicum training proceed to the next level of professional development, the post-doctoral internship. Once the internship is completed, doctoral candidates must pass the Examination for Practice in Professional Psychology (EPPP). A license to practice psychology in the U.S.A. is granted by the government of the state in which the psychologist aims to practice.

### 2.1 DEFINING THERAPEUTIC COMPETENCE IN COUNSELLING AND PSYCHOTHERAPY

Polkinghorne (1999) observes that there are two distinct approaches in the counselling and psychotherapy research. He states that traditionally, psychotherapy has used a collection of healing practices that are primarily concerned with promoting self-awareness in clients. He further distinguishes more recent forms of psychotherapy as manual-based or empirically-supported treatments (e.g. Chambless et al., 1998).

In my reading of the literature I have seen that these two traditions can be distinguished in the following ways:

1. Research conducted within philosophies of practice that either emphasize specific factors of change, such as model of therapy or the technique of the therapist,
or non-specific factors of change that are common to all therapies, such as the quality of the therapeutic relationship

2. Philosophies of practice that focus on either facilitating clients’ self-awareness and self-knowledge or on how to alleviate symptoms

It appears from my reading of the literature that these philosophies are usually expressed in mutually exclusive terms and they are not easily integrated (Persons & Silberschatz, 1998).

Understanding the difference between these philosophies is important because they influence the nature of the competencies that are expected from the therapist. Those researchers who are aligned with empirically supported treatments hold that specific factors (including “specialist” or “technical knowledge”) are the primary catalysts for constructive psychological change in clients. They believe ‘the therapist functions as an agent of psychological change,’ as the literature often describes their perspective (e.g. Brown et al., 2013). These researchers emphasize the technical competence of the therapist and therapist technique that relies on a large body of well-supported research. The type of therapy promulgated by this camp of researchers, cognitive and behaviour therapy (CBT) is the most highly recommended form of therapy for the treatment of specific disorders (Fairburn & Cooper, 2011). For the purpose of clarity, I am calling this camp of researchers the “empirically supported treatment” group. The literature published within this camp uses the term “therapy”, or “psychotherapy”, mainly to refer to CBT that is delivered according to the specifications of treatment manuals used in randomized clinical trials (RCTs). Some examples of studies from the empirically supported treatment group include the following: Brown et al. (2013), Sburlati, Schniering, Lyneham, and Rapee (2011), Shaw et al. (1999), and Chambless et al., (1998).

I borrow directly from Polkinghorne (1999) to name the other camp of researchers the “traditional psychotherapy” researchers. Unlike the empirically supported treatment camp, traditional psychotherapy researchers emphasize that the client rather than the therapist, is the agent of psychological change. A body of research done by Rogers and his colleagues supports this approach to therapy. Truax and Mitchell (1971) and Truax and Carkhuff (1967) review this body of research. Traditional psychotherapy researchers subscribe to a philosophy of practice that
considers non-specific factors (such as the therapists’ relational skills and ways of being in relationship) to be primary catalysts for constructive psychological change. Some examples of researchers who subscribe to this philosophy include Fielder (1953) and (Rogers, 1951; Rogers, 1957).

A third group of researchers who study outcomes in counselling and psychotherapy publish another body of literature, a subset of which has become known as “common factors” research (Rosenzweig, 1936). Common factors research supports the idea that the therapeutic relationship contributes more to therapy outcomes than either therapist model or technique (Lambert & Barley, 2001). Common factors researchers suggest that the therapeutic relationship accounts for approximately thirty percent of the variance in outcomes while therapy model and technique only account for about fifteen percent of the variance (Lambert & Barley, 2001). These researchers attribute the variance in therapy outcomes to client factors and extra therapeutic factors common to all therapy situations (Lambert & Barley, 2001). Thus, common factors researchers argue that non-specific factors contribute more to the therapy situation than specific factors, including the technical knowledge of the therapist and the model of therapy. This argument contradicts the views of the empirically supported treatment group (Garfiled, 1996).

The relational skills and ethical attitudes demanded of therapists using traditional psychotherapy approaches are aligned to humanistic models of therapy (Gillon, 2007; Mearns & Thorne, 2007). Gillon (2007) and Mearns and Thorne (2007) emphasize that person-centred therapists should examine their values to create a “safe therapeutic space” for clients to explore their emotions.

In contrast with the philosophy of practice of empirically supported treatment researchers, traditional psychotherapy researchers who are aligned with the humanistic tradition eschew the power differential created in the therapeutic relationship when the therapist aims to “treat” the client. In humanistic therapies the client, not the therapist, is considered to be the “agent” of change (Gillon, 2007). Traditional psychotherapy researchers support “non-directive” or “client-led” approaches to therapy (Rogers, 1951). In this model of therapy, the quality of the therapeutic relationship and the nature of the work are characterized by therapist-held ethical attitudes and ways of being in relationship that create the optimal conditions for change (Rogers, 1951, 1957; Truax & Carkuff, 1967). Rogers (1957) argues that six conditions are necessary and sufficient for constructive personality change to
occur. Three of these are known as the core conditions of empathy, congruence, and unconditional regard.

Researchers from both camps acknowledge one another’s work, and they agree that the relationship between the therapist and the client is important. My interpretation of the literature, though, is that these camps have fundamental differences. For the empirically supported treatment group, the relational competencies of the therapist are all about forming an alliance with the client on the goals of treatment (Beck, Rush, Shaw, & Emery, 1979; Crits-Christoph et al., 1991; Gelso & Carter, 1985). On the other hand, for the traditional psychotherapy researchers the relational competencies of the therapist are located in their ethical attitudes and especially the value they place on completely understanding and esteeming the client’s experiences (Rogers, 1951).

2.2 DEFINING COMPETENT PRACTICE IN COUNSELLING PSYCHOLOGY

I have included both of the aforementioned research camps in this review because my understanding of the standards for competence in counselling psychology practice suggests that therapeutic competence includes knowledge of how to deliver evidence-based interventions (e.g. CBT for anxiety or depression) and how to implement models of therapy that are relational and insight oriented (BPS, 2001; HCPC, 2012b). Counselling psychology also emphasizes skills in research and the contribution that the evidence makes to the therapist’s understanding of competent practice. My reading of the literature has led me to conclude that counselling psychologists are expected to choose an approach to treatment that is based on their understanding of the evidence base (or what “works” according to research), their training and experience, and their practical knowledge of how to work with clients (BPS, 2001, 2008; HCPC, 2012b).

The HCPC (2012b) and the BPS (2001, 2008) require that counselling psychologists be able to apply traditional models of counselling and psychotherapy (including humanistic and psychodynamic therapies) to their work with clients. These associations further specify that counselling psychologists be competent evidence-based practitioners. These expectations suggest that therapeutic competence in UK counselling psychology combines two elements: the relational competencies prized by traditional psychotherapy researchers and a commitment to uphold the philosophy and
ethics of humanistic psychology with evidence-based practice (BPS, 2008; McLeod, 
2001a; Strawbridge & Woolfe, 2010). The reason I have chosen to review the 
literature in counselling and psychotherapy is that I believe it is important for the 
discipline of counselling psychology to remain distinctly associated with the 
humanistic tradition. I feel that it is important to highlight the skills and ways of being 
in a relationship because, in my opinion, these relational competencies are 
downplayed by researchers in the empirically supported treatment camp (McLeod, 
2001a).

**Counselling Psychology Ethics**
The U.K. profession of counseling psychology possesses a distinct identity with its 
philosophical roots in humanistic philosophy and the ideals of social constructionism 
(Orlans & Van Scoyok, 2009; Strawbridge & Woolfe, 2010; Connolly et al., 2014). 
The BPS Division of Counselling Psychology (2001) states that competence in 
counselling psychology is *grounded* in values. Cooper (2009) calls this philosophical 
principle “ethics in action” (p. 120). The counselling psychologist is distinguished by 
his or her personal commitment to the humanistic values of the profession (Cooper, 
2009). This implies that the discipline of counselling psychology has an exemplary 
professional culture. Professional psychology training develops ethical competence in 
trainees by creating a professional culture that is distinguished by ethical principles 
(De Las Fuentes, Willmuth, & Yarrow, 2005; Handelsman et al., 2005).

**Ethical Competence**
Competence is an ethical principle and an important element in therapist competence 
states that good practice requires psychologists to act in the best interests of clients, 
maintain good standards of practice, and practice within the limits of their 
competence. Standards of personal integrity are emphasized.

**Incompetence**
The definition of what it means for psychologists to be incompetent seems to 
be primarily related to the standards of ethical practice imposed by the BPS and the 
HCPC: a psychologist is incompetent when he or she is practicing outside the limits
of their competence (Keith-Spiegel, 1977). Overholser and Fine (1990) clarify four ways that psychologists can be incompetent:

1. Lack of knowledge and information regarding the scientific basis of the services they provide
2. Inadequate clinical skills (e.g. the ability to form a therapeutic relationship)
3. Lack of technical skills or an ability to use specialized procedures (such as diagnostic testing) or therapy techniques in the clinical setting
4. Poor problem solving skills and clinical judgment, which involves the ability to plan for and manage a variety of clinical problems

**Measuring Therapeutic Competence**

Traditional psychotherapy researchers have developed several measures of the therapeutic relationship (Freire & Grafanaki, 2010). One example is the Barrett-Lennard Relationship Inventory that aims to measure the client’s experience of the therapeutic relationship (Barrett-Lennard, 1986). Another includes the Scales for Therapist Accurate Empathy, Nonpossessive Warmth, and Genuineness (Truax & Carkhuff, 1967).

One measure of therapist competence that is used in outcome research is the strength of the therapeutic alliance (Crits-Christoph et al., 1991; Horvath & Luborsky, 1993). The therapeutic alliance refers to the level of collaboration between the therapist and the client on the goals of the therapy (Bordin, 1976; Crits-Christoph, Connolly-Gibbons, Hamilton, & Ring-Kurtz, 2011; Gelso & Carter, 1985). The therapeutic alliance has been shown to be an important predictor of the effectiveness of therapy (Horvath & Symonds, 1991; Horvath & Luborsky, 1993). Several measures of the therapeutic alliance are used in the research literature, two popular measures include the California Therapeutic Alliance Scales (Marmar, Weiss, & Gaston, 1989) and the Working Alliance Inventory (Horvath & Greenberg, 1989).

Another method of measuring therapist competence is the therapists’ ability to deliver a therapeutic intervention within a specific model of therapy. Researchers have developed scales designed to measure therapists’ ability to work within a model of therapy. Several of these scales are mentioned in the literature including the Cognitive Therapy Scale that measures skills in CBT (Blackburn et al., 2001) and the Person Centred and Experiential Psychotherapy Scales (PCEPS) that measure the
abilities of the therapist to use the person-centred and experiential framework (Freire, Elliott & Westwell, 2011).

Despite these efforts, researchers have noted that there are methodological difficulties inherent in the task of measuring therapeutic competence (Margison et al., 2000; Mitchell, 1997). At the conclusion of their review on measuring the relationships in person-centred and experiential psychotherapies, Freire and Grafanaki (2010) acknowledge that attempts to measure the therapeutic relationship have met with limited success.

Given the inherent difficulties in measuring therapeutic competence in counselling and psychotherapy, outcomes researchers have only been able to identify a modest relationship between therapist competence and therapy outcomes (Davidson et al., 2004; Milne et al., 1999; Shaw et al., 1999; Trepka, Rees, Shapiro, Hardy, & Barkham, 2004). For example, Davidson et al. (2004) found that therapists who were judged by expert observers to be more competent obtained slightly better outcomes than those who were less competent. Trepka et al. (2004) found that the alliance and competence were both related to outcomes. Shaw et al. (1999) found a modest relationship between therapist competence and therapeutic outcomes.

The Therapist Effect

Outcomes researchers have studied the idea that the personality of the therapist, including the measure of their competence, is an important factor in therapy outcomes. Based on metadata obtained from the National Institute of Mental Health Study on the Treatment of Depression, Kim, Wampold, and Bolt (2006) found that therapist effects, or the personality and characteristics of the therapist, account for between 6 and 10 percent of client outcomes. These authors underscore the significance of this finding, “Given the fact that whether or not a person receives any treatment only accounts for about 13% of variability in outcomes, therapist variability, therefore, is an important factor” (p. 162).

The notion that the “good” therapist may be in possession of certain characteristics has attracted some attention in the literature (Beutler, Machado, & Neufeldt, 1994; Wheeler, 2000). One characteristic that has been studied includes the therapist’s ability to influence clients (Strong & Dixon, 1971). For example, Heppner and Heesacker (1983) found that clients were influenced by their perceptions of therapist as being trustworthy and attractive. Williams and Chambless (1990) found
that clients who perceived their therapists to be self-confident were among the ones most likely to improve. Personality characteristics of “good” therapists have been identified. For example, Jennings, Goh, Skovholt, Hanson, and Banerjee-Stevens (2003) found that master therapists were intellectually curious, comfortable with ambiguity, emotionally healthy, focused on their own well-being, and experts at using their relational skills in therapy.

**Professional Competence in Psychology**

In the North American literature, professional competence in psychology is defined as the skills and abilities that enable clinicians to competently perform the role of a professional psychologist. In the U.S. literature, definitions of professional competence range from general notions of professional competence to specific descriptions of foundational competencies required to implement a course of treatment or a therapeutic intervention (Fouad et al., 2009; Hatcher & Lassiter, 2007; 2004; Rodolfa et al., 2005). Intervention skills are a subset within this framework (Fouad et al., 2009; Kaslow, 2004).

Kaslow et al. (2007) point out that the definition of professional competence in psychology is rooted in the medical literature. Epstein and Hundert (2000) define professional competence in medicine as “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflections in daily practice for the benefit of the individual and the community being served”. These authors stress that professional competence depends on a practitioner’s habits of mind, including attentiveness, critical curiosity, self-awareness, and presence. These authors further observe that professional competence is developmental, impermanent and context dependent” (p. 226-227).


*Evidence-Based Practice*
Evidence-based practice is the standard for professional practice in psychology in both the U.S.A. and the U.K. (Babione, 2010; Chwalisz, 2003; Waehler, Kalodner, Wampold, & Lichtenberg, 2000). Therapeutic competence incorporates the therapists’ knowledge of the evidence base, their clinical and relationship skills, and their knowledge and experience with empirically supported treatments.

Engaging with the evidence base requires therapists to apply their knowledge of psychological theory and research to the cycle of assessment, formulation, intervention, and evaluation/research. This includes a therapist’s technical knowledge of theory and techniques, and their skill in applying those techniques. It is especially important for therapists to be able to formulate and conceptualize clients. Kuyken, Fothergill, Musaa, and Chadwick (2005) state, “Case conceptualization is at the heart of evidence-based practice” (p. 1187).

In the U.K., the British Psychological Society (2008) defines the structure of evidence-based practice. Competence in the evidence-based practice framework is based on psychologists’ skills in assessment, formulation, intervention, evaluation/research, and communication. Similar expectations are stated for the practice of professional psychology in the U.S.A. (Kaslow, 2004; Fouad et al., 2009). The BPS (2008) summarizes evidence-based practice related to professional psychology: “Applied psychologists help others through the unique application of research-based psychological knowledge and skills in a structured process. This process includes assessment (the identification and analysis of needs and problems of individuals, groups and organisations), formulation of solutions, intervention or implementation, followed by the evaluation of outcomes. Clear and effective communication skills are integral to all of these” (p. iii).

Assessment

The purpose of an assessment is to gather observations that help the therapist to conceptualize the client’s primary difficulties (Carr, 2006). An assessment can involve anything from a single clinical interview, to a psychometric test, to an assessment strategy undertaken by a team of professionals (Hatcher & Lassiter, 2007; BPS, 2008). Some examples of skills and knowledge needed to complete a competent assessment include knowledge of assessment tools such as psychometric tests and a theoretical and research-based understanding of their strengths and limitations (Hatcher & Lassiter, 2004; BPS, 2008).
**Formulation**

The formulation integrates the knowledge gained from the assessment process and draws on psychological theory to provide a framework for understanding the client’s problems or needs (BPS, 2008). A formulation expresses how the therapist conceives of the problem from a particular theoretical perspective (Johnstone & Dallos, 2014). It is a hypothesis about the factors that precipitate and perpetuate a client’s difficulties (Carr, 2006). Formulations summarize a client’s problems, explain how they relate to one another, suggest why they may be present, and give rise to a plan for intervention (Johnstone & Dallos, 2014). Formulation is an ongoing, reflective activity and a major focus of practicum training (Hatcher & Lassiter, 2007).

Accurate diagnosis is an important competence within this structure of evidence-based practice (Babione, 2010). Waehler et al. (2000) point out that formal diagnosis is the only way to classify clients. It is important to note at this juncture that skill in assessment and formulation is a required competence in counselling psychology (e.g. BPS, 2001). Gillon (2007) points out that a process of assessment and formulation that aims to diagnose clients contradicts humanistic theoretical and philosophical frameworks. A therapist working within a humanistic framework might find his or her notion of therapeutic competence challenged by the structure of evidence-based practice. For example, a “competent” humanistic practitioner would likely refrain from using diagnostic labels which might serve to dehumanize the client or introduce a power imbalance to the therapy (Rogers, 1957). Thus the tenets of evidence-based practice may be a source of tension for a counselling psychologist who is working from a humanistic framework. This potential conflict has been noted within the literature (e.g. Gillon, 2007; Orlans & Van Scoyoc, 2009). Waehler et al. (2000) point out that formal diagnosis is one of the implications of evidence-based practice that is difficult to reconcile with a counselling psychology perspective. Gillon (2007), Wilkins and Gill (2003), and Watkins (1993) argue that a counselling psychologist can conduct a person-centred evaluation even in a medical model context. Watkins (1993) further argues that person-centred principles can be maintained in diagnostic testing if it is undertaken in a collaborative framework.

**Intervention**
Evidence-based practice emphasizes specialized treatment for specific disorders. These are called empirically supported treatments (Chambless & Ollendick, 2001; Chambless & Hollon, 1998). Chambless and Hollon (1998) describe an empirically supported treatment (EST) as “A psychological intervention shown to be efficacious in controlled treatment with a delineated population” (p. 7) The U.K. Department of Health (2001) has issued guidelines for the treatment of specific disorders, which include:

1. CBT for depression
2. Exposure-based treatment and CBT for agoraphobia and social phobia
3. CBT for generalized anxiety disorder

Empirically supported interventions have become the norm for the practice of professional psychology (Strupp, 1986). ESTs meet rigorous evidential criteria for specificity including the treatment having been tested on a homogeneous diagnostic sample in a randomized clinical trial using a specific treatment manual (Chwalisz, 2003; Kazdin, Kratochwill, & VandenBos, 1986). Both the American Psychological Association and the British Psychological Society endorse ESTs. In the U.K., the Department of Health (2001) has published evidence-based guidelines for a number of psychological disorders. For example, the guidelines for the treatment of depression for adults specify cognitive therapy (NICE, 2009).

_Evidence-Based Interventions_

In the U.K., competence frameworks for therapeutic interventions have been consolidated and published for four psychotherapy traditions: Cognitive and behaviour therapies, humanistic therapies, psychoanalytic/psychodynamic therapy, and systemic therapy (UCL, 2015). Roth and Pilling (2008) state that their method for compiling therapeutic competences for these therapies was informed by using therapy manuals from clinical trials. It appears that this consolidation process was relatively straightforward for CBT but proved more challenging for identifying therapeutic competence in humanistic approaches due to a paucity of evidence regarding its effectiveness (Roth, Hill, & Pilling, 2009).

_Evaluation/Research_
Quantitative and qualitative measures are used to develop an evidence base for evaluating practice (Foster, 2000; Glover, Webb, & Evison, 2010). Evaluation of practice helps determine whether current strategies are effective. Evaluative feedback on therapy has been shown to help to inform clinical work (Lambert, 1999). One of the most commonly used quantitative measures, called the CORE assessment, measures client functioning at different stages of the therapeutic process (Foster, 2000; Gillon, 2007).

The principles of evidence-based practice require psychologists to gather research evidence to inform clinical decision-making. Hatcher and Lassiter (2004) confirm that psychologists who are completing their practicum training should have well-developed habits of applying theoretical and research knowledge in the clinical setting. The process of clinical decision-making is informed by research and the individual circumstances of the client, examples of clients’ individual circumstances include race, gender, and sexual orientation (Spring, 2007; Waehler et al., 2000; Whaley & Davis, 2007).

*Therapist Competence and Evidence-Based Practice*

The effective delivery of ESTs relies on skillful and competent implementation of technique (Brown et al., 2013; Sburlati et al., 2011; Shaw et al., 1999). One measure of therapist skillfulness is therapist adherence, the ability to adhere to procedures and techniques specified in a treatment manual (Cross & West, 2011; Perepletchikova, Treat, & Kazdin, 2007; Shaw & Dobson, 1988). Therapists demonstrate varying levels of adherence to treatment manuals, and this differentiation can produce different outcomes. For example, Hogue et al. (2008) and Barber et al. (2006) demonstrate that substance abuse dependency disorders respond best to mid-level adherence.

Brown et al. (2013) found that for novice trainees, obstacles to adherence included lack of knowledge, familiarity with the technique, and therapist self-efficacy. Training to develop CBT skills using treatment manuals has proven successful under a number of circumstances. For example, Brown et al. (2013) found that for novice therapists, training improved knowledge, skill, and self-efficacy in the delivery of CBT techniques. Weingardt, Cucciare, Bellotti, and Pin Lai (2009) demonstrated that short-term manualised CBT training helped to improve therapist adherence when it was paired with ongoing group supervision and case consultation. Short-term training
paired with structured supervision has also been shown to strengthen the therapeutic alliance and improve graduate trainees’ ability to deliver time-limited psychodynamic therapy and helping skills (Hill et al., 2015; Hilsenroth, Defife, Blagys, & Ackerman, 2006; Hilsenroth, Kivlighan, & Slavin-Mulford, 2015).

One argument against manualised CBT training is based on evidence that suggests therapists who are trained to implement treatment protocols may exhibit a lack of flexibility that erodes the quality of the therapeutic relationship (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Henry, Schacht, Strupp, Butler, & Binder, 1993). Nevertheless, adherence has been shown to be a predictive factor in outcomes and symptom improvement (Feeley, DeRubeis, & Gelfand, 1999).

Therapist competence and therapist adherence to the treatment protocol are critical features of treatment integrity (Perepletchikova, Treat & Kazdin, 2007). Thus for the purpose of efficacy research, therapists are specially trained to high levels of competence and adherence. In clinical practice, however, this is rarely the case (Weingardt et al., 2009). Some have pointed out that this research/practice divide has militated against the dissemination of ESTs (Woody, Weisz, & McLean, 2005).

Researchers have noted that empirically supported treatments do not produce the same outcomes in clinical practice as they do in controlled clinical trials (Hemmings, 2000; Stewart & Chambless, 2009). An alternative explanation has been that empirically supported treatments are not relevant to clinical practice (Persons and Silberschatz, 1998). Sburlati et al. (2011) suggests another reason for these disappointing results. They argue that current training techniques are not sufficient to develop therapist competence to appropriate levels for delivering empirically supported treatments. Efforts have been made to use manuals to train therapists to deliver empirically supported treatments (Roth & Pilling, 2007, 2008; Sburlati et al., 2011). Studies have shown that training manuals can be used to develop therapist skills in CBT, and so it does appear to be true that training for competence, narrowly defined as enhanced knowledge of CBT theory and skills, can be improved using manuals as teaching aids (Belar et al., 2001; McManus, Rakovshik, Kennerley, Fennell, & Westbrook, 2012).

**Communication**

The BPS (2008) states that communication skills underpin the competences needed for evidence-based practice. Hatcher and Lassiter (2007) argue that trainees should
have developed advanced interpersonal and communication skills before they even begin training. These authors point out that it is important for psychologists to communicate effectively with service users and their families, and other professionals.

**Counselling Psychology and Empirically Supported Treatments**

Martin (2010) and Connolly et al. (2014) state that counselling psychology is committed to the scientific method and counselling psychologists are trained to rely on a clear evidence base for practice. Thus the evidence for empirically supported treatments cannot be ignored. This is an issue for counselling psychologists. Martin (2010) argues that counselling psychologists are trained to engage with the research base but maintain a critical stance towards the evidence. A critical and evaluative perspective is a distinguishing feature of professional competence (Schon, 1987).

Several concerns have been raised about empirically supported treatments that have implications for counselling psychology (Corrie, 2010). Counselling psychologists are aware of the evidence base for CBT but are also conscious that it might not live up to its promises in clinical practice (Connolly et al., 2014; Corrie, 2010; Hemmings, 2000). Connolly et al. (2014) observe that while counselling psychologists respect the evidence base, they remain aware of important processes within psychotherapy that cannot be measured using this approach. They argue, “Real world therapy is not manualised, can take varying lengths of time and may include a variety of therapeutic approaches and interventions depending on the client and the current state of therapy” (p. 17).

This review has already identified some of the debates around empirically supported treatments. Some researchers are enthusiastic about identifying psychotherapy treatments that work (Crits-Cristoph, 1996). Opposing voices dislike the narrow boundaries defining what constitutes evidence (Westen et al., 2004). Some researchers have expressed concern over the implications for therapies that are not on the list (Bohart, O’Hara & Leitner, 1998).

My own view is that counselling psychologists should be mindful of common factors research, which suggests that therapy models account for only a small percentage of variance in outcomes (Garfield, 1996). Thus I do not think it is wise for counselling psychology to become overly enamored of empirically supported therapies. I think that as far as counselling psychology training is concerned, the
tradition that we have established as a profession of humanistic and evidence-based practitioners is too important to be put aside to make room for specialist training in empirically supported therapies. This kind of training requires a massive commitment of training resources, and for that reason there have been some practical problems in the dissemination of these therapies in the U.S.A (Woody et al. 2005).

This review has identified that training using treatment manuals helps to deliver intervention competence. I think it is important to point out that manualised training may be an effective way to develop technical skills, but I question whether it is an appropriate focus for training in counselling psychology. It is reasonable to postulate that if we wanted to develop specialist practitioners, more time in training would have to be siphoned off for that purpose. I am concerned that if this were to happen, the counselling psychology profession would be in danger of losing the diverse philosophical and theoretical traditions that set us apart from other applied psychology professions. My personal experience is that the diverse tradition of counselling psychology has given me a place to settle professionally. It is my intention to develop an eclectic practice that suits me as an individual. I also believe that this perspective works well in the profession of counselling psychology as it is currently structured in the U.K.

The literature demonstrates that there are others who share these concerns. In a survey study of professional psychology educators, Woody et al. (2005) found that educators were skeptical about the practical relevance of empirically supported treatments and they were concerned about the potential deleterious effects of specialist training. They expressed a clear preference for developing professional psychologists who are in possession of the complex clinical skills needed for competent evidence-based practice.

Some have identified potential ethical ramifications of the empirically supported treatment movement. For example, some counselling psychologists have expressed their uneasiness about empirically supported treatments because they are part of a highly medicalised model that relies on diagnostics and has the potential to dehumanize clients (Gillon, 2007; Bohart, O’Hara, & Leitner, 1998). Woody et al. (2005) identified that educators suspected that the movement for empirically supported treatments was politically motivated. Henry (1998) warned that the empirically supported movement may have a negative impact on the profession. Henry argues that the politics of validating therapies with time-limited treatment
protocols may be designed to meet the needs of third-party payers, but in the long run, these policies may serve to undermine the morale of psychologists, and this will ultimately have a negative impact on clients.

**Developing Competence through Training**

Professional training in psychology should help trainees to develop a breadth of skills for evidence-based practice (Falender & Shafranske, 2007). The prevailing view is that these skills are taught through lectures, developed in skill practice, and reinforced in supervision. For example, Hill, Stahl, and Roffman (2007) suggest that counselling skills are developed through didactic training and corrective feedback during demonstration and skill practice. One skill that may be learned in training is how to deliver a therapeutic intervention (Sharpless & Barber, 2009). Another effect of training is that it encourages trainees to reflect on practice, providing the foundation for more complex skills. Falender and Shafranske (2007) and Beidas et al. (2011) argue that broader, global competencies are developed as the trainee reflects on practice through the vehicle of supervision.

**Gaining Skills**

Counselling and psychotherapy training has a long history of developing skills for helping clients. In a review of the literature, Baker, Daniels, and Greeley (1990) found evidence for three approaches to micro skills training: Didactic Experiential Training (Truax & Carkhuff, 1967), Human Resource Training (Carkhuff, 1971), and Micro Counselling Skills Training (Ivey, Normington, Miller, Morrill, & Haase, 1968). The reviews undertaken by Baker, Daniels, and Greely (1990) and, more recently, Hill and Lent (2006) suggest that a skills-based approach to training novice therapists is valid and useful. Research shows that didactic training and structured supervision enhance therapist adherence and competence in CBT.

Hill, Stahl, and Roffman (2007) investigated a skills-based model of training. They found that teaching micro levels skills to students in graduate training improved their ability to use those skills in a helpful manner. Hill et al. (2015) found that training improved students’ ability to use helping skills. There is evidence that CBT skills can be gained through short-term training courses and novice therapists are able to gain the skills to become more competent in delivering CBT interventions (Brown et al., 2013; McManus et al., 2012, Beidas et al., 2011; Milne et al, 1999). There is a
growing body of evidence to suggest that time-limited psychodynamic therapy skills can be taught through graduate programme training (Hilsenroth et al., 2015; Multon, Kivlighan, & Gold, 1996). Hilsenroth et al. (2006) found that manualised training in time-limited psychodynamic therapy improved both patient- and therapist-rated alliance scores.

**Gaining complex therapy skills**

Bennett-Levy (2006) and Stoltenberg (2005) argue that complex clinical skills are developed by reflecting on practice. Falender and Shafranske (2007) assert that self-awareness is an attitude that forms the core of meta-competence – the ability to guide one’s learning and determine what is and is not known. These authors further assert that supervisors may help trainees to develop meta-competence by sharpening their self-assessment skills.

One complex skill that may be developed through supervision and used to enhance trainees’ competence is clinical reasoning. Clinical reasoning is defined as a cognitive process by which the practitioner brings together the best possible research evidence, clinical expertise, and understanding of the individual characteristics of the client that may affect the therapy (Babione, 2010; Spring, 2007). Martin (2010) and Kuyken et al. (2005) argue that training through supervision may help psychologists to cultivate an informed perspective on the evidence base and develop their clinical skills and ability to conceptualize clients.

Clinical decision-making is a complex skill that includes competences in clinical assessment, formulation, and case conceptualization (Stoltenberg, 2005). Loganbill, Hardy, and Delworth (1982) argue that skills in clinical decision-making are so complex that they can only be developed through one-to-one clinical supervision with a supervisor who is modeling the process. Stoltenberg (2005) similarly argues that complex skills (such as learning to implement an empirically supported treatment) require both didactic training and individual supervision. Weingardt et al. (2009) found that adding an element of supervision to didactic training helped therapists develop skills to deliver web-based CBT interventions.

**Gaining Research Knowledge**

One important body of knowledge that may be gained through training is knowledge of the scientific method (Shapiro, 1985). Psychologists are expected to use research to
inform evidence-based practice (McLeod, 2003). Research skills are solidified by demonstration of competence in producing a piece of original research, which is one criterion for qualification in counselling psychology (BPS, 2014).

**Acquiring Multi-Cultural Competence**

The literature demonstrates that multicultural awareness is a major focus of therapist competence (Worthington, Soth-McNett, & Moreno, 2007). Kaslow (2004) states that multicultural competence requires self-awareness of one’s own attitudes, biases, and assumptions along with knowledge about diversity and appropriate professional practice with persons from diverse groups. Multicultural competence contributes to effective evidence-based practice because awareness of diversity is key to understanding clients’ circumstances, values, and preferences (e.g. Spring, 2007). Multicultural competence consists of knowledge of the worldviews of culturally diverse clients and skills (appropriate intervention strategies and techniques) (Constantine & Ladany, 2000; Sue et al., 1982). Multicultural case conceptualization is the degree to which the therapist is able to integrate knowledge of multicultural issues into his or her conceptions of the etiology and treatment of a client’s concerns (Constantine & Ladany, 2000).

**Acquiring Personal and Professional Competence**

Some researchers believe that good practitioners are endowed with certain personality traits and moral values (De Las Fuentes et al., 2005; Rest, 1983; Wheeler, 2000). Wheeler (2000) has suggested that the selection process for training ensures that trainees are in possession of aptitudes for enhanced self-awareness, non-defensiveness, and openness to new learning. Some have reasoned that trainees acquire ethical standards and professional attitudes through a process of acculturation during graduate training (Handelsman & Gottlieb, 2005). Others note that the selection process ensures the best candidates already have a high moral character before they enter graduate training (De Las Fuentes et al., 2005; Rest, 1983).

**Assessment of Competence**

Epstein and Hundert (2000) argue that professional competence is an integrative construct rather than a set of isolated competencies. Schon (1983) argues that professional competence is defined by the ability to manage ambiguous situations and
make decisions with limited information. The complex nature of professional competence makes assessment of competence a challenging task (Epstein, 2007). Lichtenberg et al. (2007) argue that the psychology profession lacks the necessary measures to assess the integration of knowledge, skills, and attitudes. The extent to which the field of psychology is able to measure these factors remains limited by a lack of capacity to assess how we integrate them (Lichtenberg, 2007).

Competence is a developmental construct (Epstein, 2007; Stoltenberg, 2005; Kaslow, 2004; Epstein & Hundert, 2002). Kaslow (2004) argues that because competence is developmental, it should be assessed over the professional life of all psychologists. Kaslow et al. (2007) and Lichtenberg (2007) point out that a cultural shift in the profession is needed to implement a lifelong assessment model – currently there is no structure for assessment of competence past licensure.

Belar et al. (2001) argue that lifelong learning is a cornerstone of professional practice. They suggest psychologists who have not updated their skills in five years of practice may be unlikely to be fully qualified in their original specialty. Professional development training is no guarantee of a therapist’s competence to implement knowledge into clinical practice (Jensen, 1979). Professional psychologists in the U.K. are expected to guide their own learning and engage in self-assessment of their competence to apply skills they have developed through Continuous Professional Development (CPD) training (Falender & Shafranske, 2007). Literature on self-assessment of competence suggests, however, that trainees may need to be supported by their supervisors to develop their self-assessment skills because they may not know what it means to be competent (McManus et al., 2012). Belar et al. (2001) argue that self-assessment is an important cognitive skill gained through reflection on practice. Falender and Shafranske (2007) and Stoltenberg (2005) argue that self-assessment is a skill that is developed in novice therapists through supervision.

Kaslow (2004) and Kaslow et al. (2007) note that it is especially difficult to assess attitudes. Poor professional attitudes can be a major problem in graduate training programmes in psychology (Forrest, Elman, Gizara, & Vacha-Haase, 1999; Vacha-Haase, Davenport, & Kerewsky, 2004). In a review of the literature, Forrest et al. (1999) identify ethical infractions as one of the primary reasons for the termination of students from training programmes.

It appears that some skills, such as multicultural competence, are attitudinally based and difficult to assess because they rely on self-reports (Constantine & Ladany,
Self-report measures are subject to challenge because they measure self-perception of competence, not demonstrated competencies (Eva & Regehr, 2008). Thus measures for assessing multicultural competence have been widely criticized. For example, (Ladany, Inman, Constantine, & Hofheinz, 1997) found no relationship between a self-reported measure of multicultural counselling competence and trainees’ multicultural case conceptualization ability.

Counsellors perceive that experience is a factor in multicultural competence. For example, Allison, Echemendia, Crawford, and LaVome Robinson (1996) found that trainees’ previous experiences with ethnically diverse groups predicted their self-perceptions of multicultural competence. Racial identity also influences self-perception of multicultural competence. Holcomb-McCoy and Myers (1999) found that counsellors who belong to ethnic minorities felt more multiculturally competent than white counsellors. Lee and Tracey (2008), however, found no difference in the case conceptualization abilities of white trainees and trainees of color but they found, as did Eels, Lombart, Kendjelic, Turner, and Lucas (2005), that more experienced therapists produced higher quality case conceptualizations. Thus it appears that experience is a factor in a practitioner’s ability to conceptualize clients. It seems clear that knowledge of diversity can be taught. For example, Kemp and Mallinckrodt (1996) found that training has an effect on counsellors’ skills in assessment and case conceptualization with disabled clients.

2.3 Trainees’ Experiences in Training

Training the Reflective-Practitioner

Martin (2010) points out that the profession of counselling psychology embraces the reflective practitioner model (Schon, 1983, 1987) and the scientist practitioner model (Belar & Perry, 1992). Reflexivity and self-awareness are key skills for developing competence in counselling psychology (Connolly et al., 2014; BPS, 2001). Self-awareness is a primary competence and trainees experience self-reflexivity as a benefit of undertaking personal therapy during training (Gimmer & Tribe, 2010; Wheeler, 2000). Martin (2010) suggests that reflexivity enables practitioners to “consult new data and reform ideas and understandings on the basis of current input” (p. 553)
Developing Competence through Supervision

Falender and Shafranske (2007) and Stoltenberg (2005) argue that clinical supervision helps to develop the competencies that are necessary for the professional practice of psychology. Holloway and Neufeldt (1995) found that supervision enhances therapists’ skills in therapeutic procedures. Falender and Shafranske (2007) point out that supervision teaches trainees how to be self-reflective. Self-reflexivity helps to build the overarching skill of meta-competence, that is, “the ability to assess what one knows and what one doesn’t know” (p. 232). Roth and Pilling (2008) define meta-competence as therapists’ understanding of why something (like a particular technique) is and is not employed in a specific situation. These authors assert that meta-competencies are higher order skills that are needed for every psychological intervention. Falender and Shafranske (2007) note that meta-competence is a foundation for professional development, which requires skills in self-assessment and self-directed learning behaviours.

The BPS Division of Counselling Psychology (2001) states that competence in counselling psychology requires well-developed interpersonal skills, high levels of self-awareness, and skills in relating personal and interpersonal dynamics to the therapeutic context. Knowledge of the spiritual and cultural traditions of counselling psychology is important because the profession has a distinct identity grounded in a system of values rooted in humanistic philosophy (Connolly et al., 2014; Cooper, 2009).

These distinct professional competencies are developed through counselling psychology training programmes that have a philosophical and theoretical foundation to their curricula (Martin, 2010). The skills needed for effective practice in counselling psychology are grounded in knowledge and attitudes (Martin, 2010; BPS, 2001). Cooper (2009) and Connolly et al. (2014) point out that these ethical values include empowering clients, tolerating diversity, prioritizing the therapeutic relationship, and valuing the experience of the individual client, which is considered more relevant to a course of therapy than a diagnostic label.

Graduate Trainees

The literature demonstrates that trainees perceive they are developing competence through training (Stahl et al., 2009; Bennett-Levy & Beedie, 2007).
The Development of Novice Therapists

The literature on counsellor and psychotherapy development describes graduate trainees as novice therapists (C. E. Hill et al., 2007; Skovholt & Ronnestad, 1992). Skovholt and Ronnestad (1992) list eight phases of counsellor development; the first two are related to the novice therapist phase. This research has highlighted trainees’ perceptions of their development and their experiences in training, which has, in turn, informed the practice of training and development in counselling and psychotherapy (Hill, Stahl, et al., 2007). For example, Stahl et al. (2009) found evidence to suggest that graduate trainees may develop from the advanced student to the novice phase of professional development over the course of training. Developmental models of supervision demonstrate that trainees develop over time while working with their clinical supervisors (Hogan, 1964; Loganbill et al., 1982; Stoltenberg, 2005; Stoltenberg & Delworth, 1987; Stoltenberg, McNeill, & Delworth, 1998).

Models of counsellor and therapist professional development describe trainees in the early phases of training as threatened and anxious (Ronnestad & Skovholt, 2003; Skovholt & Ronnestad, 1992). Ronnestad and Skovholt (2003) point out that when trainees begin their clinical work they feel uncertain about their competence. Research suggests that trainees are drawn to supervisors who are supportive. For example, Heppner and Roehlke (1984) found that trainees were more satisfied with supervisors they rated as trustworthy. Trainees look to their supervisors for guidance and support. Reising and Daniels (1983) found that supervisees with less experience are more anxious, more dependent on their supervisors, and more technique oriented. Folkes-Skinner, Elliott, and Wheeler (2010) identified one important function of supervision to be helping trainees build confidence in their therapeutic skills. Trainees who are just beginning their practical work search for easily learned models and frameworks for how to do therapy (Ronnestad & Skovholt, 2003). Reising and Daniels (1983) found that supervisory behaviours such as teaching and modeling were important to beginning therapists. Loganbill, Hardy, and Delworth (1982) also suggest that beginning therapists are looking for mentors and are influenced by the theoretical orientation of their supervisors.

In a review of the literature, Holloway and Nuefeldt (1995) found that supervision influences a trainee’s attitudes including their theoretical orientation. Reising and Daniels (1983) found that trainees in more advanced phases gained more independence from their supervisors. Ronnestad and Skovholt (2003) report that
advanced trainees begin to feel more comfortable with their practice. They gain more confidence in their skills and abilities. They become more critically evaluative of their models and mentors as they begin to form an attitude toward theory. Fitzpatrick et al. (2010) found that trainees’ experiences in supervision influence their developing theories of practice.

Research that explores critical experiences of graduate trainees shows that trainees experience challenges. These challenges are related to learning therapeutic skills, which can be difficult to indicate, having negative self-perceptions of their competence, and unhelpful reactions to clients (Furr & Carroll, 2003; C. E. Hill et al., 2007; Nutt Williams, Hurley, O’Brien, & DeGregorio, 2003; Williams, Judge, Hill, & Hoffman, 1997). These same studies indicate that trainees grow through these challenges to gain an enhanced sense of self-awareness and a sense of acceptance of themselves as “good enough” therapists.

Research suggests that the primary challenge trainees face early in training is coping with feelings of incompetence and negative self-awareness. Theriault, Gazzola, and Richardson (2009) argue that feelings of incompetence have a negative impact on therapy. Nutt Williams et al. (2003) show that negative self-awareness can disrupt the psychotherapy process by distracting the therapist with feelings of self-consciousness.

Larson (1998) argues that self-efficacy beliefs affect therapists’ clinical functioning. Orlinsky and Howard (1986) established a relationship between therapist self-confidence and therapy outcomes. Experience is a factor in the self-efficacy levels of counsellors and psychotherapists. Lent et al. (2009) found that changes in trainee self-efficacy trended higher over time with experience. Similarly, in another study Melchert, Hays, Wiljanen, and Kolocek (1996) found significant differences in self-efficacy among groups of counsellors that were linked to their respective levels of training and professional experience.

Research on the experiences of graduate trainees suggests that training helps students gain confidence in their skills and abilities over time (Bennett-Levy & Beedie, 2007; Hill et al., 2015; Kamen et al., 2010; Stahl et al., 2009). There is evidence to suggest these changes are accompanied by improved client outcomes (Hill et al., 2015; Holloway & Neufeldt, 1995). Pascual-Leone and Andreescu (2013) found that training helps clinical graduate students to manage their anxious self-awareness, facilitate sessions, and improve their sense of self-efficacy and their
outcomes. Pascual-Leone, Andreescu, and Yeryomenko (2014) found that graduate trainees gain confidence during training and their clients perceive a stronger working alliance and more helpful experiences in therapy over time.

**Qualitative Studies of Trainees’ Experiences in Training**

This literature review has identified several qualitative studies that are related to the study undertaken in this research. These studies mainly sample graduate trainees in counselling and counselling psychology, except for Bennett-Levy & Beedie (2007) and Smith (2011) who sample students on diploma courses. I will now review these studies more closely to provide a context for the research that is presented in this thesis.

Figure 2.1 presents a list of the characteristics of nine studies that use qualitative methods to study trainees’ experiences in training. Four of these studies were conducted in the U.S.A., two in Canada, and three in the U.K. Three of these studies – C. E. Hill et al. (2007), Hill et al. (2015), and Stahl et al. (2009) – sampled graduate trainees, and in all three studies, doctorate level counselling psychology trainees were represented in the sample. These were not U.K.-based studies. Although this literature review did identify some U.K.-based studies, including Smith (2011), Gimmer and Tribe (2010), and Bennett-Levy and Beedie (2007), only the Bennett-Levy study purposed to examine trainees’ perspectives on therapeutic competence. Moreover, the context for the Bennett-Levy and Beedie (2007) study was a CBT certification course, not a counselling psychology course. The study focused on trainees’ perceptions of developing the skills to competently conduct CBT interventions.

**Figure 2.1 Qualitative Studies of Trainees Experiences in Training**

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Sample</th>
<th>Methodology</th>
<th>Primary Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Bennett-Levy, &amp; Beedie (2007) (U.K.)</td>
<td>Diploma Students</td>
<td>Self-report measure of competence including qualitative follow up question</td>
<td>Students’ self-perceived competence was influenced by powerful emotions and cognitions experienced in learning situations during training. Self-reflection is a key factor in self-perception of competence.</td>
</tr>
<tr>
<td>2.</td>
<td>M.A. Counselling</td>
<td>Grounded theory</td>
<td>Reading, personal</td>
</tr>
<tr>
<td>Study</td>
<td>Participants</td>
<td>Methodology</td>
<td>Findings</td>
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<tr>
<td>Fitzpatrick, Kovalak, &amp; Weaver (2010) (Canada)</td>
<td>Students</td>
<td>Study of students’ reflective journals</td>
<td>Philosophy, practice, and supervision helped trainees identify with an initial theory of practice.</td>
</tr>
<tr>
<td>Furr &amp; Carroll (2003) (U.S.A.)</td>
<td>M.A. Counselling Students</td>
<td>Qualitative survey seeking a response to one open-ended question</td>
<td>Critical incidents in counsellor development include changes in beliefs about competency, personal growth, and development of skills.</td>
</tr>
<tr>
<td>Hill, Sullivan, et al. (2007) (U.S.A.)</td>
<td>Counselling Psychology Doctoral Trainees</td>
<td>Qualitative analysis of students’ reflective journals</td>
<td>Challenges in training include self-criticism, learning to use counselling skills, and experiencing growth through supervision.</td>
</tr>
<tr>
<td>Hill et al. (2015) (U.S.A.)</td>
<td>Counselling Psychology Doctoral Trainees</td>
<td>Self-report and observer reports measures of competence. Semi-structured interviews</td>
<td>Trainees improved their skills and developed greater self-efficacy over the course of training.</td>
</tr>
<tr>
<td>Stahl et al. (2009) (U.S.A.)</td>
<td>Predoctoral Psychology Interns</td>
<td>Qualitative analysis of semi-structured interviews</td>
<td>Trainees learned lessons from beginning internship experiences with clients on how to do clinical work that they applied to work with other clients.</td>
</tr>
<tr>
<td>Pascual-Leone, Rodriguez-Rubio, &amp; Metler (2013) (Canada)</td>
<td>M.A. Counselling Students</td>
<td>Qualitative analysis of reflective journal entries post training</td>
<td>Trainees reported changes in professional development, self-development, and experiencing challenges in training. Trainees perceived they gained skills to conduct therapy and enhanced understanding of their roles as therapists.</td>
</tr>
<tr>
<td>Smith, 2011 (U.K.)</td>
<td>Diploma Counselling Students</td>
<td>Qualitative analysis of focus group transcripts</td>
<td>Trainees perceived that empathic relationships with tutors enhanced their learning.</td>
</tr>
<tr>
<td>Gimmer &amp; Tribe (2001) (U.K.)</td>
<td>MSc Counselling Psychology Trainees and Qualified Counselling Psychologists</td>
<td>Qualitative analysis of group and individual interviews</td>
<td>Participants perceived that training requirements for personal therapy helped to enhance their personal and professional development.</td>
</tr>
</tbody>
</table>
The other two U.K.-based studies looked at different aspects of trainees’ experiences in training. These studies suggest that trainees perceive some experiences to be pertinent to developing competence, including their relationships with tutors (Smith, 2011) and their experiences in personal therapy (Gimmer & Tribe, 2001). The literature review for this study did not identify any published qualitative studies that specifically explored U.K. based counselling psychology trainees’ experiences of developing therapeutic competence in training.

These studies share some similarities with my own research, but there are some key differences. The Bennett-Levy study was conducted with trainees who were seeking certification in CBT. It employed a mixed methods approach and, although grounded theory techniques were used to analyze some of the data, it was essentially a top-down study where the qualitative results were analyzed to illuminate the quantitative findings. After filling in a self-report measure of their competence, trainees were asked to reflect on their experience of acquiring skills in using CBT. The focus was on trainees’ experiences of gaining intervention competence using a CBT model of therapy.

The remaining studies employ “bottom up” approaches. Three studies, Stahl et al. (2009), Fitzpatrick, Kovalak and Weaver (2010), and Pascual-Leone et al. (2013), analyzed students’ reflective journal entries. These studies used a relatively unstructured format (a list of topic questions) but they were not interview studies. Stahl et al. (2009) and Hill et al. (2015) used an interview format but, unlike my study, they also used a semi-structured format. Furr and Carroll’s (2003) study followed a similar format to mine in that it presented trainees with a single exploratory question. The focus of the Furr and Carroll study was on defining critical incidents in trainees’ development. Two out of four clusters identified in this study related to trainees’ experiences of developing competence. These included critical incidents related to cognitive and skills development. These findings suggest that trainees’ experiences of developing competence are an important part of their development in training.

Smith (2011) points out that secure and trusting relationships with tutors are important to trainees. This makes sense because trainee therapists take a number of personal and academic risks in the learning environment. Furr & Carroll (2003) confirm that trainees perceive that challenges help them to grow as professionals while Smith (2011) shows that trainees need to feel safe enough in the learning
situation to take these risks. Gimmer and Tribe (2001) focus on another critical incident identified by Furr and Carroll (2003): trainees’ experiences of undertaking personal therapy. Trainees perceive that they gain empathy for clients by being in the role of a client themselves, and they get ideas about what (and what not) to do with clients from their experiences with their own therapists. Trainees report that the insight they gain from personal therapy helps them to work with clients.

Stahl et al. (2009) identified a number of themes related to trainees’ experiences of working with clients. Some of these were related to professional development, including trainees’ experiences of gaining clinical skills and insight into their professional role. Trainees in this study perceived that they learned through self-reflection and supervision.

Trainees’ developmental issues and challenges in training were explored in studies by Hill, Sullivan et al. (2007) and Pascual-Leone, Rodriguez-Rubio & Metler (2013). These studies provided further evidence to suggest that trainees’ experiences in training (e.g. anxiety) posed challenges to developing a sense of competence. Hill et al. (2015) demonstrated that trainees overcame these challenges, developing a sense of competence and self-efficacy as they progressed through training. Fitzpatrick, Kovalak, and Weaver (2010) explored how trainees develop a philosophy of practice. The Fitzpatrick study demonstrated that trainees gain an initial sense of their identity as professionals during their experiences in training and supervision.

The Research Question
This study purposes to answer the following research question: How do counselling psychology trainees define, acquire, and experience a sense of their own competence? This question developed out of my interest in studying trainees’ subjective experiences of therapeutic competence at a time in their professional development when they are fully engaged in the process of defining and acquiring it. This study is explorative and descriptive. It seeks to illuminate the subjective experiences of trainees. My research question addresses some issues brought up in this literature review about how trainees define and develop competence. I wanted to know, for example, are trainees defining competence in the same way that the profession is defining it? What is their commonsense understanding of competence? What, from the trainees’ perspective, contributes to their professional development? What is their perception of therapeutic competence and how does that relate to professional and
academic lines of inquiry about competence in counselling psychology? Those questions, raised in this chapter, are addressed and discussed in Chapter Five.

2.4 CHAPTER SUMMARY

This chapter has reviewed the literature to show how therapeutic competence is defined in counselling and psychotherapy and examined the standards for competent practice in counselling psychology. It has also reviewed the literature on trainees’ experiences in training and identified qualitative studies related to trainees’ experiences of developing competence in training.

This literature has shown that competence in counselling and psychotherapy incorporates knowledge and skills to include both specific (therapy techniques) and non-specific (common) factors, including the therapeutic relationship and the therapeutic alliance. It has examined relational competence in humanistic practice. It has highlighted ethical issues relevant to counselling psychology. This literature review indicates that the field of counselling psychology is committed to its philosophical roots in humanism, personal development, and evidence-based practice.

The chapter concludes with the research question that guides this study and it raises some issues linked to the subjective experiences of trainees who are engaged in the process of acquiring and developing competence during training in counselling psychology.
3
METHODOLOGY

3.0 Introduction
3.1 Epistemology
3.2 Methodology
3.3 Method
3.4 Ethical Issues
3.5 Chapter Summary

3.0 INTRODUCTION

Purpose

In this chapter I define my methodology, present the design of my research, describe the procedures I undertook to complete this study, and analyze the data. Following this introduction, Section 3.1 explains the philosophy of qualitative research in psychology and my epistemology as a constructivist researcher. Section 3.2 introduces the reader to the grounded theory method and explains how I have applied these techniques to my study. Section 3.3 describes my method and the design of my research. It outlines the phases of the study and provides an overview of how I conducted the analysis. Section 3.4 discusses ethics and the trustworthiness of the data. Section 3.5 contains a chapter summary.

3.1 EPISTEMOLOGY

Choosing Qualitative Research: The Quantitative/Qualitative Debate

According to Polkinghorne (1983), academic psychologists have been embroiled in a methodological controversy for decades. The debate is characterized by ontological and epistemological differences. The primary issue is the type of knowledge we should be seeking. Polkinghorne notes that those researchers who subscribe to the philosophy of positivism believe that we should discover knowledge that is scientifically verifiable. Positivist researchers favour objectivist research methods and are concerned with discovering knowledge of the world “out there,” which implies there is some form of objective truth (Denzin & Lincoln, 2000). Objectivist methods of inquiry are generally quantitative, they are concerned with measuring “truth” and they usually employ statistical procedures to prove their truth claims. Polkinghorne (1983) says that, on the other side of this controversy, there are those who argue that
the study of psychology should focus on “the unique sphere of meaningful experience” (p. 220). These are subjectivists. Subjectivists subscribe to a relativist ontology, which holds that there is no “single truth” (Denzin & Lincoln, 2000; Ponterotto, 2005). Subjectivist researchers have developed the methods that are appropriate for exploring meaning within the human experience. Polkinghorne indicates that subjectivist researchers base their methods on phenomenological and heuristic systems of inquiry. Charmaz (2003) points out that researchers who study subjective human experience rely on description and interpretation. Generally, these systems of inquiry fall under the umbrella of the qualitative research paradigm.

These competing philosophies of research and their commensurate methodologies are called paradigms of research inquiry (Denzin & Lincoln, 2000; Guba & Lincoln, 1994; Lincoln & Guba, 2000). These authors explain that a research paradigm encompasses ontology (beliefs and assumptions about the nature of reality), an epistemology (opinions about how we acquire knowledge), an axiology (a set of values and ethics), and a methodology (a set of assumptions that guide the research process). The two main paradigms of inquiry are known as quantitative and qualitative research. According to these authors, qualitative methods are usually used within a qualitative framework and visa versa. Recently, however, there has been a renewed interest in mixed methods research, which uses both quantitative and qualitative methods (Johnson & Onwuegbuzie, 2004). Denzin and Lincoln (2000) state that a research paradigm is a system of thought that contains a set of beliefs that guides action. Research paradigms dictate the use of particular methods partly because they provide a framework for certain kinds of questions. Consistency between method and methodology is an important indicator of quality in research (Morrow, 2007; Lincoln & Guba, 2000). Quantitative and qualitative research paradigms differ in terms of procedures and methods. For example, quantitative research employs descriptive statistics and qualitative research analyzes linguistic data. There are also different systems of inquiry within qualitative research that require further distinction. I will address these distinctions in the following section.

The academic discipline of psychology has had a long-standing interest in experimental psychology, which developed within the positivistic scientific model. Quantitative research methods suited to positivistic science have historically dominated psychology research (Polkinghorne, 1983; McLeod, 2003). Nevertheless, there is evidence of a growing interest in qualitative approaches which aim to capture
the individual’s point of view, examine the constraints of everyday life and secure rich descriptions of experience (McLeod, 2003; Rennie, Watson, & Montiero, 2002). Morrow (2007) argues that this is especially true in counselling psychology where there is a strong interest in research that is closely related to practice.

**Qualitative Research: Philosophical Guidelines**

Qualitative research is distinguished by the following philosophical assumptions:

- There is no single method for obtaining certain truth.
- The researcher is an integral part of the inquiry.
- There is no such thing as value-free interpretation.

These philosophical assumptions highlight what some describe as the problem of subjectivity in qualitative research.

Quantitative researchers usually aim for a position of neutrality in the research process (Denzin & Lincoln, 2000). One of the ways they accomplish this is through the use of objectivist research methods (Charmaz, 2003). The assumption within qualitative research, on the other hand, is that one can never fully control for subjectivity (Denzin & Lincoln, 2000). For example, Wertz (1986) points out that even researchers who use objectivist methods of inquiry are limited by their own subjectivity. Qualitative researchers do not usually seek to distance themselves from the object of their inquiry. Instead, they adopt a subjectivist position, which acknowledges that researchers’ values and assumptions influence every phase of the research. Qualitative research methodology is founded on the notion that the researcher is an interpretive human being who is at the centre of the research process (Denzin & Lincoln, 2000; Guba & Lincoln, 1994). Polkinghorne (1983), quoting Heidegger, states, “To be human is to be interpretive” (p. 224).

**Philosophical Positioning of the Study**

*Constructivist/Interpretivist Paradigm*
Just as Denzin and Lincoln (2000) distinguish between the qualitative and the quantitative paradigm, they also differentiate paradigms within qualitative research. I locate my own epistemology within the constructivist/interpretivist paradigm (Ponterotto, 2005; Denzin & Lincoln, 2000). Constructivists maintain a relativist ontology, which holds that there is no single truth that corresponds to an objective reality. Instead there are multiple truths which hold within different communities (Ponterotto, 2005; Denzin & Lincoln, 2000; Polkinghorne, 1983). A constructivist paradigm generates knowledge that is based on mutual comprehension of intersubjective experience between researcher and participant (Denzin & Lincoln, 2000). The constructivist approach emphasizes that the researcher’s task is an interpretive one. Constructivist researchers take an active approach to interviewing and seek to facilitate deep reflection and uncover hidden meaning in their participants’ narratives (Ponterotto, 2005). Social constructivist researchers are active interviewers who prefer an unstructured or a loosely structured interview format (Fontana & Frey, 2000).

*The Poststructuralist Critique*

Before leaving our discussion about the constructivist/interpretivist paradigm, it may be worth noting that there are those who criticize constructivists’ epistemology and the focus of their research. Poststructuralists challenge constructivist researchers on the grounds that they have not moved away from the goal of trying to identify large-scale systems of social truth (Schwandt, 1996). They also point out that traditional social science researchers (including constructivists) are still searching for scientific certitude (Schwandt, 1996; Smith & Deemer, 2000). My impression is that qualitative researchers seem to be using positivistic scientific principles to strengthen the credibility of their research (Denzin & Lincoln, 2000; Elliott, Fischer, & Rennie, 1999; Stiles, 1993; Tobin & Begley, 2002). Thus I think the poststructuralist critique of traditional social science research has merit but I also think that researchers should to some degree accept that there is no perfect motive for research and there is no perfect way to interpret social truth. It may appear that traditional social science researchers pander to positivistic scientific standards to legitimize their research. I am aware, however, that researchers function in a power structure that makes such tactics necessary. For example, Cooper (2008) has pointed out that the need for funding is an ever-present reality in counselling and psychotherapy research. Research is evaluated
and funded within the structure of a community that legitimizes it. I personally feel this pressure as a research student. I have to defend this thesis and I will be nodding to the prevailing power structures at the university to do this, Poststructuralists may view this fundamental flaw as evidence that traditional qualitative social science research is limited. I accept that this limitation needs to be acknowledged. I would further assert that all research is limited in its ability to interpret social truth. Maybe this is what Smith and Deemer (2000) meant when they said that all qualitative searchers must be able to accept a sense of uncertainty about truth.

The Researcher’s Epistemological Position

The Researcher’s Lens

The researcher’s ‘lens’, or the way in which he or she focuses on the data, helps to shape the research (Charmaz, 2006; Fassinger, 2005). The researcher’s lens consists of their philosophical assumptions, their values, and the nature of what it is they wish to discover (e.g. their research question). The researcher’s lens influences how he or she designs the study and interprets the data (Guba & Lincoln, 1994). I have applied an interpretive and constructivist lens to my research. Figure 3.1 (Below) illustrates how my values and assumptions as a constructivist researcher and my research question shaped the design of my research. The kind of knowledge I wanted to explore led me to choose an unstructured interview format as a method for data collection along the lines of that proposed by Kvale and Brinkmann (2009). This is because unstructured interviews invite the research participants to reflect deeply on the topic and this interactive process of interviewing provides a rich data set for the researcher to analyze. I chose to use grounded theory techniques of data analysis because I aimed to study emergent processes and latent themes in the interview data.

Constructivist/Interpretivist Values and Assumptions

Guba and Lincoln (1994) argue that the aim of the constructivist researcher is to represent his or her participant’s values and reconstruct the ways in which they are constructing their experience; to inform and even add meaning based on their own values. It is my intent to identify a relevant, contextual version of the truth. I am an active participant in this research because my values and assumptions are shaping the process of data collection and analysis. My assumptions as a constructivist researcher
are that I can understand my participant’s subjective experience and communicate his or her version of social truth (Ponterotto, 2005). To achieve this task, I am relying on two philosophical systems of inquiry: phenomenology and hermeneutics.

Polkinghorne (1983) states that phenomenology is the study of experience and hermeneutics is dedicated to understanding the latent meaning of experience. In phenomenological terms, I believe that my research participants and I have a basis for mutually shared experience (Wertz, 2005). From a hermeneutical perspective, the focus of the research process is to accurately understand and interpret this intersubjective reality.

**Researcher’s Question**

The research question I set out to answer in this study is as follows: **How do counselling psychology trainees define, acquire and experience a sense of their own competence?** The aim of this study is to build a theory that is grounded in the narratives of the research participants (Fassinger, 2005).

**Unstructured Interviews**

It is my belief that the best vehicle for the study of subjective experience is an intensive interviewing style where the participant is encouraged to be reflexive about the topic (Fontana & Frey, 2000) Thus I have chosen an unstructured interview format (Kvale & Brinkmann, 2009). I employ an active interviewing style that helps me to uncover meaning and to participate in the process of co-creating knowledge (Rennie, 1992)

**Grounded Theory Methods**

Glaser and Strauss (1967) and Charmaz (2006) argue that grounded theory methods expose the researcher up to a broad array of potential themes and ensure that the themes and categories are supported throughout the data set. Grounded theory methods of data analysis such as open coding and comparative analysis, allow for in-depth reflection on the data during the interpretive process that is data analysis (Glaser & Strauss, 1967).

Figure 3.1 Epistemological Influences
Figure 3.1 (below) illustrates how my values and assumptions influence the design of my research.

3.2 METHODOLOGY

The Grounded Theory Method: Introduction and Background
The grounded theory method is widely acknowledged to be an important qualitative approach that is popular with novice researchers (Ponterotto, 2005; Rennie, 2006). There are several versions of grounded theory. Glaser and Strauss (1967) and Strauss and Corbin (1990) established what came to be known as the classical grounded theory tradition. According to Charmaz (2003), classical grounded theorists are primarily interested in providing qualitative researchers with a method of working within a positivist framework. Grounded theory is a flexible method; however, and
researchers who are working in a constructivist/interpretivist paradigm of inquiry can use it (Morrow, 2007; Morrow & Smith, 2000; Ponterotto, 2005).

It can be difficult to find a common language within grounded theory because of its fragmented history. McLeod (2001b) points out that the methodological controversies between Glaser, Strauss, and Corbin that have divided grounded theorists over the years. McLeod identifies several versions of grounded theory that currently exist. One popular variant of grounded theory, thematic analysis, is focused on developing theoretical themes in the data (Braun & Clarke, 2006). In its initial phases, thematic analysis resembles grounded theory.

My journey through the grounded theory literature led me to one version of grounded theory that offers both practical advice and a sophisticated theoretical perspective. Kathy Charmaz’s (2003, 2006) constructivist grounded theory seems well suited for the novice grounded theorist operating in the constructivist paradigm of inquiry. Charmaz (2003) locates herself within the grounded theory tradition but leans towards an interpretive version, which seeks to liberate the method from its positivist roots.

**Grounded Theory Methodology**

*Staying Close to the Data*

A central tenet within grounded theory holds that the theory should emerge from the data (Braun & Clarke, 2013). Glaser & Strauss (1967) envisioned a method whereby researchers would stay close to the data by using constant comparative methods of analysis and by limiting their exposure to pre-existing theories. Thus grounded theory researchers are discouraged from conducting the literature review before the grounded theory is formed (Scott, 2009). I followed this procedure of reviewing the literature after data collection and analysis.

*Constant Comparative Methods*

A fundamental procedure within grounded theory analysis involves the use of *constant comparative methods* (Glaser & Strauss, 1967). Charmaz (2006) recommends associating sequential events or common incidents. Throughout the analysis, I compared and contrasted categories of meaning within and across data sets at increasing levels of abstraction (Fassinger, 2005). I applied Charmaz’s principles
to my own analysis as I noted sequential events that included trainees’ descriptions of critical experiences of developing competence and how they defined it. I became sensitized to themes in the data that indicated interactive processes of how the research participants were constructing meaning from their experiences (Charmaz, 1990). As I coded the data I found that research participants were defining and experiencing competence. Similarities and differences between these descriptions of experience and these definitions of competence were examined to develop the analytic categories.

According to Charmaz (2006), the researcher should attend to their own intuition and ideas during the analysis whilst they are comparing the data. Thus it appears that, to some extent, constant comparative methods rely on the researcher’s reflexivity and creativity to develop theoretical categories (Cutcliffe, 2000). Creative methods for analyzing the data, such as writing reflexive research memos, are encouraged (Cutcliffe, 2000; Fassinger, 2005; Charmaz, 2006). My early research memos reflect my intuition that my researcher participants’ experiences of competence involved latent processes of defining and perceiving therapeutic competence that were based on their interactions with others (peers, supervisors, colleagues and tutors) in their training and placement contexts.

Data Analysis

Classical grounded theory researchers use constant comparative methods to develop codes and categories that describe action in the data. Charmaz (2006) describes these procedures. She observes that the method begins with line-by-line coding where each line is coded for action and meaning. The next step is open coding where the data is organized into broad categories. Open coding identifies a number of analytic categories for comparison. This process leads to a discovery of the relationship between codes.

The next level of coding is called intermediate or axial coding (Glaser & Strauss, 1967; Strauss & Corbin, 1990). At this level of coding a hierarchical arrangement of concepts, subcategories, categories, and core categories is developed.

The final stage of coding, when it is employed, is called theoretical coding which is the point at which the grounded theorist develops an explanation for the data. One key goal within the classical grounded theory tradition is to develop an overarching theoretical category or “theoretical code” to explain the data (Charmaz,
2006). The focus of the classical grounded theory approach is developing substantive theory using “theoretical sampling”, a strategy whereby participants are continuously sampled on the basis of an emerging theory (Glaser, 2009). Theoretical sampling requires that the researcher employ procedures for continuously querying the data to achieve theoretical saturation (Fassinger, 2005). These procedures normally involve further participant interviews, writing memos and consulting the literature (Charmaz, 2006; Fassinger, 2005; Cutcliffe, 2000). I did not engage in theoretical sampling in this study due to time limitations that prevented me from arranging further interviews. Charmaz states that although the goal in classical grounded theory is to develop an overarching theory to explain the data, many grounded theorists develop theoretical frameworks and do not go on to produce a grand explanatory (or substantive) theory. Because I did not engage in theoretical sampling it would be difficult to claim, in the classical sense, that I achieved theoretical saturation of my categories (Glaser, 2009). Therefore, it is important to highlight that my findings should be considered as a tentative theoretical construct (Fassinger, 2005).

I began my own analysis using line-by-line coding. I developed theoretical categories using Charmaz’s (2006) coding methods to produce a theoretical framework to illuminate the processes and constructs related to trainees’ experiences of developing competence.

**Constructivist Grounded Theory**

Constructivist versions of grounded theory employ analytic methods developed by Charmaz (2006) and Rennie (1998). Ponterotto (2005) underscores the importance of the constructivist grounded theory approach. He states, “The most popular approach to grounded theory, particularly in Counselling Psychology, appears to be the constructivist-leaning approach endorsed by Charmaz and Rennie” (p. 133)

Constructivism is relevant to counselling psychology because counselling psychology embraces the following humanistic principle: All knowledge is interpretive and therefore individual experience is counted as valid data (Warmoth, 1998). This humanistic principle guides the practice of counselling psychology and it has several implications for counselling psychology research. For example, it legitimizes the study of subjective and intersubjective experience, and it encourages researchers to employ interpretive research methods (such as constructivist grounded theory) that seek to illuminate the processes by which actors construct meaning in the
social world (Charmaz, 1990). I would argue that constructivist grounded theory is uniquely suited to counselling psychology because the philosophy of counselling psychology practice (with its valuing of the client’s subjective and intersubjective experience) merges with the epistemology of constructivist research which, according to Charmaz (1990), is rooted in phenomenology and symbolic interactionism.

Charmaz’s (2006) version of constructivist grounded theory varies from the classical grounded theory tradition in that it uses a very interpretive approach to coding. Charmaz (2003) notes that for constructivists, theoretical coding “provides an interpretive framework that offers an abstract understanding of relationships” (p. 140) Charmaz’s studies are narrative and personal and her theories are highly contextualized (Charmaz, 1983, 1990). Because of my interest in constructivism, I am very interested in developing contextualized theory. I determined after reading Charmaz’s work that her strategies for coding could be easily adapted to suit my study.

Charmaz’s (2006) procedures for data analysis are summarized in Figure 3.2 (below) which presents a three step coding process: Initial, Focused, and Theoretical coding.

**Initial Coding**
The first phase of the analysis, initial coding, lays the groundwork for the researcher to follow the grounded theory requirement: *Study your emerging data* (Glaser, 1978). Charmaz (2006) advocates line-by-line coding as a first step. Qualitative researchers refer to this initial process of interaction with the data in different ways. For example, Braun and Clarke (2006) call this first analytic step the immersion phase, but in the grounded theory tradition it is referred to as initial or open coding.

**Focused Coding**
Charmaz’s (2006) second method of coding creates hierarchies based on “theoretical weighting” in which categories are elevated on the basis of their explanatory power. She maintains that focused codes emerge from a comparative analysis of the data. She acknowledges that theoretical weighting is not a straightforward, linear process but incorporates lateral thinking and requires that the researcher interpret the data to discover latent themes.
Charmaz (2006) directs the researcher to reflect on the data to develop focused codes. She explains that the researcher should focus on the codes that carry the potential to explain the data and help to categorize it. Coding is a process that combines the researcher’s skill of analytical decision with his or her creativity and intuition (Cutcliffe, 2000). Charmaz’s framework gives the researcher a primary role in interpreting the data and constructing the theory. She writes, “Focused coding means using the most significant and/or frequent earlier codes to sift through large amounts of data. Focused coding requires decisions about which initial codes make the most analytic sense to categorize our data incisively and completely” (Charmaz, 2006, p. 57).

Theoretical Coding

In Charmaz’s framework, theory is built by a process of assigning theoretical “weight” to the themes identified in the data. Unfortunately, Charmaz (2006) is not very clear about this concept of theoretical weighting. It appears that the researcher has the flexibility and the responsibility to decide which themes carry the most analytical weight. Those themes that are determined by the researcher to carry the most analytical weight become elevated to theoretical codes.

Figure 3.2 Phases of Data Analysis

| 1. Initial Coding | Study the emerging data and remain open to theoretical possibilities |
| 2. Focused Coding | Select the most theoretically promising codes and use them to develop theoretical categories |
| 3. Theoretical Coding | Build a coherent analytic story that explains the data |

Procedures for Coding the Data

The data in this study was coded using Charmaz’s (2006) strategies for coding. These procedures are presented in Figure 3.3. Appendix A of this thesis provides the reader with an example of how I adopted these strategies in my own analysis.

Figure 3.3 Strategies for Coding
Breaking down the data into their component parts or properties
Defining the actions on which they rest
Looking for tacit assumptions
Explicating implicit actions and meanings
Crystallizing the significance of the points
Comparing data with data

Charmaz (2006) advocates breaking down the data and reconstructing the story from an interpretivist perspective, which seeks to offer an abstract understanding of relationships. This set of strategies relies on several key grounded theory procedures, including line-by-line coding, to generate multiple ways of looking at the data and researchers’ practice of remaining open to myriad theoretical possibilities. It is a framework that emphasizes the interpretive lens of the researcher (Fassinger, 2005). Thus the quality of a constructivist grounded theory study relies on a transactional connection between the researcher and the participant that is sufficient to establish a deep sense of shared meaning (Fassinger, 2005). Charmaz encourages the use of narrative analytical procedures (like memo-writing) that develop the researcher’s tacit understanding of his or her connection to theory and provide an audit trail for others (Cutcliffe, 2000; Fassinger, 2005).

I used memo writing as an analytic procedure throughout this analysis. Some memos took the form of journal entries and some were reflexive pieces of writing. Some of these memos are presented in Appendix H. I wrote memos to help define my categories and record the decisions I made about the data. I used them to keep track of my thinking processes as I was developing theory. My reflexive memos provide an audit trail for the decisions I made about the data. I believe that this method of writing memos enhanced my reflexivity and improved my understanding of the concepts and categories.

I verified my codes by conducting member checks. Member checks were sent out at several points during data collection and analysis to check my coding practices and ensure that my findings made sense to research participants. Examples of member checks can be found in Appendix B.
3.3 METHOD

Having outlined the philosophy of my methodology and identified my approach to grounded theory, I now turn to the task of describing my method. This section will describe my participants, data collection and analysis, procedures, and trustworthiness of the data. It will explain my strategies for sampling, recruitment, data collection, and analysis. It will then go on to present and explain a summary of the phases of the research.

Summary of the Method
A total of eleven trainees were interviewed for this research. Trainees were recruited from the researcher’s own contacts and through the BPS professional network. The interviews were digitally recorded and transcribed and analyzed using grounded theory methods of data analysis. An unstructured interview schedule consisting of a single question and a series of prompts guided the conversation. After the first two pilot interviews the interview schedule was changed. Copies of both interview schedules can be found in Appendix C of this thesis.

Description of the Sample

Qualification Routes

The counselling psychology trainees that were interviewed for this course were enrolled on one of two training routes: the BPS independent training route (Q-COP) and professional doctorate training programmes (taught courses). Both training routes make the candidate eligible for chartered membership in the British Psychological Society and registration with the Health Care and Professions Council. These qualification routes are organized differently. Q-COP trainees are engaged in autonomous study and become qualified through the BPS (2014). Trainees on taught courses become qualified by completing an accredited doctoral training course. For the purposes of this study it should be noted that the primary differences between these two groups of trainees are that the Q-COP trainees organize their own training programme under the supervision of BPS curriculum advisors and supervisors, while taught-course candidates are enrolled on an accredited training programme that meets BPS and HCPC requirements.
Demographics

Figure 3.4 presents the demographic configuration of the research participants. Three participants were males and eight were females. Ten trainees were White British and one trainee was of other ethnic descent. Six of the trainees were aged between 30-39 years, three trainees were aged between 40-49 years, one trainee was aged between 20 and 29 years, and one trainee did not choose to disclose age.

Figure 3.4 Demographics

<table>
<thead>
<tr>
<th>Gender</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Males</td>
</tr>
<tr>
<td>8</td>
<td>Females</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 White British</td>
</tr>
<tr>
<td>1 Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Not Disclosed</td>
</tr>
<tr>
<td>1 20-29</td>
</tr>
<tr>
<td>6 30-39</td>
</tr>
<tr>
<td>3 40-49</td>
</tr>
</tbody>
</table>

Figure 3.5 describes the sample in terms of the number of years spent in the capacity of a helping professional (including voluntary work). Six trainees had spent between one and five years in related professional employment or voluntary work prior to becoming enrolled on a professional training programme in counselling psychology. Related employment experience included professional and voluntary helping roles such as telephone counselling, one-to-one counselling, and mental health nursing. Five trainees had spent more than six years in a professional role. Research participants had accumulated at least some professional experience before enrolling on their courses. Three of the research participants were experienced counsellors, and two participants had a considerable amount of paid professional experience working in mental health.
Figure 3.5 Professional Experiences

<table>
<thead>
<tr>
<th>Years of Related Experience Previous to Enrollment</th>
<th>Trainees</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5 year</td>
<td>6</td>
</tr>
<tr>
<td>6+ years</td>
<td>5</td>
</tr>
</tbody>
</table>

Figure 3.6 describes the length of time the participants have been enrolled on a training programme in counseling psychology. Two participants were in their first year of training, four participants were in their second year of enrollment, three participants were in their third year, and the remaining two trainees had been enrolled in part-time training for more than four years.

Figure 3.6 Years in Training

<table>
<thead>
<tr>
<th>Years of Enrollment in Training Programme</th>
<th>Trainees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>2</td>
</tr>
<tr>
<td>Year 2</td>
<td>4</td>
</tr>
<tr>
<td>Year 3</td>
<td>3</td>
</tr>
<tr>
<td>Year 4+</td>
<td>2</td>
</tr>
</tbody>
</table>

Figure 3.7 describes participants’ training routes, the therapy models they learned and used in their training, and the contexts in which they were placed at the time of interview. Three of the participants were enrolled on the independent route. All of the independent route trainees were experienced in mental health work although one of these trainee participants had just enrolled on the programme. Most of the remaining trainees were registered on full-time taught courses. Trainees from two taught courses participated in this research. Research participants had been trained in different models. Ten trainees had received instruction in cognitive and behavior therapy and eleven trainees had been training in Person-Centred approaches. Three participants had been trained in psychodynamic therapy approaches. Five trainees were placed within the National Health Service; two of these were in Improving Access to Psychological Therapies (IAPT) placements. Four trainees were placed in counseling charities and two were working in non-NHS mental health placements.

Figure 3.7 Training and Placement Context
Training Route
3 Independent
8 Taught course

Training Models
8 Cognitive-Behaviour Therapy & Person-Centred
1 Person-Centred & Psychodynamic
2 Cognitive-Behaviour Therapy & Psychodynamic

Clinical Placement Type
5 National Health Service
4 Charity
2 Private

Phases of the Study
Having completed a description of my participants I will now explain the procedures I undertook to complete the four phases of this study that are summarized below in Figure 3.8.

Figure 3.8 Phases of the Study

<table>
<thead>
<tr>
<th>Phase</th>
<th>Procedures</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| 1. Recruitment         | • Approached two colleagues to request their participation in pilot interviews  
                        | • Advertised for research participants through professional networks      | • Obtained 11 research participants                                    |
| 2. Data Collection     | • Purposive sampling  
                        | • Simultaneous data collection and analysis  
                        | • Interview questions were trialed.  
                        | • Research interviews conducted using revised interview schedule  
                        | • Simultaneous data collection and analysis | • Data obtained by conducting pilot interviews with two “good informants”  
                        |                                                                                   | • Two pilot interviews simultaneously transcribed and coded  
                        |                                                                                   | • Revised the interview schedule  
                        |                                                                                   | • Nine further interviews simultaneously transcribed and coded          |
| 3. Analysis of the Pooled Data | • Initial coding: Applied Charmaz’s (2006) methods to develop five focused | • Developed five focused codes that influence trainees’ experiences of |
### Intermediate coding

- Subsumed initial theoretical codes into a Glaserian framework (Birks & Mills, 2011) to further define and describe the codes and categories.
- Applied constant comparative methods (Glaser & Strauss, 1967)

### Competence

- Philosophy, Ethics, Feedback, Challenges, and Making Progress
- Developed a coding hierarchy to define core categories

### Developing the theoretical framework

- Conceptualized the story of the data to address the research question
- Wrote report of findings
- Described a conceptual framework on the basis of available data
- Summarized the findings

## Phase 1 Recruitment

### Sampling Strategy

In the initial phase of this research I engaged two research participants from my training cohort to participate in pilot interviews. I considered them to be well informed about the topic because they were amongst those with the most clinical experience. They had also expressed interest in the topic. Choosing a set of “good informants” to establish the initial set of dimensions of the theory is a common sampling strategy in grounded theory (Cutcliffe, 2000, p. 1477). This intentional selection process is called purposive or purposeful sampling (Cutcliffe, 2000).

It is not uncommon for grounded theorists to have initial hunches about the theory (Cutcliffe, 2000). As I conducted these initial interviews, I intuited that the trainee’s context (university experiences and clinical placements) played a role in how they understood and experienced therapeutic competence. I followed this hunch to sample for heterogeneity.

I believed that a broad sample would generate a variety of responses and this would strengthen the categories. Cutcliffe (2000) points out that sampling for breadth “generates extensive data that has the potential to cover behavior in a variety of situations” (p. 1478) My sampling strategy was to include a cross representation of trainees to better ensure that my topic would be adequately explored.
**Sample Size**

Grounded theory studies do not use probability sampling and consequently have no pre-set requirement for the number of participants in the study (Cutcliffe, 2000). In this study I aimed to recruit a sample size of between eight and twelve participants. This intention was made on the basis of my constraints as a single researcher (Patton, 2002). Established precedent within the qualitative research community also influenced my choice. McLeod (2001b) suggests that a qualitative study can be sufficient with a sample size of between eight and twenty participants. Braun and Clarke (2013) say that a sample size of six to twelve participants is sufficient to constitute a small-scale qualitative study. In all, eleven participants took part in the project.

**Procedures for Recruitment**

Figure 3.9 Recruitment Methods

<table>
<thead>
<tr>
<th>Recruitment</th>
<th>Number of Trainees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Course Colleagues (Pilot Interviews)</td>
<td>2</td>
</tr>
<tr>
<td>Trainees Recruited through Professional Networks</td>
<td>9</td>
</tr>
</tbody>
</table>

Figure 3.9 presents my procedures for recruitment. Some trainees found out about my research by word of mouth, and others were recruited through a presentation at a BPS professional network meeting and a research advertisement. A copy of this advertisement is presented in Appendix D. Volunteers were recruited in the following ways:

1. I invited two colleagues on my course to participate in the pilot interviews.
2. One colleague on another taught course found out about my research and volunteered to participate. She recruited another colleague from her course.
3. I presented my research at a professional meeting attended by the members of the British Psychological Society’s Northwest Division of Counselling Psychologists. Five attendees indicated their interest in participating in the project. Two attendees at the professional meeting were excluded; one was not available for interview and one had not yet begun working with clients. The three remaining individuals were interviewed.
4. I advertised for research participants through the newsletter published by the BPS Northwest Division of Counselling Psychologists. This newsletter is sent out electronically to approximately 100 members throughout the Northwest. The advertisement was also posted on the BPS website. I received five emails from trainees indicating their interest in the research. One potential participant excluded himself from the project. The remaining four trainees were interviewed.

Phase 2 Data Collection

Data Collection Procedures
I conducted a total of eleven research interviews between May 2013 and May 2014. The data for the first two interviews (the pilot phase of the project) was gathered in May 2013. The remaining nine interviews were conducted between December 2013 and May 2014. The interviews lasted for approximately one hour. They were conducted in and around two major metropolitan areas in England. Interviews were digitally recorded and transcribed. The data was simultaneously collected and coded. Prior to the interviews, the research participants received an information sheet that contained details of the nature of the research and informed them of their right to withdraw from the study. On the day of the interview the participants were reminded of confidentiality and their right to withdraw from the research and asked to sign a participant consent form. The participant information sheet and consent form are included in Appendix E.

The interviews began with warm up questions to build rapport (Braun & Clarke, 2013). I employed active listening skills, including the techniques of summary and reflection. Occasionally, I interjected ideas. I was alert to both the content and process of the interviews. I was aware of my own thoughts and emotions. This helped me to gather additional data that helped to inform my analysis.

The Research Interviews
I used an unstructured interview format that consisted of a single research question and a list of prompts. Kvale and Brinkmann (2009) describe the qualitative research interview as a “life world interview” which explores meaning from the perspective of the research participant. These authors indicate that an unstructured
interview format provides the researcher with the opportunity to glimpse “local” truth that is limited to a particular context. Charmaz (2006) calls this kind of local truth a “slice of life” (p. 26)

I adopted an interactive style of interviewing that helped me to discover meaning in my participants’ narratives (Guba & Lincoln, 1994). The interviews began with warm up questions to build rapport (Braun & Clarke, 2013). I employed active listening skills, including the techniques of summary and reflection. Occasionally, I interjected ideas. I was alert to both the content and process of the interviews. I was aware of my own thoughts and emotions. This helped me to gather additional data that helped to inform my analysis.

Pilot Interviews

In my pilot interview phase I purposefully sampled two participants with sufficient awareness of the issues to develop ideas about the topic (Cutcliffe, 2000; Fassinger, 2005). Purposeful sampling is the beginning of the grounded theory process because it serves as a starting point from which to generate and delineate theoretical categories (Glaser, 1978). As I conducted the initial interviews I coded them in keeping with the grounded theory procedures of simultaneous data collection and analysis (Braun & Clarke, 2013). I coded the interviews line-by-line (Glaser & Strauss, 1967; Charmaz, 2006). This process helped me to develop sensitivity for the topic. My improved understanding of the topic helped inform further interviews.

In advance of the interviews, I emailed a copy of the information sheet and consent form to my research participants. These forms are presented in Appendix E. I used an interview schedule that I later revised. Both interview schedules and a list of prompts have been presented in Appendix C. Figure 3.10 presents a summary of how the interview schedule was revised.

Figure 3.10 Revising the Interview Schedule

<table>
<thead>
<tr>
<th>1. Pilot Interview Question:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What aspects of your training experience do you consider facilitated/hindered your sense of developing competence when working therapeutically with clients?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Revised Interview Question:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What does it mean to you to have a sense of competence when working therapeutically with clients?</td>
</tr>
</tbody>
</table>
Fassinger (2005) has suggested that researchers may benefit from trialing their questions in the initial phases of the project. My interview schedule evolved over the course of the study. At the conclusion of the pilot phase, I reflected that the potential discourse of the interviews (the “how” rather than the “what” – see Sarup, 1996) could be extended by a more comprehensive interview question.

I chose to incorporate the data from the pilot interviews because I had gathered a considerable amount of rich data from those participants who proved to be good informants. I wanted to open up the discourse, so I changed the interview schedule, but I felt the data already gathered from those initial pilot interviews was advantageous to the study.

**Phase 3: Analysis of the Pooled Data**

*Overview of the Procedures for Data Analysis*

A total of eleven interviews were analyzed using comparative methods. The interviews were coded separately, first the two pilot interviews and then each subsequent interview. I used Charmaz’s (2006) grounded theory procedures for coding beginning with line-by-line coding, proceeding to initial coding, and finishing with focused coding for each of the eleven research interviews. The data were pooled for further analysis.

The data from each interview were pooled in the following way. The focused codes from each of the eleven interviews were treated as initial codes for the comparative analysis. The data were compared and common incidents were discovered. For example, I noted that trainees described similar experiences that contributed to their perceptions of competence and that they defined the skills and abilities they considered indispensable to competence. I followed Glaser’s (1978) practice of naming the data segments using gerunds. I attended to my participants’ own language, which helped me stay alert to the possibility of developing “in-vivo” codes, or codes that had specific meaning within the context (Charmaz, 2006, p. 55). These analytic procedures helped me to distinguish five focused codes. I identified a number of common responses and compiled two lists, one list of influences on trainees’ sense of competence and another list of therapeutic competencies that was generated by the research participants. I then built on this initial phase of analysis by engaging in intermediate coding using a method I adopted from a Glaserian tradition
of data analysis (Birks & Mills, 2011). The intermediate codes provided another level of theoretical abstraction that helped me to explain the data. Both lists were incorporated into the intermediate coding hierarchy.

**Data Analysis Procedures**

*Initial coding*

Using Charmaz’s version of grounded theory, I identified five focused codes in the initial phase of analysis that defined the major actions and processes in the interviews. These focused codes established the foundation of the grounded theory, which was linked to trainees’ experiences of becoming acculturated to the philosophy of counselling psychology and ethics, experiencing challenges while developing competence, and critical experiences of receiving feedback on competence and making progress. These themes are more fully described in Chapter Four.

*Intermediate coding*

The data were subjected to a further theoretical abstraction during the intermediate phase of coding. During intermediate coding, I adopted a Glaserian approach to enhance my codes and categories and to answer my research question (Birks & Mills, 2011). I became a theoretical “bricoleur” who borrows from more than one approach “in response to the nature of the research question and emerging data” (Morrow, 2007, p. 214).

I became a theoretical “bricoleur” because Glaser’s approach helped me to more precisely define the theoretical categories. This method is acceptable because I remained within the grounded theory tradition (Lincoln & Guba, 2000). Grounded theorists have different interpretations of how to apply grounded theory. They may use different approaches but what holds grounded theorists together is their approach to the data – inductive analysis and constant comparative methods. The spirit of the grounded method is to not “force” the categories and to ensure that the theory is well supported by the data. I noted, as I moved from initial to intermediate coding, the codes fit comfortably into both theoretical frameworks. When I adopted Birks and Mills’s (2011) framework, categories and subcategories were identified and refined, but nothing new on a theoretical level was encountered that was not already contained within the focused codes.
Phase 4 Developing the Theoretical Framework

In this fifth phase of the study, my core theoretical categories were developed and my framework was established. The process of how I developed the grounded theory will be described more fully in Chapter 4. I present a formal answer to my research question in Chapter 5.

Data Trustworthiness

The criteria of trustworthiness is concerned with establishing procedures for maintaining methodological rigor in qualitative research (Lincoln & Guba, 1985). The idea behind demonstrating trustworthiness is that the researcher should be able to provide a transparent and reflexive account of the research. Stiles (1993) articulated criteria for quality control in qualitative research that are widely acknowledged in the field (Morrow, 2005; Ponterotto, 2005). These include “reliability” (the trustworthiness of observations and data) and “validity” (the trustworthiness of interpretations or conclusions).

Stiles (1993) argue that adopting standards for reliability and validity are one way to address the problem of researcher subjectivity. The criteria for data trustworthiness are addressed by the procedures I have undertaken to provide a reflexive account of the project. I have attempted to address the issue of research subjectivity by following steps to ensure data trustworthiness. These steps are outlined below in Figure 3.11.

Memo Writing

Memo writing is a procedure for enhancing transparency in qualitative research. Birks, Chapman, and Francis (2008) and Charmaz (2006) encourage qualitative researchers to deeply engage with the data and to use memos as an audit trail for the research. Memos record a researcher’s ideas, musings and reflections (Birks, Chapman, & Francis, 2008). Glaser (1978) argues that memo writing should be a researcher’s priority. Memos capture a researcher’s reflexive thinking about codes and categories that are not easily identified and expressed in any other way during the research process. Fassinger (2005) points out that memos chronicle the research journey, providing a record of the researcher’s thinking that can be helpful in establishing an audit trail for the study. Research memos can be well-developed
pieces of writing that chronicle how the researcher engages with the theoretical categories; they can take the form of reflexive journal entries or even field notes that chronicle researchers’ observations (Birks, Chapman, & Francis, 2008). I kept a reflexive journal throughout data collection and analysis. I wrote a number of memos which chronicle my decision making process and my thinking about codes and categories. Examples of these memos are presented in Appendix H.

Insider Researcher

As a counselling psychology trainee, I am both a researcher and a member of this group. Some of my research participants were also my colleagues on the course. Corbin Dwyer and Buckle (2009) suggest that being an insider researcher can be considered an advantage and a disadvantage. I discovered that my position as an insider researcher both limited and enhanced this research. I believe that my shared experience with my research participants helped me to quickly establish common ground. We shared a context and a professional language, which I found helpful. I found that the potential disadvantage of being identified with fellow counselling psychology trainees was not unlike the difficulties I sometimes encounter in clinical practice when I’m counselling a client with whom I share a common life experience. I dealt with this potential problem in the same way I deal with it in my work with clients – I stayed curious about my research participants’ experiences throughout the interview. I tried to maintain a naïve perspective and avoid the assumption that I knew about his or her individual experiences – even though mine were similar. In my interviews, I used my counselling skills to help me achieve this naïve perspective, including the techniques of open questioning, summaries, and reflection. These techniques of active listening and open questioning helped me to keep an open dialogue throughout the interviews.

One potential disadvantage of my position as an insider researcher is dual relationships. It might be that potentially research participants would feel obliged to participate in a colleague’s study. I sought to minimize this potential disadvantage by recruiting through formal channels. Colleagues and acquaintances on the course had either heard about the project or they were attendees at the professional meeting. I did not ask any of my colleagues to participate (except the pilot interviewees who were carefully briefed) – they all volunteered. My position as an insider researcher did have an impact on data analysis in the sense that I sometimes felt I was too close to the
material. I handled this by focusing very carefully on what the participants were saying in the interviews, not what I knew about them as individuals outside of the research context. Keeping a reflexive journal was helpful for me to keep a perspective on these particular interviews.

**Summary of Procedures to Ensure Data Trustworthiness**

Figure 3.11 presents a summary of the steps I undertook to maintain data trustworthiness in this study.

Figure 3.11 Procedures for Data Trustworthiness

| 1. Defining my research paradigm |
| 2. Declaring my values and assumptions |
| 3. Participating in a bracketing interview |
| 4. Maintaining a reflexive journal |
| 5. Writing theoretical memos |
| 6. Initiating member checks |
| 7. Engaging in coherence checks |

1. Morrow (2007) maintains that to evaluate qualitative research it is necessary for the researcher to state a paradigm. This was addressed in Section 3.1 in this chapter.
2. I have identified and reflected on my values and assumptions in Chapter 1 and Chapter 5.
3. The bracketing interview allows the reader to identify my values and assumptions that helped shape this research. Appendix F presents a transcript of my bracketing interview, which was conducted before data collection and analysis.
4. I have maintained a reflexive journal throughout data collection and analysis. Some of these journal entries are presented as memos in Appendix H.
5. I have written theoretical memos that detail analytical decisions I have made about the data. An example of one theoretical memo is presented in Appendix H.
6. I initiated member checks to ensure that my participant’s views were being fairly represented (Fassinger, 2005). These member checks are presented in Appendix B.

7. I engaged in regular coherence checks with my research supervisor who is also an expert in the grounded theory method.

3.4 ETHICAL ISSUES

The ethics committee at the University of Manchester approved this research in advance of data collection. The procedures used to complete this research were conducted in compliance with the ethical guidelines published by the University of Manchester Institute of Education and the British Psychological Society’s Code of Human Research Ethics (BPS, 2010; UOM, 2012).

Braun and Clarke (2013) state that the key ethical principles that apply to qualitative research are the values of maintaining the confidentiality of participants, obtaining their informed consent, and informing participants of their right to withdraw from the research. I addressed these ethical concerns in the following ways:

1. Participant information sheets and research participant consent forms were sent out in advance of the interviews. Signed consent forms were obtained from each participant prior to the interview. At the interview clients were reminded of their right to withdraw from the research. A copy of these forms can be found in Appendix E.

2. A pseudonym was assigned to each participant to protect his or her confidentiality. Efforts were made to eliminate any identifiable information in the quotes. For example, descriptions of the sample outlined in this chapter were generalized to prevent any individual participant from being identified. Names of places, such as research institutions, were not listed in the report. In compliance with data protection procedures approved by the University of Manchester, raw data were encrypted and written consent forms were kept in a locked cabinet in the researcher’s office.

I determined that my topic could potentially stir up uncomfortable feelings or lead to inappropriate self-disclosure. I used my counselling skills to minimize the risk of doing harm to my research participants. My research supervisor’s contact details were
also made available to my research participants. Interviews took place during regular business hours to minimize inconvenience.

Standards of Integrity were upheld during the course of this research (UOM, 2012). Every effort was made to ensure the quality of the analysis. Queries about my competence to perform the analysis are addressed by my attendance at research supervision sessions. I submitted my work to my research supervisor for regular coherence checks. To the best of my knowledge, no part of this research was reproduced without credit being given to the original source.

3.5 CHAPTER SUMMARY
This chapter explains the philosophy behind this study, my epistemology as a researcher, the design of my research, and the methods I used to collect my data and analyze my findings. It outlines the philosophy of qualitative analysis and introduces the grounded theory method. It declares my assumptions and my values as a researcher. This chapter describes the phases of my study, which include: 1, Recruitment, 2. Pilot Interviews, 3. Data Collection, 4. Data Analysis, and 5. Developing the Theoretical Framework
4
THE FINDINGS

4.0 Introduction
4.1 Research Question
4.2 Initial Coding Results
4.3 Intermediate Coding Results
4.4 Chapter Summary

4.0 INTRODUCTION

Purpose

This chapter purposes to present the findings of the research study. It details the data analysis obtained from the research interviews conducted with eleven counselling psychology trainees. It signposts the reader to the relevant appendices which account for the reflexive decisions I have made about the data.

Following these introductory comments, Section 4.1 presents the research question. Section 4.2 reports the result of the initial coding phase of the data. Section 4.3 reports the results of the intermediate coding phase. This chapter concludes with a summary which is presented in Section 4.4.

Background

Building the Grounded Theory

The grounded theory was built in two stages. In the initial stage eight focused codes were developed. These were refined into five focused codes (See Figure 4.1). Appendix G presents a diagram that shows how this process was done. In the second stage these five focused codes were subsumed into an intermediate coding hierarchy (See Figure 4.10). Appendix I present an account of this process.

Analyzing the Data

This study was analyzed in two phases. In Phase One, the initial coding phase was done using Charmaz’s (2006) coding procedures. Charmaz (2006) uses the term, “focused coding” to refer to this initial phase of coding. Phase Two was done using Birks and Mills’s (2011) framework for intermediate coding. Birks and Mills use the terms “core categories” to refer to the main theoretical categories and “subcategories” to refer to lower order categories. My decisions about developing the intermediate
The coding framework are recorded in reflexive research memos using procedures outlined by Birks, Chapman, and Francis (2008). Excerpts from these memos are presented in Appendix H.

**The Constructivist Lens**

My decision to detail both phases of coding in this report is linked to my values as a constructivist researcher working within a constructivist/interpretivist paradigm of inquiry. Studies based on constructivist grounded theory methods seek to present highly contextualized, relevant perspectives on local truth (e.g. Charmaz, 2006, 1990, 1983). In the constructivist grounded theory tradition, continuity between theoretical themes and first hand accounts is one criterion for context and relevance (Charmaz, 2006). As a constructivist researcher, I have the responsibility to ensure that the context of my theory is fully represented and that the story of the data has been told. Since this is a grounded theory developed on the basis of my participants’ narratives (e.g. Fassinger, 2005) I have included, for the sake of transparency, the initial themes (the following five focused codes) that support the theoretical framework presented in Figure 4.8.

Figure 4.1 (below) presents the focused codes. From an analytical perspective, these motifs remain closest to research participants’ first hand accounts. Theoretical abstraction is part of the process of developing grounded theory, but in the constructivist grounded theory tradition there should be links between participants’ first hand accounts and theoretical abstraction (Charmaz, 2006). Appendix G shows that eight original focused codes were developed and then refined into the five focused codes that are presented in this report.

In this report I define the codes/categories using trainees’ comments. This helps to maintain transparency. The quotes are narrated and distinctions are made to describe the themes. Trainees’ descriptive quotes have been edited for clarity.

### 4.1 THE RESEARCH QUESTION

The purpose of this research was to explore the experiences of trainee counselling psychologists who are in the earliest phases of their training. This research sought to answer the following question:
How do counselling psychology trainees define, acquire, and experience a sense of their own competence?

4.2 PHASE 1 INITIAL CODING

Figure 4.1 reproduces the results of the initial phase of the theoretical analysis. Details of how these codes were derived are presented in Appendix G. Figure 4.1 presents five focused codes; Ethics, Philosophy, Progress, Challenges, and Feedback. The direction of the arrows indicates that the focused codes are factors that influence how trainees experience and intellectualize competence.

Figure 4.1: Five Focused Codes

Ethics

Trainees perceive that therapeutic competence is partially defined by ethical practice. Trainees’ experiences of ethical practice include learning to interpret and apply professional and personal ethical principles to their work with clients.

Figure 4.2 Ethics

<table>
<thead>
<tr>
<th>Focused Code</th>
<th>Spread of the Data</th>
<th>Example Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Ethics**

| 7 Trainees | “I think the heart of competency is ethics and behaving in an ethical, transparent way, and working within the limits of competence to me is a major facet in being ethical.” (Eva) |

**Being an Ethical Practitioner**

Seven trainees report that one way in which they experience therapeutic competence is by understanding their ethical responsibilities. Eva’s quote illustrates one of the main themes that define this code. She intends to be transparent and to work within the limits of her competence. Eva’s remark expresses a tacit dynamic. Many research participants communicate, as does Eva, a commitment to ethical practice and to the process of becoming competent.

Those trainees that discuss ethics remark that they have a duty to practice within the limits of their competence. Thus trainees are aware that their ethical duty is to discern the limits of their training and experience and, when in doubt, take appropriate action to ensure they are fit to practice. Key themes in the discussions are personal responsibility and ethical accountability.

Trainees know they are not fully competent. They are aware that they are learners and that overconfidence may be a problem. Harry states, “I’m confident that if there’s learning to be had, I’m not in a place where I’ll ignore that. And I think that gives me self-confidence. I think I would have to … voice concern if I was saying, ‘I know what I’m doing.’” Trainees take advice. They commit to study theory, ask questions, and learn from their supervisors and colleagues. They aspire to full honesty in supervision so that they can gain competence.

**Reflecting on Ethical Dilemmas**

Some trainees emphasize that reflecting on ethics is part of gaining competence. Mary calls this “developing a framework for ethical decision-making”. Mary makes the following remark about her reflections, “Where do I feel the boundaries of confidentiality no longer apply and I now need to act in a way which is completely contradictory to all of our previous relationships?” Mary indicates, as do other trainees, that there is no clear-cut answer to an ethical dilemma. Trainees regularly comment that it is their responsibility to be transparent about the decisions they do make, and an important part of their role as counselling psychologists is to be prepared to justify their work on ethical grounds.
Philosophy

Trainees perceive that competent practice is informed by philosophical principles. The focused code philosophy accounts for trainees’ experiences of cultivating a practical understanding of the philosophical and theoretical principles that guide their practice.

Figure 4.3 Philosophy

<table>
<thead>
<tr>
<th>Focused Code</th>
<th>Spread of the Data</th>
<th>Example Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philosophy</td>
<td>11 Trainees</td>
<td>“So there’s something about understanding your own philosophy base, your own moral base, for your own practice. The ontology-type stuff? Building it up to the type of models that you’d use, how you would use them and how you would integrate them.” (Brenda)</td>
</tr>
</tbody>
</table>

Brenda references a philosophy of practice. She indicates an awareness of having a philosophical foundation that underpins her practice. Her remark suggests that she is thinking about a personal ontology that serves as a framework for integrating theories of practice.

The Philosophy of Counselling Psychology

Most trainees describe their philosophy of practice as guided by either a humanistic or a pluralistic perspective. They emphasize that therapeutic competence is based on the ability to use more than one theoretical approach to therapy. Suzanne comments, “I would really struggle to be in one particular model, it’s just not me, because I don’t think you can put all clients into one model. That’s the real philosophy inside me.” Harry states, “I would feel potentially incompetent to work completely within a model, because I would think – Why am I doing this and is this for the benefit of the client?” Some trainees highlight their relational skills. For example, Suzanne says, “If I’m unsure [about using an intervention] I will default to the relationship, because that’s where I feel competent, that’s where I know my stuff.” Some trainees de-emphasize the importance of using models of therapy. Brenda summarizes this perspective, “I’ve gained more of an awareness of it [competence] not being about the model of therapy, but the relationship within that, the more learning about the
integrative work of working with a person.” Mary works with more than one model, but she chooses to use single model approaches in tandem, depending on the clients’ issues and how they want to work. Mary comments, “I’m not a huge fan of an integrated way of working because I think that could be a bit muddy, potentially it could lack focus or lack an evidence base.”

Most trainees associated therapeutic competence with evidence-based practice. For example, George says, “Competence is about me being able to evidence my practice in some way, there’s a theoretical base for it, so that in my head as I’m going through the process it kind of chimes with the research base and I can provide a rationale as to why I’m doing a particular intervention at that time.”

Some trainees highlighted the importance of reflective practice. For example, Mary comments, “I think the reflective practitioner is important in terms of competence, so not just be blindly carrying on, maybe doing a CBT protocol but instead really reflecting on it, so it’s not just a quick automatic ‘This is what I do with this client with these presenting issues.’”

**Making Progress**

Trainees indicate awareness that competence is developmental. Eva states, “Competence is a continuum and a process.” It may be that the more experience a trainee has, the more competent they become. The focused code, Making Progress, includes trainees’ accounts of a growing awareness of how they have developed competence and how their practice has progressed over time.

![Figure 4.4 Making Progress](image)

<table>
<thead>
<tr>
<th>Focused Code</th>
<th>Spread of the Data</th>
<th>Example Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Making Progress</td>
<td>8 Trainees</td>
<td>“Obviously it takes time to develop competency as a counsellor and therapist … and eventually, sort of about 18 months or something, I was like oh, I actually have that sense of competence quite a lot of the time, or at least I feel that I can get through most things. (Mary)&quot;</td>
</tr>
</tbody>
</table>

Mary describes a moment when she felt a sense of competence as a therapist. After practicing for 18 months Mary realized she’d developed skills that enabled her to
handle most of the issues her clients were bringing. Mary reports that she had gained a sense of confidence in her ability to handle these issues.

**Developing Competence**

Trainees indicate that one of the ways they experience a sense of competence is by becoming aware that they are making progress towards becoming competent. All of the trainees acknowledged they were gaining skills and knowledge by reflecting on practice. Suzanne remarks, “I think it was a bit of a hallelujah moment yesterday because I sat there and thought ‘Yeah, that’s what I do’, and I’m quite confident in that, and therefore I feel more competent. For the first time I actually thought, ‘Wow, you have moved on.’”

A key theme in this code includes observing client outcomes. For example, Carmen comments that she feels competent when she sees that the client is “gaining a sense of hope” and “seeing things in a new way.” George reports that he feels a sense of competence when clients are “meeting their goals for therapy”.

All eight of the trainees who discussed making progress report that they had gained ground over the course of their training. Eva comments, “I can actually see that change in me, and I guess part of that journey is my supervisors have also seen it which is reflected in the reports. I am growing and that creates a sense of competency but not complacency.”

One theme in this code was a sense of aspiration to become more competent. For example, Eva says, “I’m not here to rest on my laurels. I keep asking myself how can I develop and keep safe and grow as a practitioner and be more effective?”

Trainees report learning in the classroom and in clinical placements. Jonathan says, “The discussions that we have in classes really force me to think about what skills I’m using.” Suzanne comments that classroom presentations were helpful for developing competence. She states, “Concentrating on one area in great depth, I’ve found useful. And the fact that you needed to present that learning to somebody else.” Eva describes how learning from her experience of being on placement has increased her desire to develop more competence. She remarks, “The biggest facilitators of my competence have been attending the multidisciplinary team meetings, clinical supervision, colleague interaction, picking up information, and working with clients. I found that reading challenged my perspectives and really developed that sense of competence.”
Challenges
Trainees report that it can be difficult to gain a sense of competence during training. Challenges become learning experiences when they are successfully addressed. The focused code, Challenges, describes trainees’ experiences of defining and overcoming professional and personal challenges encountered in their clinical practice.

Figure 4.5 Challenges

<table>
<thead>
<tr>
<th>Focused Code</th>
<th>Spread of the Data</th>
<th>Example Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Challenges</td>
<td>8 Trainees</td>
<td>“One of the things I really struggle with in this industry is that there’s no clear line between failure and passing … like when you’re a nurse it’s clear that you’re giving these drugs out right or you’re not. I think in this career it’s harder to know when you’re doing right and when you’re not … it helps to have quite firm guidelines and boundaries and I feel that’s been lacking somehow in the training.” (Julie)</td>
</tr>
</tbody>
</table>

The Challenge of Uncertainty
One of the main difficulties trainees face is responding to a sense of uncertainty about their therapeutic competence. Julie talks about the challenges of training in an industry where there is no clear consensus for right and wrong. Julie’s remark echoes the concerns expressed by many trainees, which is that competence is subjective. For example, trainees report that it is difficult to know if they have become competent. Suzanne states, “I wasn’t feeling professional enough – I didn’t know if I was rehearsed enough in certain interventions.”

Trainees believe that they have to strike a balance between developing confidence in their skills and being overly confident and blind to their own incompetence. Lois remarks, “I feel quite strongly that you’re never really confident in what you’re doing and you can never be sure that you’re totally competent… I think this is the nature of the work, we should always be questioning what we’re doing and questioning whether this is the right thing to do.”

Competence in Changing Contexts
A theme in this code was that competence changes according to context. Trainees report that building a new repertoire of skills can be a challenging process. Trainees
comment that there are few clear guidelines at university, and the goal posts move on a regular basis. For example, Carmen states, “Even though my co-ordinating supervisor has said ‘this looks like a good piece of work’ I submitted my first process report and it failed. So that was awful, it was gut-wrenching.” Jonathan highlights the difficulty of being forced to apply a new set of skills over the course of his training programme: “I went from feeling like I understand this pretty well and I know what I’m talking about to, well, I don’t know this very well and I don’t know what I’m talking about.” Trainees say that having multiple placements can be challenging because each context requires a different skillset. For example, Alison reports that it has been a struggle to gain a sense of competence at her IAPT placement where the benchmark for competency is to follow a proscribed CBT protocol.

**Feedback**

Trainees perceive that feedback influences their sense of competence. The focused code, Feedback, accounts for trainees’ responses to observer feedback on their work. These observers included trainees’ clients, supervisors, tutors, and colleagues.

**Figure 4.6 Feedback**

<table>
<thead>
<tr>
<th>Focused Code</th>
<th>Spread of the Data</th>
<th>Example Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feedback</td>
<td>11 Trainees</td>
<td>“I had a fantastic supervisor in the past, who was so good for me, so challenging and really pushed me hard, but God did she make me feel crap. It was a useful experience but I really didn’t feel competent because nothing was ever good enough”.</td>
</tr>
</tbody>
</table>

R: “But you felt that was useful?”
P: “I wouldn’t change a thing about that experience” (Lois)

**Feedback on Competence**

Lois indicates that feedback on competence can be challenging but potentially useful for helping trainees to develop competence. Lois found that negative feedback from her supervisor highlighted that she was not meeting the required standards of her context and this knowledge motivated her to improve her performance.

Trainees report that feedback on their competence is necessary during training. Julie says, “I don’t mind getting things wrong, I just need to be told sometimes.” Most trainees report that negative feedback can be hard. Mary says, “I know people get
quite upset sometimes in that assessment process, if they get feedback that they don’t like, it can be quite destructive.” Julie indicates that feedback offers guidance, which is important for helping her to develop competence. She comments, “I feel that even if I do something wrong I’ll know, because the kids will start complaining and the staff will say ‘you need to do this right’ and that’s fine. Part of that is about me saying, ‘right, this isn’t quite working, I need to do something else.’”

Most trainees report that positive feedback boosts their sense of competence. Mary remarks, “It’s good to know that you’ve met most of the major criteria.” Eva comments, “The psychiatrist was very complementary of my work and that increased my sense of competence.”

Negative feedback can be experienced as unhelpful for learning. Carmen remarks, “I’ve had what I perceive as quite catty feedback about my transcript and how I’ve worked with a client but I’ve thought it was a decent piece of work with a really tough client. You don’t know me and I don’t know how you can say these mean things about how I work with this client.” Carmen indicates that maybe her confidence was briefly affected by this experience, but ultimately she felt she was just “playing the game”. Carmen comments, “I just rewrote the paper and passed it the second time. You know what they’re looking for and you can give them the goods.”

It appears that inadequate or insufficient feedback may affect trainees’ perceptions of their own competence. Alison reports an early experience of having insufficient supervision that made her feel “absolutely at sea and totally incompetent.” Alison describes, “feeling terrified” during her first experience with a client at that placement. She believed that she was incompetent and this caused her to engage in negative self-talk. Alison comments, “I had all these thoughts about what was going on in my client’s mind that demonstrated how anxious I felt about my competence.”

Alison reports that even though the client continued in therapy (a possible indication of positive feedback from a client) her sense of incompetence persisted. This is because potentially Alison’s most powerful perceptions might be self-formed. She says, “Maybe those outcomes are not that important. When I’m asked to define what is therapeutic competence and what does it mean, I think conceptually ‘outcomes, it must mean that.’ But what I’m realising as I’m talking is that it’s more about the felt experience in the room, that’s where a feeling of competence comes from for me.”

Section 4.2 has identified the common influences on trainees’ experiences of therapeutic competence. Five influences on trainees’ experiences of competence have
been specified: Philosophy, Ethics, Challenges, Feedback, and Making Progress. Thus trainees indicate that their practice is defined by philosophical principles and professional ethics, and it is developed through responding to challenges in practice, receiving feedback on competence, and gaining an awareness of making progress towards developing competence. Appendix G presents additional details on how these five focused codes were developed. Section 4.3 describes an intermediate phase of analysis that refines these codes and specifies relationships between them. Appendix H contain research memos that show how the transition was made from Phase 1 to Phase 2 of the analysis.

4.3 PHASE 2 INTERMEDIATE CODING
Grounded theorists generally go through two and sometimes three levels of coding (Birks & Mills, 2011). In Phase 2 of data analysis the initial focused codes were subsumed into a second analytical “layer” of categories and subcategories (Birks & Mills, 2011; Glaser and Strauss, 1967). In constructivist grounded theory it is important to ensure that the participants’ constructions are represented at each level of theory (Charmaz, 2006). In the initial coding phase, my aim was to identify the common influences on trainees’ experiences of competence. These five focused codes developed at Phase 1 most closely relate to trainees’ self reports. Phase 2 of the analysis introduces further theoretical abstractions as it seeks to explain trainees’ experiences of competence. It constructs a theoretical framework to specify how these trainees understand the knowledge, skills and attitudes required for competence.

Developing the Grounded Theory
The data from Phase 1 of this analysis were integrated into the theoretical framework presented in Figure 4.7.

Core categories
The two core categories, “Perceptions of Competence” and “Defining Competence” define the main action shown by the data, which was trainees’ development of perceptions of competence and definitions of the skills and abilities required to become competent. Phase 1 of this analysis is linked to the core categories and subcategories listed in Figure 4.7. Appendix I presents a more detailed account of how the five focused codes were integrated into the hierarchy. The focused codes
“Feedback” “Making Progress” and “Challenges” were identified as primary influences on trainees’ perceptions of competence and, “Philosophy” and “Ethics” figured prominently into the way that trainees’ defined competent practice.

Figure 4.7 The Theoretical Framework

Developing the analytical categories

The steps for data analysis have already been outlined in Chapter 3. The data was analyzed and coded for action, critical incidents, and common themes. These coding procedures are consistent with the recommendations made by Charmaz (2006). The critical incidents identified in the data were related to observer feedback, self-reflection on competence, clinical experience, and supervision. Key skills and knowledge for defining competence were categorized under reflexive thinking/self-awareness and theories and models. Reflexive Thinking was highlighted as a key learning process for helping trainees define competence. Supervision was also highlighted as a primary vehicle for developing competence.

The analytical categories were refined and more fully defined by the inclusion of two discreet sets of data related to trainees’ experiences of perceiving, acquiring and defining competence: Influences on Trainees’ Perceptions of Competence (Figure 4.8) and Trainees’ List of Competencies (Figure 4.9).

Perceptions of Competence
Figure 4.8 lists trainees’ perceptions about the factors that influence their sense of competence. The left hand column lists the factors trainees reported to influence their perceptions of competence. The right hand column includes the number of trainees who verbalized these as influencing factors. This list has been incorporated into the coding hierarchy under the core category, Perceptions of Competence.

Figure 4.8 Influences on Trainees' Perceptions of Competence

<table>
<thead>
<tr>
<th>Influencing Factors</th>
<th>Number of trainees</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Coursework (theory/philosophy)</td>
<td>7</td>
</tr>
<tr>
<td>2. Feedback (supervisors, tutors)</td>
<td>5</td>
</tr>
<tr>
<td>3. Affirmation from colleagues</td>
<td>5</td>
</tr>
<tr>
<td>4. Qualitative/quantitative outcome measures</td>
<td>3</td>
</tr>
<tr>
<td>5. Feedback (clients)</td>
<td>5</td>
</tr>
<tr>
<td>6. Making Progress</td>
<td>5</td>
</tr>
<tr>
<td>7. Positive/negative emotions</td>
<td>5</td>
</tr>
<tr>
<td>8. Self-Confidence</td>
<td>5</td>
</tr>
<tr>
<td>9. Resonance with a professional context</td>
<td>6</td>
</tr>
</tbody>
</table>

**Defining Competence**

Figure 4.9 is a summary list of skills and capabilities trainees report to be important elements of competent practice in counselling psychology. The left hand column lists the competencies and the right hand column refers to the number of trainees who made reference to those competencies. This list has been incorporated into the coding hierarchy under the core category, Defining Competence.

Figure 4.9 Trainees’ List of Competencies

<table>
<thead>
<tr>
<th>Trainee Definition of Competence</th>
<th>Number of trainees</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Working within the boundaries of confidentiality</td>
<td>3</td>
</tr>
<tr>
<td>2. Working with the therapeutic relationship/therapeutic process</td>
<td>4</td>
</tr>
<tr>
<td>3. Facilitating a working relationship with clients</td>
<td>3</td>
</tr>
<tr>
<td>4. Modeling a sense of confidence in the work</td>
<td>2</td>
</tr>
<tr>
<td>5. Applying knowledge of client presentations to practice</td>
<td>6</td>
</tr>
<tr>
<td>6. Adapting therapy model to suit client needs</td>
<td>6</td>
</tr>
<tr>
<td>7. Personal and professional development</td>
<td>3</td>
</tr>
<tr>
<td>8. Having a base level of competence/being safe</td>
<td>5</td>
</tr>
<tr>
<td>9. Self-care</td>
<td>5</td>
</tr>
<tr>
<td>10. Awareness of self in the therapeutic process</td>
<td>6</td>
</tr>
<tr>
<td>11. Personal values and professional ethics</td>
<td>4</td>
</tr>
<tr>
<td>12. Having a framework for ethical decision making</td>
<td>4</td>
</tr>
<tr>
<td>13. Applying psychological theory to practice</td>
<td>6</td>
</tr>
<tr>
<td>14. Theoretical integration</td>
<td>2</td>
</tr>
<tr>
<td>15. Understanding the science and research behind evidence-based practice</td>
<td>5</td>
</tr>
<tr>
<td>16. Capability to conduct research</td>
<td>5</td>
</tr>
<tr>
<td>17. Understanding and applying models of therapy</td>
<td>9</td>
</tr>
<tr>
<td>18. Skills in assessment and formulation</td>
<td>5</td>
</tr>
<tr>
<td>19. Individual supervision/staying safe</td>
<td>5</td>
</tr>
<tr>
<td>20. Group supervision/rationalizing and justifying the work</td>
<td>5</td>
</tr>
<tr>
<td>21. Training programme</td>
<td>6</td>
</tr>
</tbody>
</table>

Figure 4.10 (below) presents the coding hierarchy for the theoretical framework. Two core categories “Perceptions of Competence” and “Defining Competence” are presented. Each of these core categories is broken down into a list of subcategories. The first core category, Perceptions of Competence, is made up of three subcategories: Coursework, Observer Feedback, and Self-Reflection of Competence. The second core category, Defining Competence, consists of four subcategories: Clinical Experience, Reflexive Thinking/Self-Awareness, Theories and Models, and Supervision. The subcategories are divided into a list of concepts that appear as bullet points underneath each subcategory.

**Figure 4.10 Coding Hierarchy**

<table>
<thead>
<tr>
<th>Core Category 1: Perceptions of Competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Coursework</td>
</tr>
<tr>
<td>• Theory</td>
</tr>
<tr>
<td>• Philosophy</td>
</tr>
</tbody>
</table>
2) Observer Feedback
   - Feedback from supervisors/tutors
   - Affirmation from colleagues
   - Qualitative and quantitative outcome measures
   - Feedback from clients

3) Self-Reflection on Competence
   - Making progress
   - Positive and negative emotions
   - Self-confidence
   - Resonance with a professional context

Core Category 2: Defining Competence

4) Clinical Experience
   - Working within the boundaries of confidentiality
   - Working with the therapeutic relationship/process
   - Facilitating a working relationship with clients
   - Modeling a sense of confidence in the work
   - Applying knowledge of client presentations to practice
   - Adapting models to suit client needs

5) Reflexive Thinking/Self-Awareness
   - Personal and professional development
   - Having a base level of competence/being safe
   - Self-care
   - Awareness of the self in the therapeutic process
   - Personal values and professional ethics
   - Having a framework for ethical decision making

6) Theories and Models
   - Applying psychological theory to practice
   - Theoretical integration
   - Understanding the science/research behind evidence-based treatment
   - Capability to conduct research
   - Understanding and applying models of therapy
   - Skills in assessment and formulation

7) Supervision
   - Individual supervision/staying safe
   - Group supervision/rationalizing and Justifying the work
   - Training programme

The subcategories of Perceptions of Competence describe the factors that influence trainees’ perceptions of competence. Thus trainees’ experiences of gaining
understanding through coursework, observer feedback, and self-reflection on competence influence how they perceive their own competence. The bullet points that appear beneath the subcategories further describe the nature of these influences. For example, under Subcategory One, Coursework, trainees say reading about theory and learning about the philosophy of humanism have influenced their perceptions of competence.

The subcategories of Defining Competence represent how trainees acquire the skills and abilities to become competent. Trainees perceive that they learn how to do counselling and psychotherapy by:

- Working with clients in clinical practice
- Participating in personal therapy to gain self-awareness and becoming more reflexive
- Gaining technical knowledge of how to implement specific models of therapy
- Participating in supervision to reflect on practice under the guidance of their supervisors and senior colleagues

Trainees’ definitions of these skills and abilities are listed in the bullet points beneath each subcategory. For example, under Subcategory Three, Clinical Experience, trainees define the ability to “work within the boundaries of confidentiality” as a competence. Under Subcategory Four, Reflexive Thinking/Self-Awareness, trainees define “personal and professional development” as a path to acquiring competence. Under Subcategory Five, Theories and Models, trainees define “applying knowledge of psychological theory to practice” as a competence. Under Subcategory Six, Supervision, trainees define competence as their practice of engaging in “individual supervision in order to stay safe”.

I. CORE CATEGORY: PERCEPTIONS OF COMPETENCE

The core category Perceptions of Competence incorporates trainees’ references to the process of having formed an opinion of their own therapeutic competence based on coursework, observer feedback, and self-reflection. Trainees are influenced by what
they are taught, they receive confirmation of their competence from observers, and they reflect on practice to form perceptions of their competence.

**Subcategory 1 Coursework**

Trainees are influenced by the curriculum that is taught by their tutors. They remark that coursework helps to inform their practice. Trainees’ comments indicate that coursework influences their sense of competence because it helps them to feel prepared to use theory to inform their client work.

**Learning from Theory**

Figure 4.11 Coursework Example Quote 1

| Coursework | Something that maybe has puzzled me or I’ve not been able to make sense of, I see it in a theory and I’m like “Oh, that’s what was going on.” So I’ve got more of an understanding of how that fits in with what I’m doing and where I might want to go with it. *(Jonathan)* |

Jonathan’s comment indicates that reading about theory helps to inform his practice. Seeing something in theory helps Jonathan make sense of what is going on with his clients. Reading about theory influences trainees’ sense of competence because it helps them to feel prepared to respond to clients. For example, Jonathan remarks, “I keep having this experience of reading something and then weeks later it becomes relevant to a client that I’m working with and then I end up using it. I keep thinking – what would I have done if I hadn’t read about that?”

**Philosophy**

Trainees acknowledge that their practice is influenced by humanistic philosophy. Philosophical and ethical principles of humanistic practice include the idea that the focus of the work should be based on the client’s individual experience of psychological distress – not the therapist’s expertise or professional opinion.

Figure 4.12 Coursework Example Quote 2

| Coursework | Somebody might make a referral for somebody to achieve a certain target, because his or her behaviour is seen as unusual, but I would ask the question, “Whose problem is it?” That’s a big issue for me in terms of competency with the client, the kind of client-centred approach in the way I try to work. *(Brenda)* |
Brenda describes her practice as person-centred. Her comment indicates that she has adopted a humanistic perspective because she focuses on her client’s subjective experience of the problem. Brenda remarks that her client’s perception of the problem is her main concern. It appears as though Brenda prioritizes and is prepared to advocate for her client’s point of view over her colleagues’ perspectives. This suggests that she has incorporated humanistic ethics into her practice.

Subcategory 2 Observer Feedback
Trainees identify the factors that influence their perceptions of competence, including feedback from supervisors and tutors, affirmation from colleagues, quantitative and qualitative outcome measures, and feedback from clients. The data suggests that when trainees receive positive feedback from observers it makes them feel more confident.

Feedback from Supervisors and Tutors

Figure 4.13 Feedback Example Quote 1

| Feedback from Supervisors and Tutors | “It is frightening but it’s also … once you’ve done it and you know you’ve met most of the major criteria, it’s actually good to have feedback that says you’ve made the grade and you’ve had that, not just from your tutor but you’ve had it from your peers, and you’ve had feedback on it as well.” (Mary) |

Gaining Confidence
Mary is reflecting on the significance of having passed an assessment of competence. She comments that it feels good to “make the grade”. She implies that the assessment has given her a sense of trust in her competence because the tutor and her peers have confirmed it. This assessment has given Mary an experience of feeling competent, which contributes to her sense of being a competent practitioner.

Mary’s example shows how observer assessments can contribute to a sense of competence. Other trainees also report that passing an assessment can give them a sense of competence. Similarly, failing an assessment can bring a sense of incompetence. Some trainees’ comments indicate that they bounce back from experiences of negative feedback. For example, Carmen remarks, “I got some negative feedback, temporarily I felt that maybe it dented my confidence for a brief
time.” Other trainees say that it can be a struggle to regain their sense of competence after experiencing negative feedback. For example, Alison states, “When is this feeling that I don’t feel competent going to go away? It’s so painful.”

Jonathan indicates that multiple experiences of positive feedback from observers improved his confidence. He comments, “When my supervisor did my end of year report it was reassuring to see all the things that she had picked up and recognized… The supervisor’s perception of me seemed to match the teacher’s perception of me, they seemed to be virtually saying the same things in what they prepared having never met or really spoken to each other at all.”

Trainees remark that negative feedback can be useful as long as it is positively framed and appropriately managed. Mary states, “I think as long as there’s a kind of a sense that the people in the room are sort of holding you as well, so they’re not just giving you negative feedback, but feedback which helps you to move forward.”

Trainees report that one useful outcome of negative feedback is learning. Trainees say that feelings of incompetence alert them to gaps in their knowledge that affect performance. Trainees’ comments indicate that the impact of negative feedback varies. For example, Harry describes feelings of incompetence as “feelings of doubt that lead to learning.” Lois comments, “Feelings of incompetence can be demoralizing, but you have to find a way of working with that.”

**Affirmation from Colleagues**

Figure 4.14 Feedback Example Quote 2

| Feedback | “It was a colleague who actually invited me to work with this client because she was struggling to know where to go and that really, you know, boosted my competence. Colleagues were turning to be because I could offer something and I also turned to them and asked for their ideas and perspectives.” (Eva) |

**Perceiving Competence through Positive Feedback**

Eva is describing an experience of affirmation from her colleagues in a professional context. Affirmation from colleagues is a form of positive feedback. Eva remarks that another colleague has sought her out because she was able to contribute to her placement context. Eva’s comment highlights the notion that she sees competence as a shared experience. Her reference incorporates the contributions made by her
coworkers. She acknowledges this reciprocal dynamic strengthens the overall quality of the work.

Eva indicates this experience of affirmation has given her a sense of confidence in her skills and abilities as a therapist. She perceives herself to be competent because others are reflecting their positive opinions of her work. Eva appears to be taking in that sense of affirmation and using it to inform her perception of competence.

**Qualitative and Quantitative Outcome Measures**

Figure 4.1 Feedback Example Quote 3

| Feedback | “There is a sense of understanding a therapist’s competence by the kind of feedback they get from their clients. Clients give written feedback hopefully … every client gives written feedback at the end of their therapy. And also we’ve got all of our outcome measures but outcome measures do not measure the competence of a Therapist at all.” (Carmen) |

Carmen does not consider outcome measures to be reliable indicators of therapist competence. She says instead that the most important measure of a therapists’ competence is the written feedback they get from clients. Carmen remarks, “The question is, “Does the client feel the therapy has helped them?”

George considers that one measure of therapeutic competence is his ability to help the client meet their goals for therapy. George remarks, “I suppose I want to say that competence would be my capacity to meet the client’s goals, maybe in the broadest sense. But I do see other dimensions to it as well, that it is about in some ways improving wellbeing, so it’s about improving outcomes, it’s about being able to have interventions that are worthwhile in terms of doing that.” George identifies reflection as one of the ways he would assess his clients’ progress. He comments, “I think a lot of the times within the therapy a decision about progress would fall to the client’s reflections and where they are, and I suppose my own sense of intuition and reflection on how it looks across the sessions.” George’s comments suggest that competence can be measured by the perception that some objective process has taken place; the client has made progress. He suggests there should be some confluence of opinion between himself and his client that confirms a change has taken place.

**Feedback from Clients**
Alison indicates that positive feedback from clients impacts the way she evaluates her sessions. She reports that positive feedback from clients contributes to her perceptions that the sessions “felt okay”. Alison’s example links a client’s verbal feedback with perception of competence. Trainees are aware that client feedback is not always expressed verbally. Julie remarks, “You don’t often get verbal feedback from clients because of the power discrepancy.” Carmen notes that positive feedback from clients can be “as basic as the client keeps coming back”, or they say, “I have made some changes this week.”

Trainees note that observing positive changes in their clients’ lives gives them a sense of satisfaction and contributes to a sense of confidence in their ability to do the work. For example, Brenda remarks, “My client who had felt a certain type of social phobia for so long and had difficulties in her identity as a Muslim woman, walked in and said, ‘I’m now volunteering to do this and that, I can look people in the eye, I don’t feel the same level of fear,’ and I remember actually after the session walking round the block, because it’s like clearing the cachet between clients, and feeling really, really emotional that I’d been part of that process for her that had completely changed her quality of life and what her hopes and dreams were for the future.”

**Subcategory 3 Self-Reflection on Competence**

One of the ways that trainees form perceptions of their competence is by reflecting on practice. Trainees report that they reflect on practice both during and after therapy sessions. It appears that this reflective process becomes a form of self-evaluation for many trainees. Trainees indicate that they develop thoughts, experience emotions, and form opinions about the work. In the main, positive emotions bring a sense of competence and negative emotions result in negative evaluations of the work that sometimes leave trainees feeling incompetent.

*Making Progress*
Suzanne’s quote indicates that, potentially, trainees’ sense of confidence and competence increases with experience. Trainees note improvements in their practice over time. Lois comments, “I don’t feel like I’m doing worse than in my first year of training, where you really don’t know what you’re doing, and I’m obviously in my third year now and I’m a lot more comfortable with my practice.” Julie highlights evidence that she has experienced a growing sense of competence since she started training. She noted that a recent formal challenge to her competence has made her aware that she has made progress in handling professional issues. Julie states, “If that had happened in the first year of the course I probably would have been like, ‘I could have done this differently,’ and I would have doubted myself. But now I don’t doubt myself in any way.”

Lois reports having improved her sense of competence by gaining experience of applying models in practice. She remarks, “Becoming more competent means that you’re not so reliant on that very rigid textbook protocol, you’re able to think more independently within the theoretical framework, but thinking for yourself.”

Alison reports that she suffered from anxiety about her competence as a beginner. She remarks, “I guess a few things that have helped me with my sense of competence are that in these performance reviews that I’ve had so far all the supervisors that I’ve had have said that I’m doing okay and that has helped, so written-down stuff that then goes back to the university that says ‘she’s doing okay, she’s at the level I would expect, she’s working hard, she’s trying hard.’”

Researcher: “Making progress?”
Participant: “Making progress, yeah.”

**Positive and Negative Emotions**

Figure 4.18 Self Reflection Example Quote 2

| Self-Reflection | “I’m actually being a lot more relaxed, maybe a lot calmer, so that I can actually really hear the story … staying much more in the room, much more in the moment and just kind of going with the flow and feeling competent enough that I can pick up the theme. All these sort of things which are maybe going through your mind as one track where you’re” |

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Mary associates having positive emotions with doing competent work. She comments that when she is feeling competent she feels calm and relaxed enough to really listen to her client. Feeling calm allows her to focus on the work, which Mary describes as “tracking” her client. Mary’s remark suggests that her evaluation of competence is related to her feeling calm and present enough to attend to the process of therapy. Mary indicates, as do other trainees, that feeling calm is a prerequisite for competent work.

In the main, trainees report that feelings of comfort or discomfort, calmness or anxiety, experienced during sessions have an effect on how they evaluate their work. Other trainees report, as does Mary, that they are making positive or negative evaluations of their competence based on their thoughts and feelings about the work. Trainees often report that some of this reflective activity takes place during the session. Most trainees associate negative emotions with a poor outcome. Trainees indicate that this is primarily because therapist anxiety takes the focus off of the client.

**Self-Confidence**

Figure 4.19 Example Quote 3

| Self-Perception of Competence | “In terms of increasing my ability and competence, I’m competent in my ability to learn and probably at the rate of knots as well, I think. The more I learn the more I realize I don’t know but the quicker I seem to pick up on things a lot more.” (Harry) |

**Self-Confidence and Perception of Competence**

Harry’s comment indicates that he is a confident learner. He believes in his ability to learn quickly and become informed. He expects to develop competence because he trusts that he can learn. Harry states, “I’m learning more about who I am as a therapist and I’m building that side of things up.” Many trainees report, as does Harry, that they believe in their innate abilities. Suzanne says, “I believe that I have the qualities that make me able to become a counselling psychologist.”

Eva suggests that she has gained a sense of confidence through working in her professional placements. She indicates that this has influenced her perceptions of
competence. Eva states, “When it comes to working as a psychologist I know now that I can justify and explain everything that I do from a psychological paradigm … and my identity. I would describe myself now as a psychologist rather than a counselor.”

Alison suggests that she has gained some clinical experience that has given her confidence in her skills and abilities. This learning has helped her to clarify what she wants from supervision. Alison comments, “I do have some knowledge and I need some space in how to think about using that knowledge. I’ve got to the stage with supervision where I need a bit more space to reflect on what I have decided to do, rather than someone telling me what to do.”

**Resonance with a Professional Context**

Figure 4.20 Example Quote 4

| Self-Perception of Competence | “I sort of know what sort of environments I can be in and can’t be in, what speaks to me, what doesn’t speak to me… I’ve been able to learn … and it’s really interesting … from my sense of confidence and how competent I feel, which one I’m going to go for.” (Suzanne) |

Suzanne comments that she feels confident in some contexts and not in others. She indicates that feeling confident in her placement is a priority. Eva expresses a similar opinion: “Where do I really feel at home? Because I’m likely to be most competent where I really feel most at home.”

**Competence in Context**

Trainees note how perceptions of competence vary according to how they feel within a context. Knowledge and skills can be context specific. Eva says “In a given context we can feel really competent and in another kind of running like ants trying to learn.”

Trainees indicate that definitions of competence are linked to the model of service delivery. Mary remarks that in certain contexts, for example an NHS referral for someone who is traumatized, she would have to “be seen to be using the most obvious and the most evidence-based protocol that I’m trained in to use for that client, because that’s the standard that they’re going to demand.” Alison also highlights the
importance of context to competence. She states, “I think the IAPT thing is quite a powerful force in saying you have to do it like this, this is protocol.”

_Gaining a Sense of Competence through Multiple Experiences_

The more experience trainees have with numerous clients, the firmer their perception of competence. For example, Carmen indicates that she gains a sense of confidence in her ability to fulfill a professional role by observing her track record. Carmen states: “I only feel competent as a practitioner because I’ve had hundreds and hundreds of clients who have helped me to be a better practitioner.” Carmen’s comment indicates that having a track record helps to reinforce her sense of competence in her role as a helping professional.

II. CORE CATEGORY DEFINING COMPETENCE

Trainees identified several methods for acquiring the skills and abilities to become competent. These included gaining knowledge through clinical experience with clients, developing reflexive thinking skills and self-awareness, acquiring theoretical and practical knowledge of how to do therapy, and interacting with their supervisors. Trainees gained knowledge from tutors, colleagues, supervisors, and clients. The challenges of practice motivated them to further develop their skills and abilities. Trainees who participated in this research generated a list of skills and abilities. This list was incorporated into the coding hierarchy (see Figure 4.8) as bullet points that are listed under the relevant subcategories of defining competence.

_Subcategory 4 Clinical Experiences_

Trainees report that they learn from their experiences with clients in their clinical practice. For example, trainees comment that they gain basic, practical experience of explaining confidentiality and the counselling contract. George remarks, “When a client comes I now know if they maybe say … the confidentiality, how important that is to them … I know that I could say something like ‘this stays within the room, unless it affects someone else or so on’, so they understand and believe it.” Trainees report that they develop therapeutic competence by gaining understanding of the therapeutic relationship. This includes building a rapport with clients. Julie states, “I think I’ve got to a place now where I recognise when clients are feeling safe. At the same time, I think I know when people aren’t happy as well.” Trainees’ definitions of
competence related to “Clinical Experience” are listed as bullet points in Figure 4.8 and are further described below.

**Working within the Boundaries of Confidentiality**

Figure 4.21 Clinical Experience Example Quote 1

| Clinical Experience | “Having hours under your belt definitely helps, and having had experiences … of having to break-confidence and contacting other services and things like that are quite … which actually helped with feeling that you’ve coped with that quite competently as well, so it’s been really helpful.” (Mary) |

This quote demonstrates that trainees gain a sense of competence by competently handling challenging therapeutic events and appropriately executing their professional duties. Mary provides the example of following procedures for safeguarding. This clinical experience gave Mary several opportunities to define competence in practice. She gained a clearer understanding of the counselling contract because she had to enforce it. She discerned what needed to be reported. She responded to the challenge of performing her duties in an acceptable manner. She took the opportunity to reflect on her values to develop an ethical framework.

**Working with the Therapeutic Relationship/Process**

Figure 4.22 Clinical Experience Example Quote 2

| Clinical Experience | “If I’m with an engaging client that always makes me feel more competent because I can feel I’ve got the means of collaboration – they’re giving me something so I can give something back.” (Suzanne) |

For some of the trainees interviewed, one central therapeutic competence is the ability to work with the therapeutic relationship. Susan illustrates how she has defined the therapeutic relationship in her practice. She expresses the therapeutic process in terms of the give and take of the therapeutic relationship. When Susan develops rapport with her clients it helps her to understand that the relationship provides the means for collaborative work.

**Facilitating a Working Relationship with Clients**

Figure 4.23 Clinical Experience Example Quote 3
Trainees report that the ability to facilitate a working relationship with a client is a therapeutic competence. Julie reports having observed that some point during the course of therapy clients develop a sense of trust in her and in the work. At some point she perceives the client beginning to take the initiative. Julie’s practice experience has helped her define collaboration within the working relationship. She describes the onset of that collaboration in the therapeutic relationship as realizing that she no longer needs to “dish out new ideas all of the time”.

**Modeling a Sense of Confidence**

Figure 4.24 Clinical Experience Example Quote 4

| Clinical Experience | “If I come in and I’m all nervous and I’m shaky and I feel like I can’t help them then they’re going to feel that too. I may go back to my supervisor and say ‘boy, what am I doing here?’ But I don’t want my client to feel my sense of lostness or stuckness or uncertainty.” (Carmen) |

Carmen points out that clients need to feel confident in the work. As a therapist, she notes the importance of modeling a sense of confidence for the client. She defines this as “projecting the persona of the competent therapist”.

**Applying Knowledge of Client Presentations to Practice**

Figure 4.25 Clinical Experience Example Quote 5

| Clinical Experience | “Being ill is part of their experience, so I think it is important to have looked at one or two papers to see how disabling is this condition, how does that affect them, what are any potentially specific psychological aspects to it?” (Mary) |

Trainees report that an informed perspective on client presentations helps to lay the foundation for developing therapeutic skills. Mary says that she finds it useful to become informed about her clients’ health conditions. It helps her to lay the foundations for empathy and informs the assessment process. Other trainees also
report that therapeutic competence evolves from gaining experience with specific client groups. They find that experience is informative, and even a cursory understanding of client presentations can help to underpin the therapy.

Adapting Models to Suit Clients’ Needs

Figure 4.26 Clinical Experience Example Quote 6

| Clinical Experience | “The weird thing with CBT, for me as a counselling psychologist maybe, is that as well as having all these things which I would define as CBT therapeutic competence, the other side of that coin is that sometimes I think it’s important to do CBT in a more flexible way and that’s what the competence is, not doing it to the letter and getting it technically right, but being able to flexibly adapt it to the client.” (Alison) |

Alison has learned about her own competence from her evolving use of CBT in her practice. Alison notes the difference between applying a protocol and using CBT in a relational way. Many trainees report, as does Alison, competence emerges when they can apply a theoretical framework and adapt that model to suit the needs of a particular client. Lois states, “So being competent as a CBT therapist is for me about working within that CBT framework, but also being able to adapt to the person in front of you and what they’re bringing at that particular time, and to balance those particular requirements.” Suzanne also indicates that competence is the ability to “dip in and out” of therapeutic models. Suzanne provides an example of flexibly applying models to suit clients’ needs. She states, “the formulation led us to explore the emotions and that literally opened up a whole different area.”

Subcategory 5 Reflexive Thinking/Self-Awareness

This subcategory demonstrates how reflexive thinking and self-awareness contribute to therapeutic competence. This subcategory contains several important themes. Trainees report that reflexivity and self-awareness are central to therapeutic competence. Harry comments, “Understanding myself gives me a grounding, and the fact that I feel I know myself, I feel that’s one of the competencies required to be a therapist.” Trainees indicate that in order to be competent, therapists need to understand their personal issues. Mary remarks, “personal therapy and working on my own issues is a big part of competency.” Trainees are committed to being ethically minded, competent practitioners. Brenda states, “A sense of competency, for me
brings me back to my own personal morals and ethics.” Personal accountability for
upholding professional ethics is a central theme in this subcategory.

The subcategory Reflexive Thinking/Self-Awareness incorporates the
following trainee definitions that are listed as bullet points in Figure 4.8 and further
described below:

**Personal and Professional Development**

Figure 4.27 Reflexive Thinking/Self-Awareness Example Quote 1

| Reflexive Thinking/Self-Awareness | “It’s been more than a qualification; it’s been a real life-changing journey, because of the amount of personal therapy that we do. Personal therapy takes the hypocrisy out of this profession because it’s that levelling yourself with your client, that nobody is the expert, and it’s just a journey that you’re privileged to walk alongside somebody else. I think it’s that collective, being a member of the human race rather than being a professional, that I think distinguishes counselling psychology from many other professions.” (Brenda) |

Brenda comments that self-development through personal therapy has helped her to become a better professional and that personal therapy has helped her to become more empathic with her clients. Her experience has helped to remind her that she is not the “expert” in the client-therapist dyad – she is on the same level as her clients because she is sharing in that parallel process.

Brenda’s quote illustrates an important theme. Some trainees indicate that they are more than just helping professionals. They are individuals on a personal journey of self-development, and dedicated members of the helping profession. Trainees appreciate that there is an overlap between their personal ethics and their professional lives. For example, Carmen reports that her work life is meaningful because her personal values resonate with her professional ethics. This gives her the sense that the profession “feels right” for her, and this is very important to Carmen.

**Having a Base Level of Competence/Being Safe**

Figure 4.28 Reflexive Thinking/Self-Awareness Example Quote 2

| Reflexive Thinking/Self-Awareness | “I have that belief that I’m at a sufficient level to use my life experiences and theoretical experiences to work with clients. And I think the level for me of competency … someone said this to me recently actually… I do no harm. That’s the fundamental thing. I feel like if I’ve got that level of competency then that’s |

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Harry says that he feels confident he can fulfill the ethical requirement “Do no harm”. It appears his assessment is based on his capacity for self-reflection and his theoretical understanding of practice. Harry’s comment illustrates that trainees view reflexivity and self-awareness as a core competence.

Many trainees state that professional ethics encompasses the notion “do no harm”. Like Harry, trainees indicate that they feel personally accountable for ensuring that they take a reflexive stance towards their work to safeguard clients. Professional competence is a prominent ethical theme. Trainees see reflexivity as a tool for ensuring that they practice within the limits of their training and level of experience.

**Self-Care**

Figure 4.29 Reflexive Thinking/Self-Awareness Example Quote 3

| Reflexive Thinking/Self-Awareness | “Competency to me would not be having a massive row with my partner and then going in and conducting a therapy session, because if I’m unable to give undivided attention to that individual I don’t feel fit to provide what that person needs, and I think there’s a responsibility with that to ensure that self-care comes at the top of a priority list.” (Brenda) |

Brenda indicates that competence is predicated on her ability to discern her personal limits. Brenda’s ethics dictate that client work requires her full attention. She recognizes when she needs to take care of herself. Brenda’s example illustrates that trainees value self-care. Suzanne states: “to be competent you’ve got to look after yourself, I mean you’ve *got* to look after yourself because you’ve got someone opposite you.” Trainees report that self-care is vital for ensuring therapeutic competence. Maintaining one’s fitness to practice is a professional responsibility. Eva states, “Therapeutic competence is about watching for signs of compassion fatigue and burnout, and monitoring what’s happening in your personal life.”

**Awareness of Self in the Therapeutic Process**

Figure 4.30 Reflexive Thinking/Self-Awareness Example Quote 4

| Reflexive Thinking/Self-Awareness | “Yeah, it would scare me a little bit, seeing people angry, and I’d just try and ignore it because I wasn’t dealing with my own anger … in sessions it would be difficult for me to work with someone’s anger when I’m not processing and managing my
Mary talks about how her own issues used to get in the way of her therapeutic work. Mary believes that personal therapy has played a big part in helping her to manage her personal issues. Brenda also highlights the importance of personal therapy to developing therapeutic competence: “The thing about competence for me is about self-care and about understanding things that go on within a transference with somebody, so I know what my own issues are. So the training around my own personal therapy, I find very important in developing competence in therapy work.”

**Personal Values and Professional Ethics**

Figure 4.31 Reflexive Thinking/Self-Awareness Example Quote 5

| Reflexive Thinking/Self-Awareness | “I think that sense of competence is aligned to a sense of being in the right place, doing work that feels right, it feels socially right, it feels ethically right, it feels right for my values as a person, as an individual.” (Carmen) |

Carmen’s personal values are aligned with her professional ethics. She indicates she finds a sense of competence as a helping professional to be very rewarding. Carmen says, “there is nothing more amazing and wonderful than a feeling one has after a good session, and indeed the feeling one has after an accumulation of good sessions with a client with whom one has an intensely positive relationship. It just makes our work worth it.” Several other trainees indicated that they felt personally connected to their role as a counselling psychologist. This personal connection seemed to influence the way that some trainees described competence. For example, trainees say that they feel more competent in some areas than others. Suzanne comments, “When I feel unsure I default to the relationship because that’s where I know my stuff – that’s where I feel competent.”

**Addressing the Power Imbalance**

Brenda demonstrates that her personal values are consistent with her professional ethics. For example, she is committed to empowering her clients. She
remarks, “I worked on a psychiatric ward in quite a large asylum before the Community Care Act came in, so there were still people trying to manage people’s behaviour by giving rewards of basic human rights and … there were bullies working in those situations. Which brings the thinking again around to something that’s very important to me, and that’s trying to get away from power relationships, and that’s why it’s so important to me to promote this kind of walking alongside, rather than being the expert, when working with another human being.” Brenda’s comment illustrates how her personal ethics intersect with the egalitarian ideal that delineates thinking within humanistic psychology. Thus, for Brenda, a competent practitioner is one who facilitates parity in the client-therapist relationship.

**The Scientist Practitioner**

Eight trainees report that they use evidence-based interventions in their practice. Some trainees indicate a high level of personal commitment to their role as the scientist practitioner. George comments, “I am in a process of developing my competence through research, through application, and that’s a key system process; it’s consistently in flux throughout my progress.” He comments, “As a therapist and a researcher I’d say that counselling psychology is research-informed practice and practice-informed research.”

**Having a Framework for Ethical Decision Making**

Figure 4.32 Reflexive Thinking/Self-Awareness Example Quote 6

<table>
<thead>
<tr>
<th>Reflexive Thinking/Self-Awareness</th>
<th>“Reflecting on ethics clarifies for me my own values and what I’ll pass on and what I won’t, and why I do that.” (Mary)</th>
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Mary’s comment suggests that she thinks it is important to reflect on ethical issues. She indicates that she is engaged in the process of defining ethical boundaries in practice.

One definition of ethical competence identified by trainees is the ability to work within the boundaries of confidentiality. Trainees report that confidentiality is a “grey area” in the counselling contract that requires personal reflection. Mary thinks that it is useful to have and to use an ethical framework for decision-making. She
comments, “Sometimes just really practical things, like how do I react in this situation, what are my own boundaries? You really think about it and reflect on it … how do I feel about that and why was it important to do what I did?”

Subcategory 6 Theories and Models
The subcategory, Theories and Models, incorporates trainees’ understanding that they are working in accordance with philosophical principles and a model of practice that is reinforced by a body of research. Trainees indicate that the theory they have learned and the research they have undertaken during training provides specialized knowledge that they bring to the therapy situation. They maintain that this knowledge is part of therapeutic competence. Suzanne comments, “If you don’t know these tools and you haven’t got those techniques you might be aware of a client’s needs, but you might not have anything to bring, to respond to that.” Nine trainees say that they are committed to using scientific knowledge to inform practice. Eight trainees link therapeutic competence with knowledge of how to implement evidence-based interventions. For example, George remarks, “I use outcomes measures or reference to science and theoretical frameworks, validated interventions, to serve as a check that I’m not just doing any old thing, and that’s competent.” Carmen emphasizes the importance of a therapist’s technical skills and scientific knowledge. She comments, “I actually believe that you can have a technically skilled therapist who gets good results with their clients who may not be brilliant in the therapeutic relationship.”

The Theories and Models subcategory incorporates the following trainee definitions that are listed as bullet points in Figure 4.8 and further described below.

Applying Psychological Theory to Practice
Figure 4.33 Theories and Models Example Quote 1

| Theories and Models | “I did a lot of reading and that’s really helped my competency… I’ve gone back and really read work on attachment, which I hadn’t really read, and I read the work on belonging and the importance of people belonging and the social aspects of life and engaging and all sorts of things. It kind of makes a lot more sense actually. I guess I just wanted the evidence. I wanted to know why humanistic counselling is really, really working.” (Mary) |

Mary believes that reading the psychological literature has improved her competency because it helped her to understand how counselling works. Mary indicates that an in-
depth understanding of theory provides her with an intellectual foundation for her practice. Suzanne reports a similar dynamic: “For me to feel confident I feel that I really need to understand something; if I don’t understand the fundamental philosophy behind that particular thing, can I really use it competently? I wouldn’t say I was competent in something that I don’t really understand.” The data reflects that trainees believe that knowledge is an important component of competent practice. Jonathan emphasizes that knowledge of psychological theory provides him with a sense of competence because it helps him feel prepared to respond to the needs of his clients. Eva thinks that the competent practitioner is able to draw on psychological theory in order to inform practice, “When I see a client and I hear their story, hear their narrative, I often see patterns emerging, and for me that’s something about functional competence, and then being able to draw in that psychological theory as a psychologist makes me feel competent.”

**Theoretical Integration**

Figure 4.34 Theories and Models Example Quote 2

| Theories and Models | “The self, identity, values, empathy… Well I wondered, how does it work? I’ve gone off and done a lot more reading from other viewpoints. So now when somebody asks me about how I work I can give a coherent answer so it feels very fluid, it feels like it’s been incorporated into the way that I work and it feels very easy in terms of being able to describe it, being able to get a rationale for it, into what I’m doing and how I’m doing it.” (Mary) |

Mary describes a process of reflecting on the psychological theories that underpin her practice. Mary has consciously set about to construct a foundation to inform and to explain her work. Brenda, like Mary, was clear about this process reporting that she has become personally identified with a philosophy of practice.

The data on theoretical integration is mixed. Eleven trainees mention that they apply philosophical principles, but only two trainees describe their intention to develop a coherent philosophy of practice. These two trainees were aware that they were developing competence through a process of theoretical integration. Other trainees seemed to be integrating theory, but they did not describe it in those terms.

**Understanding the Science/Research behind Evidence-Based Treatment**

Figure 4.35 Theories and Models Example Quote 3
George’s comment indicates his philosophy of practice, which is based on verifiable evidence. He defines therapeutic competence as the ability to understand and apply scientific principles to practice. Carmen specifies that part of competence is to understand the science behind the therapeutic model. She remarks, “Other ingredients make therapy work, technical competence and skill, and actually understanding the nature and the mechanisms behind the sorts of issues that clients typically come into therapy for.”

Many trainees reported a strategy of using the evidence base as a means to inform and to justify clinical decision-making. For some trainees therapeutic competence requires an informed perspective on evidence-based treatment. Eva comments, “If we’ve got an evidence base, we can veer from how we deliver the treatment as long as we know what we’re delivering what the evidence base is. My case study is on imagery re-scripting, so I talk about the evidence base for OCD [obsessive compulsive disorder] for trauma and its growing evidence base for eating disorders. I’m not just pulling this from thin air.”

**Capability to Conduct Research**

Figure 4.36 Theories and Models Example Quote 4

| Theories and Models | “We are supposed to be doing research, and we need to be engaging with research, and I take that challenge seriously.” (Carmen) |

Carmen’s remark indicates her commitment to the scientist practitioner model. Trainees make many references to engaging with the literature. Most of these are related to using their skills in research to help understand their clients and to keep up with the latest knowledge. Trainees also report that conducting research helps them to develop their clinical skills. For example, Mary says that her M.A. research has informed her client work.
Trainees consider the research base to be a valuable source of information about how theory relates to practice. Harry describes a reciprocal relationship between research, theory, and practice: “If you are going to practice it’s important to have research informing it and to add the theories … it’s only when theory is put into words that it truly gives practice some structure. So actually your practice needs to be informed by some literature.”

**Understanding and Applying Models of Therapy**

![Figure 4.37 Theories and Models Example Quote 5](image)

| Theories and Models | “I feel competent when things kind of flow quite naturally… I think maybe earlier on in my practice I would be thinking before sessions ‘what am I going to do?’ I’m going to give them a thought record or I’m going to give them some thought-challenging and that’s going to be the homework.” (Lois) |

Like many other trainees, Lois thinks that building proficiency in a model of therapy helps to develop therapeutic competence. Lois describes an experience of having progressed in her understanding of theory and how to apply it. This experience reinforced a sense of competence both because she had done it and because she noticed she was not able to ‘feel natural’ in the work earlier in her practice. This illustrates a dynamic function between clinical experience and therapeutic competence – witnessing a sense of progress in practice reinforces a sense of competence.

**Skills in Assessment and Formulation**

![Figure 4.38 Theories and Models Example Quote 6](image)

| Theories and Models | “I tend to move more towards the evidence base, I think it’s more robust for the anxiety disorders, whereas if you’re working with people with low mood, who are maybe more depressed, I think there’s probably more leeway in working and how a client wants to work, but also making sure that it’s an evidence-based intervention as well, and that it’s not taking overly long or we’re missing aspects of something that’s really central but sometimes being missed.” (Mary) |

Mary says that her philosophy of practice is cognitively based and built on skills and experience of diagnostic assessment. Mary’s assessments determine how she applies the evidence base to her practice. Eva remarks that formulation is central to
therapeutic competence: “We bridge the gap between theory and practice by using formulation.” Trainees appreciate that skills in assessment and formulation contribute to therapeutic competence. For example, Carmen states: “A good therapeutic relationship does not guarantee a good outcome for clients; you need a decent formulation, you need a decent set of goals and you need the client to feel like their goals are being achieved.”

**Subcategory 7 Supervision**

The subcategory Supervision refers to the ways in which trainees gain therapeutic competence by participating in supervision in clinical placements and at university. Trainees make a number of references to supervision, including individual and group supervision and supervision by peers, colleagues, supervisors, and tutors. Learning to become competent by picking up information from colleagues and other professionals is a theme in this subcategory. Trainees suggest that supervision provides them with guidance, safeguards clients, and helps them to monitor the quality of their practice.

This subcategory incorporates the following trainee definitions that are listed as bullet points in Figure 4.8 and further described below.

**Individual Supervision/Staying Safe**

Figure 4.39 Supervision Example Quote 1

<table>
<thead>
<tr>
<th>Supervision</th>
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<tbody>
<tr>
<td>“I think supervision is really important in this, as part of the feedback mechanism, am I practicing competently or not? If you’re open with your supervisor about what you’re doing and they’re like ‘yeah, you’re on the right track there or maybe try this’ and if you feel you’re on the level and they’re kind of happy with your work…” (Lois)</td>
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Lois finds supervision useful for helping her to judge whether she is practicing in a competent manner. Lois comments that when she is honest and the supervisor seems happy she believes she is competent. Trainees remark that an honest supervisory relationship contributes to developing competence. They indicate that bringing their mistakes into supervision develops their clinical skills. Trainees also highlight that honesty in supervision is an ethical issue. Trainees believe that a positive supervisory relationship is a method of safeguarding clients. Brenda states, “I make sure I’m
working with a supervisor that I feel comfortable to be 100% honest with. So that supervision element for me is crucial in terms of competency.”

Trainees express the idea that as beginning therapists they know they are only minimally competent. Mary likens this initial phase of therapist development to having just “passed your driver’s test”. Trainees agree that they have much to learn, and using supervision is part of learning how to become competent. Harry reports that he trusts himself to be competent while he is training because he can make appropriate use of supervision. Harry says, “I know I’m competent enough to learn because I am aware of what material I need to take to supervision.”

Alison communicates that supervision is an important source of guidance and support, and effective supervision contributes to a sense of competence. Alison recalls a time of not having appropriate supervision at her clinical placement, a situation that made her feel “lost and totally incompetent”.

Trainees also report that supervision can be helpful for maintaining psychological boundaries with clients. The ability to maintain boundaries was identified by trainees as a therapeutic competence.

**Group Supervision/Rationalizing and Justifying the Work**

Figure 4.40 Supervision Example Quote 2

| Supervision | “I think competency involves an ability to analyze and make a professional judgment about the course of treatment and to be able to justify that decision. I think it’s important to be quite transparent and quite confident in that. Not arrogant but confident in the analytical process. It’s also about being able to modify that judgment. So go to a Multidisciplinary Team Meeting and actually be open enough and humble enough to say, ‘Yeah I haven’t really thought about it that way,’ or ‘that’s really useful’ … that’s helped me know where I am going with that client. To be modest enough to modify professional judgment – so there’s flexibility in competency as well.” (Eva) |

Eva identifies two aspects of therapeutic competence that are reported by trainees: the ability to make reasoned clinical decisions and to justify those choices. Eva’s highlights the advantages of having other colleagues’ perspectives to help inform the work. Other trainees indicate, as does Eva, that competence is not based on doing what we alone think is right. Mary comments, “Competence is that sense of being able to maybe play a client’s work to either my peer group or the supervisor and actually see…what they can see.”

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Trainees highlight the role of groups in developing competence. Mary reports that group supervision experiences are often affirming and they give her a sense of competence. Trainees suggest that group supervision broadens their understanding of how to work with clients. Julie reports that getting feedback during group supervision has helped her to understand her personal style and gain confidence in her clinical decisions. Group supervision also gives trainees an opportunity to share their struggles. Jonathan remarks, “Case discussions have been useful in terms of gaining a new perspective and new ideas on how to work with a particular client; seeing other people’s approaches and discovering similarities with what other people find difficult.”

Trainees clarify that they expect to be able to justify and rationalize their work to other professionals. This suggests that trainees identify an element within therapeutic competence of being able to effectively communicate with other members of a professional team, or with colleagues and supervisors. Trainees indicate that to justify and rationalize their work, they must be prepared to articulate their treatment strategies to other professionals – and to provide an account for having deviated from evidence-based practice. Mary comments, “As long as I can justify [what] we did this way, [that] the rationale for this is that, and I can explain that to my supervisor…that helps with the competence.”

**Training Programme**

Figure 4.41 Supervision Example Quote 3

| Supervision | “There’s something about the class that allows for participation that doesn’t make it seem like a classroom, that makes it feel like a small focus group discussion or something like that, that I find gives me a feeling that I’ve engaged with the material and gives me a feeling of competence.” (Lois) |

Lois and other trainees report that the structure of a training programme provides in-depth learning experiences that contribute to developing their competence. Lois comments that participating in small group discussions in class has helped her to personally engage with the material. Some situations that trainees have found useful include coursework, lectures, skill practice and professional issues presentations. There is some notion within the data that suggests trainees experience a boost in their confidence by being on a training programme. For example, Jonathan indicates that
the training programme has expanded his understanding of what he could achieve as a professional. Jonathan remarks, “Having done the same job for so long and feeling like there might not be anything else that I could do, coming on a programme like this one with a variety of placements, getting feedback, seeing how other people see me; that has made me feel more competent than I felt having just done the same job.”

**Situational Factors that Influence Trainees’ Sense of Competence**

Several factors within trainees’ contexts, including placements and their university or training programme, were identified as having an influence on trainees’ sense of competence.

**Model of Service Delivery**

Counselling psychology trainees report that they develop ways to justify their approach to fit context-related expectations. For example, one trainee commented that when she decides to use a humanistic approach, she justifies her work to fit within the NHS structure. She uses the evidence base to help her make those clinical decisions. For example, trainee participants commented that within the NHS, the standards for therapeutic competence are skillful application of evidence-based interventions.

**Funding of Services**

Trainees comment that the NHS focuses primarily on the reduction of symptoms and this is the outcome they expect to fund. Thus the focus of the therapeutic work is specified and usually confined to a limited number of sessions.

**Training Programmes**

Trainees’ comments indicate that as they proceed through training they reflect on the values and philosophy of the training programme and the curriculum to consider whether they have the requisite skills and abilities to be considered competent. Trainees report that critical experiences of competence include undergoing formal assessments of competence as they advance through training. Trainees’ report these assessments of competence to be challenging and highly influential on their self-perceptions of competence.

**Placement Supervision**
Trainees report that formal and informal experiences of supervision influence their perceptions of competence. Trainees comment that their self-perceptions of competence vary according to their level of confidence within a professional environment. For example, in one placement context a trainee can feel self-confident and in another they can feel out of their depth because the requirements for context specific knowledge and the philosophy of competence varies according to the trainees’ placement context.

**Ethical Attitudes**

Trainees report that ethical attitudes are integral to therapeutic competence. Trainees comments indicate that they perceive the importance of two kinds of ethical issues: professional ethical issues and philosophical concerns. Professional ethics include recognizable standards of practice such as maintaining client confidentiality and enforcing the boundaries of the counselling relationship. Philosophical concerns highlighted in this study include managing the power imbalance in the therapy relationship, a reluctance to diagnostically label clients’ experiences.

Figure 4.42 summarizes the situational factors (left-hand column) and lists examples of how they influence a sense of competence (right-hand column).

<table>
<thead>
<tr>
<th>Situational Factors</th>
<th>Influences on Sense of Competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model of Service Delivery</td>
<td>Defines competent therapeutic practice.</td>
</tr>
<tr>
<td>Funding</td>
<td>Determines the focus and structure of the work.</td>
</tr>
<tr>
<td>Training Programme and Curriculum</td>
<td>Philosophy and theory of the training programme influences trainees’ definitions of competence.</td>
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<td>Assessments of competence influence trainees’ perceptions of competence.</td>
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<td>Supervision in Placement Context</td>
<td>Formal and informal supervision influence trainees’ perceptions of competence.</td>
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<td>Standards for competence are specific to a professional environment.</td>
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<td>Ethical Attitudes</td>
<td>Ethical attitudes become integrated during training through</td>
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experiences in practice. Ethical issues include professional ethics and philosophies of practice specific to counselling psychology.

4.4 CHAPTER SUMMARY

This chapter summarizes the findings gained from two analytical phases. The initial phase produced five focused codes that are explained in Section 4.1. The intermediate phase develops this analysis to produce a coding hierarchy that describes two core categories: Perceptions of Competence and Defining Competence. Seven subcategories were developed. Three of these subcategories, Coursework, Observer Feedback and Self-Reflections on Competence, were associated with Core Category One, Perceptions of Competence. Four subcategories – Clinical Experience, Reflexive Thinking/Self-Awareness, Theories and Models, and Supervision – were associated with Core Category Two, Defining Competence.

This research addressed the research question *How do counselling psychology trainees define, acquire, and experience a sense of their own competence?* The primary findings were that trainees experienced a sense of competence by applying definitions of competence to clinical situations and developing perceptions of their competence based on observer feedback and self-reflection on competence.
5

DISCUSSION

5.0 Introduction
5.1 Key Outcomes of the Study
5.2 Discussion of Key Findings
5.3 Methodological Discussion
5.4 Concluding Remarks
5.5 Future Research
5.6 Chapter Summary

5.0 INTRODUCTION

Chapter Aims
This chapter aims to illuminate the research question and discuss the key findings of this research for practice and research. It identifies trainees’ personal interest and experience of therapeutic competence and then discusses this in light of the wider literature. It also aims to critically discuss how the research design and the method have both limited and enhanced the study.

Section 5.1 of this discussion chapter summarizes the key findings to answer the research question. Section 5.2 contains a critical discussion of the findings, bringing in themes from the wider literature that was reviewed in Chapter 2. Section 5.3 provides a critical evaluation of the method and the limitations of the study. Section 5.4 summarizes the researcher’s concluding remarks about the implications of the research for understanding competence, the researcher’s personal reflections, recommendations for practice and further research. Section 5.5 contains a summary.

5.1 KEY OUTCOMES OF THE STUDY

A Theoretical Framework for Therapeutic Competence
One outcome of this study is its contribution to knowledge in training and development. A theoretical framework has been developed to explain how a group of eleven trainees understand competence. This is the only qualitative research study to date that uses grounded theory to discover how trainees define, acquire and experience a sense of their own competence whilst enrolled on a professional psychology training programme in the U.K.

This study contributes to the literature because it opens up themes in an under researched area, which is trainees’ experiences in training and professional development (Gross, 2005). Thus the theoretical framework developed in this study
can be used as a foundation to inform further research. Because this study samples trainee counselling psychologists, it explores how therapeutic competence is perceived in an early phase of professional development (e.g. Ronnestad & Skovholt, 2003; Orlinsky et al., 1999). It provides the benefit of a naïve viewpoint that can be used as a basis for comparison for future research.

Most of the literature on competence in psychology has been published in the U.S.A. This research has provided a U.K. focus on training in counselling psychology. Training is structured differently in the U.K. as compared to the U.S.; and the development of the profession in the UK has its own unique history and origins (Stein & Lambert, 1985; Strawbridge & Woolfe, 2010).

**Research Question**
This study has asked and answered the following research question: How do trainees define, acquire, and experience a sense of their own competence? This question has three parts: 1) How do trainees define therapeutic competence? 2) How do they perceive that they acquire competence? and, 3) How do they experience a sense of their own competence? These outcomes will be briefly summarized and discussed in relation to the literature.

**What is Competence?**
McLeod (1992) defines competence as the qualities and abilities of a person to fulfill a role or a task. The study findings suggest that trainees perceive therapeutic competence to be a process of gaining experience in practice and by an emergent sense of confidence in identifying and developing the skills and abilities needed to fulfill their professional role.

**Defining Competence in Counselling Psychology**
This study finds that trainees define therapeutic competence as technical skill in applying models of therapy (Strupp et al., 1988; Shaw and Dobson, 1988), personal qualities and relational skills sufficient to enable the therapist to create and sustain a therapeutic alliance (Gelso & Carter, 1985; Bordin, 1976), and ethical values and attitudes that are necessary for establishing a therapeutic relationship with appropriate boundaries to suit a professional context (Rogers, 1951; Gillon, 2007). The research participants indicate that therapeutic competence is founded on ethical principles that
include the practitioner’s personal commitment and aspiration to enhance their self-awareness and provide a good standard of practice, engage in professional development to improve their understanding of how to help clients, and the personal flexibility (and intellectual capacity) to apply their knowledge in multiple service delivery contexts.

One major thread running throughout this data is that this group of trainees has made an ethical commitment to their profession. Trainees’ perspective on the relationship between ethics and competence is consistent with literature. Mearns and Cooper (2005) suggest that competence is located in the values and ethics of the counsellor. Cooper (2009) argues that a key value is “ethics in action.”

Findings indicate that humanistic principles have been incorporated into these trainees’ perceptions and definitions of therapeutic competence. Research participants articulate a commitment to a humanistic philosophy that is inherent in the structure of training in the UK (Martín, 2010). Practice is founded on the ethical principles of empowerment, client autonomy, and the notion that the client is the expert in his or her own change process (Gillon, 2007). The commitment that counselling psychology makes to understanding subjective and intersubjective experiences of the client presuppose a belief that there is no single therapeutic truth and no singular way to do therapy (Gillon, 2007; Cooper & McLeod, 2011). This group of trainees describes themselves as integrative practitioners.

**Acquiring a Sense of Competence**

**Reflecting on Practice**

The data reflects trainees’ perceptions that one important method for developing competence is reflecting on practice. Trainees’ self-reports suggest the following process of developing a sense of competence from training: gaining an understanding of what it means to be competent and then reflecting on their skills to assess whether they have the capabilities to become competent practitioners. An analysis of trainees’ narratives indicates that they develop their skills and abilities to do therapy by first understanding what it means to be competent and then applying that knowledge in practice with clients.

The literature on training and development identifies that this reflective process facilitates learning how to do therapy (Bennett-Levy and Beedie, 2007; Bennett-Levy, 2006; Stoltenberg, 2005) and enhances professional development
(Schon, 1983, 1987; Thompson & Thompson, 2008). Chow et al. (2015) found one of the key factors in therapeutic competence to be time spent in “deliberate practice” that they define as intense self-supervision and reflection on practice.

**Learning Therapy Skills**

The theoretical and empirical research literature supports the idea that trainees develop the skills to do therapy by reflecting on practice. Bennett-Levy (2006) posits that trainees go through a process of learning first-order skills (declarative knowledge) from lectures and coursework, and then they reflect on this knowledge to understand how and when to apply it (reflective knowledge).

The theoretical literature on formative learning helps to clarify how trainees acquire competence by reflecting on practice. Sadler (1989) explains that students use feedback to accelerate their learning. Sadler’s work suggests that in order to develop competence, students need to understand the relevant criteria for competence, be able to measure their own performance against those standards, and reflect on their performance whilst they are engaging in the task (e.g. while they are conducting psychotherapy sessions). Then students can identify gaps in their learning that need to be addressed.

Much of the literature on supervision expresses that the central role of the supervisor is to provide opportunities for guided reflection on practice to help the supervisee develop the complex skills and abilities necessary to do therapy (Stoltenberg, 2005). Loganbill, Hardy and Delworth (1982) argue that supervisors are both teachers and mentors in a professional environment. Sadler (1989) highlights the role of feedback and the impact of the learning environment on students’ internal processes of learning. One implication of Sadler’s work for training is that feedback on trainees’ performance from within the learning environment (classrooms and clinical placements) has the potential to exert a significant influence on trainees who are taking in cues from the environment and using them to direct their learning.

**Learning from Practice**

Trainees comment that they learn lessons about doing therapy from their experience in practice with clients. This finding is supported by Stahl et al. (2009) who similarly discovered that trainees developed competence by applying their theoretical knowledge to concrete experiences of practice.
From their experiences in practice, trainees identified gaps in their knowledge that challenged their sense of competence. Trainees said that they filled in these gaps by reading and preparing for practice. Trainees also reported that they experienced negative feedback from observers (tutors and supervisors) as a challenge. Unfortunately, the data was insufficient to support any conclusions about how trainees resolved those challenges. This may be because very few research participants offered to discuss their experiences of feeling incompetent.

Experiencing a Sense of Competence

The experiences of competence were linked to a sense of confidence in skills and abilities that were acquired over time during training. This process of developing competence during training is reported elsewhere in the empirical literature. Hill et al. (2015) completed a longitudinal study that found doctoral students improved their competence and self-efficacy beliefs during training. In the context of this present study, trainees’ comments indicate that they recognize progress in their skills over time. They reported “knowing more than they used to” or “knowing enough to handle most things” or “feeling more comfortable with their practice.” Trainees report that experiencing this sense of progress enhanced their perceptions of their own competence.

One way trainees experienced a sense of competence was through their thoughts and feelings about their client work. Trainees commented that they spent time reflecting on practice as a way of reviewing or assessing their work. These self-assessments of competence influenced trainees’ perceptions of their own competence. Nicol and Macfarlane-Dick (2006) suggest that trainees are using self-assessment and formative feedback from supervisors to address their strengths and weaknesses and improve their performance. Research participants confirmed that their experiences of competence were influenced by interactions with colleagues and clients in the training environment. They reported that positive affirmation from colleagues and supervisors gave them a sense of confidence in their skills and abilities. Trainees recounted other experiences that influenced their sense of competence including positive and negative emotions about the therapy process with certain clients, their own self-confidence, and the quality of their experiences in placement.

Trainee Characteristics and Therapeutic Competence
The philosophy of humanistic approaches to therapy, which partially locate therapeutic competence in therapist held values and attitudes (such as regard for their clients), is founded on the personal qualities of the therapist (Rogers, 1951). Jennings, Goh, Skovholt, Hanson, and Banerjee-Stevens (2003) identify intellectual curiosity, emotional well being and openness to change as key characteristics of successful therapists. Skovholt and Ronnestad (1992) highlight that personal motivation for self-development is a desirable characteristic in a therapist.

Trainees report that self-awareness contributes to therapeutic competence and indicate that they value, among other things, self-knowledge. They consider that competence includes the capacity for self-awareness, learning new things, the ability to monitor their emotional well-being in order to be effective, and the ability to reflect on the therapeutic process. The training literature suggests that a key value for trainees is self-awareness (Wheeler, 2000). Thompson & Thompson (2008) argue that self-awareness (or reflexivity) is part of reflective practice.

*Therapeutic Competence and Personal Therapy*

Trainees comment that personal therapy helped them to become more self-aware and this contributed to their competence. Gimmer and Tribe (2001) report that trainee counselling psychologists identified personal therapy as a factor in training that had positive outcomes on trainees’ professional development. Wheeler (2000) found, however, that time spent in personal therapy was not related to therapist competence.

One difficulty in interpreting these findings is reconciling trainees’ perspectives on personal therapy with the empirical literature. Wheeler (2000) found that although self-awareness is an important quality for a therapist, time spent in personal therapy was not related to therapy outcomes so there is no statistical link between therapist competence and time spent in personal therapy. One way to explain this discrepancy between trainees’ perceptions and the empirical literature might be to consider the implications of Wheeler’s work and that of other researchers who have studied therapist characteristics (e.g. Buetler et al, 2004). The research on therapist characteristics suggest therapists, by virtue of their vocational choices, already belong to a group of highly self-aware individuals that are dedicated to personal development. Bearing this thought in mind, it could be said that for some trainee participants, personal therapy as a self perceived factor in competence is merely the
“icing on the cake” and that other consequences of being in personal therapy during training that have been reported by trainees, such as an improved sense of empathy for clients and modeling their own personal therapists in practice, are more influential to developing competence than the personal insights trainees gain from therapy (see Gimmer & Tribe, 2010).

This is not to say that personal insights gained from therapy are irrelevant to therapist competence. This study implies that there are two main reasons why personal insight is relevant to competence 1) Trainees point out that they rely on personal insight to work through transference and counter transference reactions with their supervisors and 2) Trainees perceive personal therapy to be an important part of their development.

Although there is no established statistical connection between personal therapy and therapist competence, qualitative research into trainees’ experiences of competence has identified that personal therapy is an important part of trainees’ professional development and a formative experience (Gimmer & Tribe, 2010; Grafanaki, 2010). This current research study concurs that trainees consider personal therapy to be important. It also demonstrates that trainees believe that reflexivity is a key skill for developing competence. This finding links in with Thompson and Thompson (2008) and Ridley, Mollen, and Kelly (2011) who argue that self-awareness is one key element of reflexivity.

This line of thinking highlights that competence is a multi-faceted construct that is difficult to define and measure (Ridley, Mollen & Kelly, 2011; Margison et al., 2000). It also shows that trainees perceive that several training factors, including personal therapy and clinical supervision, facilitate the development of reflexive thinking skills.

These findings have implications for counselling and psychotherapy research. One implication is that therapeutic competence is difficult to study using quantitative research approaches. This may explain why some researchers find they have problems verifying the effects of training and that it can be difficult to establish a robust statistical relationship between therapeutic competence and therapy outcomes (Shaw et al., 1999; Ladany, 2007). It may be that qualitative research or mixed methods approaches are better suited to the aim of broadening our understanding of competence.
Trainee Confidence and Competence

This research analyzed trainees’ self reports to explore their perceptions of competence. One finding revealed that trainees’ perceptions of competence were linked to a sense of confidence in their skills and abilities. Thus trainees’ self-efficacy beliefs are a factor in their perceptions of competence.

Support for the notion that confidence is linked to competence has been highlighted by Bandura (1977). Bandura argued that self-efficacy beliefs are self-reinforcing and the effects are cumulative. His work suggests that as trainees experience a sense of competence in their client work that experience triggers positive self-efficacy beliefs. This may explain why trainees who note a sense of progress in their practice over time during training say that that this awareness contributes to their sense of competence.

Support for the idea that self-efficacy beliefs contribute to a sense of competence can be found in the empirical literature. Wheeler (2000) points out that one important outcome of counsellor training is improved self-efficacy on the part of the counsellor. Melchert, Hays, Wiljanen, and Kolocsek (1996) and Orlinsky and Howard (1986) reached related conclusions, being in training helps to improve self-efficacy beliefs and self-confidence is a factor in a therapists’ work with clients. This empirical research and these findings dovetail with one another: trainees who feel confident perceive that they are competent. Whether they are actually competent is another matter because the empirical literature also suggests that therapists are not accurate assessors of their own competence (Brosan, Reynolds, & Moore, 2008; Mathieson, Barnfield, & Beaumont, 2008). This study does not purpose to ascertain whether trainees’ perceptions of competence are accurate. There is some evidence to suggest that trainees’ perceptions about certain aspects of their own competence (such as the quality of the therapeutic alliance) can be accurate. A recent study by Hill et al. (2015) was able to confirm that their sample of graduates developed competence over time during training by comparing both therapist and client measures of the therapeutic alliance.

Competence in Context

One implication of this research for practice is that it highlights the influence of context on trainees’ perceptions and definitions of competence. One major theme in the data is that trainees identify the influence of context on training and practice.
Research participants say that therapeutic competence is defined differently in different contexts. Trainees’ self-reports indicate that situational factors directly impact their perceptions and definitions of competence. Every trainee is impacted by these situational factors. The two contexts highlighted in this study include the research participants’ training programmes and their clinical placements.

**Training Programmes**
Folkes-Skinner, Elliot, and Wheeler (2010) suggest that training programmes support trainees who are transitioning from classroom learning to clinical practice. Helpful processes for making this transition identified by the Folkes-Skinner study included supportive relationships with tutors and supervisors who served as mentors and models for students. Smith (2010) similarly discovered that trainee counsellors found empathic relationships with tutors to be helpful for facilitating their learning and professional development.

Another function of the training programme is that of acculturation into a system of professional values and ethics (Handelsman & Gottlieb, 2005). Walsh, Frankland, and Cross (2004) points out that training programs are distinguished by a distinct philosophical and theoretical “flavour”. Thus it may be inferred from the theoretical literature that tutors have a role in inculcating students into the profession as they transmit specialized knowledge about the discipline of counselling psychology. One way of explaining the influence of the training context might be to consider that tutors, who are forming supportive relationships with students, are serving as models and mentors. Trainees report that feedback from other professionals influences their sense of competence. It may be inferred from the data that tutors, who also have the responsibility for assessing students’ competence, transmit their own personal values and attitudes about competence to students who then use those standards to evaluate and refine their practice, especially in the beginning stages of their professional development. Evidence for line of reasoning can be found in the literature by considering Fitzpatrick, Kovalak and Weaver’s (2010) argument that the philosophy of mentors and supervisors helps to shape trainees’ initial theories of practice. The influence of mentors on trainee development is considerable. Ronnestad and Skovholt (2003) found that beginning students rely heavily on support and guidance from their tutors and supervisors.

**Clinical Placements**
Research participants indicate that the context of their clinical placements influenced their practice. It may be inferred from the work done by Ronnestad, Helge, and Skovholt (Mar/Apr 1993) that the culture of a trainees’ clinical placement influences their experiences of competence because it is a key factor in supervision. Trainees in this study reported that their perceptions of competence were influenced by their experiences in training and practice as they worked alongside other professionals who were assessing their competence. Trainees reported that when they received positive affirmation about their competence from colleagues and supervisors it gave them confidence in their competence. This suggests that placements are an important influence on trainees who are forming their identities as therapists (Mantica, 2011).

Two major variables reported by trainees related to placement context include the standards for competent practice and supervision.

*Service Context*

Research participants were placed in several contexts including a private hospital, several charities and the NHS. Trainees report that the standards for therapeutic competence are dependent on the philosophy and culture of their service context. For example, the National Institute for Health and Care Excellence (NICE) guides the structure and focus of therapeutic work in the NHS (e.g. NICE, 2009). In the NHS model, treatment manuals specify how therapeutic interventions should be executed (Clark, 2011). Thus one standard for competent practice within the NHS would be the technical skills of the therapist to work within a specific model of therapy (Chambless, 1996).

Funding is a factor for influencing practice. For example, one research participant pointed out that the treatment philosophy of the NHS, which is to alleviate symptoms, influenced her to focus on the client’s symptoms even when other factors were present and relevant to the client’s goals for therapy. The NHS demands financial accountability and its power (in the form of funding) influences the landscape of therapy and the corresponding competencies of the therapist who is seeking employment in that arena (Corrie & Calanan, 2001).

*Challenges of Context*

This present study finds that placements influence trainees’ perceptions of competence through professional interactions that either support or do not support trainees’ perceptions of themselves as competent practitioners. Trainees’ perceptions that clinical supervision is context dependent are borne out in the literature.
Ronnestad, Helge and Skovholt (1993) argued that the institutional culture strongly impacts supervision and a lack of identification with the values of the culture on the part of the student can be experienced as particularly tense. One example of how trainees identified clinical supervision as having an impact on their perceptions of competence was through formal assessments of competence. In training, supervisors are called upon to formally comment on trainees’ competence. Not only are trainees sensitized to their supervisor’s opinions about their competence by virtue of their roles as mentors and teachers, they also rely on them to pass their courses. This gives supervisors considerable power and influence over trainees. Trainees comment that the standards for knowledge (the basis of these assessments of competence) are context specific and that changing contexts influenced their sense of competence because in one context they might feel confident with their knowledge and in another they may feel completely out of their depth. Trainees are expected to perform well in multiple placements, a condition that puts additional strain on them as they transition between different placement contexts. Trainees report that supportive and helpful supervision is a major factor in their learning experiences on placement. This finding is broadly consistent with the empirical literature. For example, Heppner and Roehlke (1984) found that student counsellors who were just beginning their training appreciated supervisory behaviours related to building rapport and helping them develop their counselling skills.

Supervision in Placements

Trainees in this study reported that informal experiences of feedback from colleagues also influenced their perceptions of competence. Trainees commented that some helpful learning opportunities encountered in placements included multidisciplinary team (MDT) meetings and group supervision/case discussion sessions. Trainees that discussed informal experiences of supervision reported that a professional context helped them to experience a sense of competence in three ways:

1. They develop a sense of competence from managing professional relationships
2. They use peer supervision to develop contextually relevant skills and knowledge
3. Feedback that is experienced as helpful or unhelpful in a professional situation influences a trainee’s sense of competence
One implication for practice that has been generated by this research comes in the form of a potential professional challenge related to trainee development. Woody, Weisz, and McLean (2005) and Kamen, Veilleux, Bangen, VanderVeen, and Klonoff (2010) highlight that placement contexts influence trainees learning and professional development.

Competing philosophies of practice between training and placement contexts put a strain on supervisees (Ronnestad, Helge & Skovholt, 1993). Training emphasizes humanistic values but some placement contexts especially within the NHS are based on a medical model that emphasizes diagnosis and treatment of specific mental health disorders (Gillon, 2007).

Trainee participants in this study identified some of the contextual challenges that impact on their perceptions of competence. The implication for the profession is that perhaps more can be done to support them. I have included recommendations for training practice that I will return to later.

Another professional challenge is to gain a greater awareness of therapeutic competence. One way to address this need is through further qualitative research to explore some of the themes that have been discovered in this study. One obstacle to research is the absence of agreement on the factors that constitute competence (Margison et al., 2000). Another is a lack of information on how trainees and psychologists are working out their values in practice. This is an area that might be of interest to future researchers.

This study discovered that one implication for practice is that therapeutic competence is defined differently in different contexts. This can potentially become confusing for trainees. For example, in an NHS context the standard for competence may be adherence to a CBT protocol (Cross & West, 2011). Trainees who have been educated in a humanistic ethical framework may struggle to conform to this expectation resulting in negative perceptions of competence and a consequent lack of confidence. It may be that this issue is particularly acute early on in training because this is when trainees are beginning to develop a blueprint or a strategy for practice (Kamen et al., 2010; Ronnestad & Skovholt, 2003).

A narrowly defined definition of competence has implications for practice. Boucher (2010) points out that the tendency towards an over commitment to an empirically supported treatment in NHS contexts does not equate to therapeutic
competence. This insight is especially applicable to counselling psychology that operates from a pluralistic value base.

Trainees report that they make adjustments to fit practice to their context. For example, one trainee reports that when she works for the NHS (which primarily uses CBT approaches) she either has to justify using an alternative model using the NICE guidelines or work outside of that therapy model. It is worth noting that trainees are picking and choosing how they approach practice on the basis of context rather than client presentations. There is insufficient data to discuss the basis on which trainees are making these decisions. Further exploration of how this occurs in practice could be a useful area for further research to highlight how competence is defined and applied in practice.

This study highlights that NHS placements posed a significant challenge for at least one trainee participant. Other participants alluded to experiencing challenges to their sense of competence but did not disclose details about how they were resolved. Based on these findings, it can only be said that each trainee has challenges to their competence in his or her own way. This study did not find sufficient data to support an in depth discussion of the impact of challenges on individual trainees because few trainees offered to discuss overcoming challenges to their competence in practice. Such a discussion could prove useful for understanding how trainees were coping with negative feedback and using it to inform their learning. Thus it might be of interest to future researchers.

**Unusual Findings**
There were some unusual findings in this research. Some expected themes were conspicuously absent. For example, there was no mention of therapeutic competence in relation to ethnicity, race, or sexual orientation. Given that counselling psychology has its philosophical roots in humanistic philosophy, which is concerned with tolerance, autonomy, and “humanizing” organizations and social structures, this is perhaps surprising (Warmoth, 1998). Trainees also did not discuss psychopharmacology. This is also surprising because counselling psychologists are expected to “be able to critically evaluate psychopharmacology and its effects from research and practice” (HCPC, 2012b, p. 19). Barnett and Neel (2000) assert that knowledge of psychopharmacology is crucial for competence in psychological
assessment and for ensuring that the patient is fully informed about the evidence for psychopharmacological treatment as well as talking therapies.

Psychopharmacology, multicultural competence, social justice, and diversity are professional issues related to therapeutic competence (Vera & Speight, 2003, Kaslow, 2004; Constantine and Ladany, 2000; Sue et al. 1982). Trainees did not discuss these competencies. Because these issues are topical in counselling psychology, I expected to hear trainees talk about them. This data is absent despite the commitment of the profession to cultivate an awareness of these values and attitudes (e.g. BPS, 2001), structure training to develop this knowledge (e.g. Martin, 2010), and required demonstration of multicultural awareness in practice (HCPC, 2012). The absence of this data is noteworthy and it may raise some questions for those involved in training and supervision and therefore may be of interest to future researchers.

5.2 DISCUSSION OF KEY FINDINGS

The aim of this section is to discuss the findings in relation to the literature. It is divided into seven sub sections related to each of the seven sub categories of the theoretical framework that was presented in Chapter Four. This discussion will highlight 1) Trainees understanding of and connection to therapeutic competence and 2) discussion of findings related to interest in therapeutic competence and the relevance of therapeutic competence. Each sub category will be discussed separately and critically evaluated in relation to the literature. The subcategories to be included in this discussion are as follows:

1. Coursework
2. Observer Feedback
3. Self-Reflection on Competence
4. Clinical Experiences
5. Reflexive Thinking/Self-Awareness
6. Theories and Models
7. Supervision

1. Coursework

Research participants commented that coursework was valuable for developing competence because it informed them about the philosophy and theory that guides practice. Trainees say that having to write theory papers or complete other course
requirements (such as classroom presentations) helped to improve their understanding of psychological theory and models of therapy. They believe this knowledge helped to enhanced their sense of competence and inform their practice. One participant said that knowing theory helped him to feel more prepared to work with clients. Another reported that having to delve deeply into the topic of dissociation to complete an assignment had helped to raise her awareness about psychological theory, and she related an experience where she used that information to help a client.

The structure of training and qualification in counselling psychology requires counselling psychologists to be both producers and consumers of research (BPS, 2014). Martin (2010) points out that universities want to ensure the standards of qualification for professional doctorates remain analogous to those of a Ph.D. and this requires advanced skills in academics and research. Several trainees mentioned that the experience of doing research as part of their coursework helped them to develop skills they perceived to be valuable for their practice. The data reflects research participants to be more identified with competencies associated with practice. Only two of the seventeen competencies identified by trainees (the capability to conduct research and understanding the science behind evidence based practice – see Figure 4.10) were related to scientific competencies. This may be because the research question is oriented towards discovering knowledge about practice.

Training exposes students to multiple theoretical orientations (Martin, 2010). One trainee commented that she enjoyed the diversity of her training and felt that it made her feel more competent to practice.

Fitzpatrick, Kovalak, & Weaver (2010) pointed out that trainees develop a philosophy of practice early in their training and philosophical assumptions were the most accurate predictor of theoretical orientation. The Weaver study also found that integrative practitioners develop the capacity to synthesize theory through reading materials that support principles of change rather than single theories.

The findings from this current research study suggest that trainees’ definitions of competence are shaped by the primacy of a humanistic philosophy (Martin, 2010). Most trainees describe their practice as integrative, pluralistic or multi-theoretical. An integrative or pluralistic philosophy of practice is in keeping with the theoretical assumptions that underpin counselling psychology. Gillon (2007) states that the philosophy of counselling psychology recognizes that there is no single therapeutic truth. One research participant verbalized a connection between an integrative
philosophy of practice and competence. He commented that he would not feel competent to stay within one model of therapy because he knows there is no single, right way of doing therapy. Another trainee mentioned that she felt inspired by working in a multi-theoretical way, and she intended to cultivate a practice that is informed by multiple theories of therapy.

2. Observer Feedback

Trainees identify that feedback influences their perceptions of competence and facilitates their professional development. The trainee participants in this study reported having both formal (e.g. fitness to practice evaluations, supervisor’s reports) and informal feedback (e.g. positive comments and constructive feedback from supervisors and colleagues) during training. Trainees’ comments indicate that feedback from observers (supervisors, tutors, and especially clients) influenced their sense of competence and helped them to develop their skills and abilities.

Trainees reported that they looked to others for confirmation of their competence. Four trainees emphasized that feedback from observers (especially tutors and more experienced colleagues) influenced their self-perceptions of competence. This finding links with Ronnestad and Skovholt’s (2003) observation that “advanced” students who are learning to function at a professional level “actively seek confirmation and feedback from seniors and peers” (p. 15).

Trainees also report that negative feedback resulted in feelings of incompetence. They acknowledged that negative feedback was challenging but it had ultimately helped them grow as professionals. This observation is consistent with the empirical literature. Furr and Carroll (2003) discovered that although students found negative experiences challenging, they were forced to grow from the experience and gained a stronger sense of their identity as therapists.

Developing Autonomy

Some trainees indicated that they were becoming less reliant on external feedback to assess their competence. This is broadly consistent with the theoretical literature on therapist development. Ronnestad and Skovholt (2003) and Stoltenberg and Delworth (1987) observed that in the advanced phases of training, students show signs of become more independent and self–referent as they moved towards a more autonomous practice.
Outcome Measures and Therapeutic Competence

Outcome measures are routinely collected in Improving Access to Psychological Therapies (IAPT) and other mental health service delivery contexts throughout the U.K. (Glover, Webb, & Evison, 2010). One purpose of quantitative outcome measures is to assess the effects of therapy by tracking changes in a client’s perception of his or her well-being throughout the course of treatment.

Three trainees mentioned using outcome measures to inform their perceptions of competence. One trainee stated, “One of the answers to the question of therapist competence might be – do the numbers indicate that the client is better off at the end of therapy then he or she was at the beginning?” It may be an intuitive assumption that competent therapists get better outcomes but the empirical data suggests that there is little evidence to support that assumption (e.g. Shaw et al., 1999; Stein & Lambert, 1995).

One reason that outcome measures may not reflect therapist competence that has been discussed is that clients vary in their ability to participate in a therapeutic alliance (Horvath & Luborsky, 1993). Lambert and Barley (2001) estimate that client factors account for a substantial variance in outcomes. Sometimes the nature and severity of the clients’ problems mean that they do not make very much progress in treatment. In such cases, quantitative and qualitative outcomes may be both an insufficient measure of the effects of therapy and an inaccurate reflection of therapeutic competence.

Negative Feedback

Four trainees mentioned the influence of negative feedback on their perceptions of competence from supervisors, tutors and clients. In each case the trainee experienced a period of self-doubt. In one case criticism from a supervisor resulted in a prolonged experience of self-doubt.

Ronnestad and Skovholt (2003) point out that negative feedback from clients and supervisors can be extremely challenging even for experienced therapists. These authors also say that advanced students, who are moving from training into professional roles, can become anxious about their competence, making them sensitive to negative feedback from clients and more experienced professionals.

Feelings of incompetence experienced by novice therapists are widely reported in the literature (Theriault, Gazzola, & Richardson, 2009). My research
participants found these feelings of incompetence to be difficult, but they reported that these experiences resulted in a heightened sense of self-awareness that furthered their professional development.

3. Self-Reflection on Competence

Eleven research participants in this study reported that they reflected on competence to evaluate their practice. Several trainees noted that self-reflection helped them enhance their competence. Some trainees’ comments indicate that they reflected on practice to assess their competence by reviewing their thoughts and feelings about the work. The nature of these self-evaluations (e.g. whether they were positive or negative) of competence influenced their perceptions of competence.

Theriault, Gazzola and Richardson (2009) and Ronnestad and Skovholt (2003) found that beginning trainees and novice therapists could experience anxiety about their competence that had a negative impact on the work. Nutt Williams, Hurley, O'Brien, and DeGregorio (2003) discovered that a heightened sense of self-awareness in therapists could sometimes feed feelings of self-consciousness and anxiety experienced by a trainee who is counselling a client, especially early on in their practice. Some trainees in this present study reported self-consciousness and negative emotions about the work, especially at the beginning when they first started doing work with clients.

Cognitive Development

One positive contribution to competence linked to self-reflection that has been identified is cognitive development, a term which describes the forging of new schemas for gathering information that can be used to guide practice (Ronnestad & Skovholt, 2003; Furr & Carroll, 2003; Ridley, Mollen & Kelly, 2011). One trainee provided an example of cognitive development when she reflected on a safeguarding incident to develop an ethical framework for practice.

Research participants in this study indicated that they developed competence by engaging in self-supervision which is defined in the literature as reflecting on learning and practice to inform the work (Bennett-Levy, Thwaites, Chaddock, & Davis, 2009; Chow et al., 2015). Chow et al. (2015) identified that time spent in deliberate practice (or self supervision) improved therapist competence. It appears that the participants who discussed self-supervision believed that reflecting on events
in sessions helped them learn what it means to do counselling and psychotherapy. These findings are reflected elsewhere in the literature. For example, Skovholt, Ronnestad, and Jennings (1997) report that self-reflection facilitates the process of developing expertise in therapy. Bernstein and Lecomte (1979) and Dennin and Ellis (2003) also suggest that self-supervision enhances competence.

**Self-Efficacy Beliefs and Competence**
Trainee participants in this study indicated that having a sense of confidence about their work helped them to develop competence. This finding is broadly consistent with the empirical and theoretical literature on training and counsellor development. Nicol and Macfarlane-Dick (2006) suggest that student’s self-efficacy beliefs influence their learning. Orlinsky and Howard (1986) linked self-confidence to positive outcomes in therapy. Melchert et al. (1996) applied self-efficacy theory to counsellor development (Bandura, 1977). The Melchert study found that counsellors improved their skills as they raised their expectations of success, which in turn reinforced further development.

It may be that when trainees comment they are making progress and feeling calmer in sessions, it indicates that their self-efficacy beliefs are being reinforced through their positive experiences. This interpretation of the data suggests that positive feedback contributed to trainees’ self-efficacy beliefs, facilitated their learning and helped them to develop competence.

4. Clinical Experiences

**Developing Competence in Clinical Work**
Beginning work with clients is widely reported to be a critical factor in therapist development (Furr & Carroll, 2003; Stahl et al., 2009). Research participants identified clinical practice as an important source of learning how to develop their skills and abilities. Hill et al. (2015), a longitudinal study that measured the development of skills during training, verifies trainees’ perceptions that they are actually gaining skills through their clinical experiences.

One impact of client work on therapists that has been identified in the literature is that therapists learn to appreciate the partnership aspect of the therapeutic relationship (Stahl et al., 2009). This study supports the development of this insight in trainees. For example, one trainee noted that collaborative work gains momentum as clients take more initiative. She interprets these phenomena as evidence that the client
is “gaining a sense of trust in the work – and in me.” In other words, for this trainee the client’s initiative is evidence of the therapeutic alliance, a prerequisite for collaborative working and a key factor in therapy outcomes (Gelso & Carter, 1985).

Trainees also reported that they were focused on integrating theory, informing their work with specific client groups, and developing knowledge and skills for evidence-based practice including competencies in assessment and case formulation, ethics, and other professional competencies. These are identified in the literature as higher order skills (Hill & Lent, 2006; Stoltenberg, 2005). It may be that the reason trainees in this study were focused on higher-level skills is due to the nature of the sample. Graduate training programmes in professional psychology have stringent requirements that presuppose candidates have already acquired counselling experience therefore there is less attention being paid to developing micro skills in training (UOM, 2011).

One reason why trainees develop skills and abilities when they begin to practise with clients is that they prepare for clinical work. Preparing for practice helps to consolidate trainees’ skills because it helps to develop schemas to organize new information (Skovholt & Ronnestad, 2003). Trainees report that they prepare for clinical work in the following ways:

1. Reading widely and consulting research to develop their understanding of psychological theory and client presentations
2. Integrating theories and models into their client work and testing their effectiveness in practice (e.g. Fitzpatrick, Kovalak, & Weaver, 2010)
3. Gaining practice of working with the therapeutic relationship (Rogers, 1957, Bordin, 1976)
4. Self-evaluation of their skills and abilities to deliver evidence-based interventions
5. Developing their clinical judgment from the feedback they receive on their formulations from supervisors and senior colleagues

**Learning from Clients**

Stahl et al. (2009) discovered that as beginning trainees become exposed to new client presentations in their practice, they gain an improved understanding of how to work with specific diagnoses and the limits of what therapy can accomplish. The Stahl study identified, for example, that trainees discover the importance of the
partnership element of the therapeutic relationship. Trainees in this current study report that they learned theory from coursework but they deepened that experience by applying theory to practice as they began working with clients. For example, trainees comment they gained an awareness of how client factors (client presentations and client characteristics) affect the quality of the alliance. One trainee reflected, for example, that the client’s willingness to engage in therapy could sometimes present an obstacle to the therapy. Her comment was that certain clients “give her nothing to work with.”

Learning from Experience

The literature reflects that trainees learn to develop their own individualized approach to their client work (a theory of practice) by learning from their experiences in clinical practice (Fitzpatrick, Kovalak, & Weaver, 2010; Loganbill, Hardy, & Delworth, 1982). The more clinical experiences a trainee has, the more opportunities they have to develop that competence (Skovholt & Ronnestad, 2003).

Case Conceptualization Skills

Trainees in this study report that when they started working with clients they learned to rationalize and justify their work to supervisors and other professionals. This is one way of saying that they learned to develop case formulation skills. Support for this interpretation of the data can be found in the training literature. For example, Bitar, Bean, and Bermudez (2007) argue that practical work exposes trainees to a range of clients, which develops their ability to conceptualize clients’ problems. O’Byrne and Goodyear (1997) found that trainees improve their assessment skills as they gain experience working with a range of clients.

5. Reflexive Thinking/Self-Awareness

Using Reflexive Thinking Skills and Self-Awareness to Develop Competence

Self-awareness, self-reflection and reflexivity are related concepts that form part of this dense subcategory, Reflexive Thinking/Self Awareness. This category has been developed from trainees’ comments that suggest reflexivity and self-awareness is part of therapeutic competence. Trainees’ comments indicate that reflexivity helps them to reflect on practice and self-awareness is a form of self-monitoring that helps them to fulfill their ethical obligation to remain safe and effective as therapists.
This interpretation of the data is broadly consistent with the literature on therapist training and development. Thompson and Thompson (2008) point out that reflexivity (the ability to be self aware and to see oneself as a source of influence in a process) is part of reflection on practice. Martin (2010) identifies that training is oriented toward developing reflexivity, which is seen as a skill or a habit of thinking that is necessary for competent practice. Trainees in this study have identified that reflexive thinking is a skill they use to develop their competence. This study has found that trainees identified learning processes such self-assessment, self-reflection, and reflection on practice as methods by which they develop competence.

**Developing Reflexivity**

The literature identifies several methods of developing reflexive thinking skills. Stoltenberg (2005) maintains that reflexive thinking is developed by participating in supervision. Another method that has been highlighted is personal therapy (Gimmer & Tribe, 2010). A third approach is to develop critical thinking skills and knowledge of the scientific method by completing coursework (Martin, 2010).

**Self-Care and Safe Practice**

This study has found that trainees are committed to the ethics of competence and that they identify self-care as a method for maintaining safe and effective practice. Norcross (2000) argues that psychology is a demanding profession and that psychologists who are not aware of this, and do not engage in self-care, might actually be incompetent. Schwebel and Coster (1998) found that psychology programme directors believe that self-awareness/self-monitoring contribute to optimal functioning among psychologists. Thus the literature suggests that self-awareness is part of self-monitoring and that self-monitoring contributes to competence.

Eight trainee participants in this study identified that self-care is important for maintaining effectiveness. Some trainees expressed the importance of modeling self-care and being fully “present” with clients, which in turn depended on them looking after themselves.

Trainees’ reflexivity around their own values as helping professionals is also part of the subcategory. Some trainees in this study verbalized a sense of personal connection to their vocation and of personal satisfaction gained from helping people. Hill et al (2013) found similarly, that trainees undertaking training in counselling and
psychotherapy said that they valued helping people, which was a core element of their personal ethics. The Hill study found that aspiring therapists are motivated by altruistic values and find personal meaning through their vocation. Norcross (2000) similarly reports that most mental health practitioners feel “enriched, nourished and privileged in conducting psychotherapy” (p. 712).

6. Theories and Models

**Developing Technical Competence**
Trainees report that it is important to develop their knowledge of how to use evidence-based interventions. The theoretical and empirical literature reviewed in Chapter 2 is pertinent to this discussion. A therapist’s ability to implement a model of therapy is called “technical skill” (Fairburn & Cooper, 2011). A therapist’s level of skill to implement an empirically supported treatment protocol is referred to in the literature as “intervention competence” (e.g. Sharpless & Barber, 2009). Intervention competence has two components, adherence and skillfulness (Shaw & Dobson, 1988). The literature review in Chapter 2 demonstrated that intervention competence is pertinent to efficacy studies of therapy treatments because the only way to test a treatment is to ensure that it is delivered in the manner it was intended (Sburlati, Schniering, Lyneham, & Rapee, 2011). Thus treatment fidelity and intervention competence are mutually interdependent concepts in the research literature (Cross & West, 2011).

Trainees understand that psychological theory, psychotherapy, and empirical research contribute to therapeutic competence. Comments indicate that they are aware of a body of research that supports evidence-based interventions. Nine trainees suggested that a factor in developing technical competence includes the ability to apply the research literature to inform practice.

**Developing a Theory of Practice**
The research participants in this study are not only interested in building skills in evidence-based practice, they are also thinking about moving between models, integrating psychological theory, and developing their own style of working. Nine trainees indicated that they were developing a way of working which they described as pluralistic, multi-theoretical, or humanistic. All eleven trainees indicated that their practice was informed by cognitive behavior therapy and most mentioned that they
were using humanistic therapy. Four trainees mentioned incorporating elements of psychodynamic psychotherapy and mindfulness.

**Theoretical Integration**
A brief discussion of theoretical integration is pertinent to this discussion because counselling psychology values integrative practice (HCPC, 2012b). Two trainees articulated that they were consciously developing a philosophy of practice. The theoretical literature pertaining to supervision is broadly consistent with the idea that therapists develop a working philosophy and a personal style of practice as part of their professional development and that helping students to integrate theory and practice is a supervisory concern (e.g. Loganbill, Hardy, & Delworth, 1982; Stoltenberg, 2005). Thus it might be important in this discussion on theories and models to understand more about how and on what basis trainees were handling the task of theoretical integration.

Some trainees’ narratives suggest that they were engaged in theoretical integration as a prelude to developing a philosophy and a personal style of practice even though they did not articulate this perception. Most of these trainees seemed to be integrating theory on the basis of “Broad Band Eclecticism” which is when practitioners have an overarching philosophy or meta theory that may incorporate techniques from various approaches (Hollanders & McLeod, 1999). For example, many of the trainees who discussed having a strategy for theoretical integration commented that their approach to practice was “multi theoretical” “integrative” or “pluralistic.” Most trainees indicated that they were integrating different theoretical approaches on the basis of the perceived needs of the client. They identified integrative processes such as “using CBT in a flexible way” and “focusing on the therapeutic relationship while integrating CBT techniques.” This perspective on theoretical integration as part of competence is found in the literature. For example, Boucher (2010) has discussed using a flexible approach to CBT and he suggests that strict adherence to a CBT protocol is not necessarily evidence of therapeutic competence. Ashley (2010) points out that counselling psychologists can incorporate CBT into a theory of practice that is informed by a humanistic philosophy. Milton (2010) states: “Counselling psychologists are not humanistic therapists but scientist practitioners who navigate different models in a constant process of reflection” (p. 103).
Although most trainees expressed their preference for an integrative practice, this was not a universal opinion. It is worth pointing out that at least two trainees expressed a clear preference for using CBT on the basis of clinical evidence of its effectiveness for most mental health disorders (e.g. Chambless & Ollendick, 2001). Further nuances on integrating theory were evident in the data. For example, one trainee described working with more than one model but she clarified that she did not use the term “integrative” because it connoted a style of working that was not clearly evidence based. Her process of working with multiple models was to apply discrete theoretical orientations with her clients in tandem as appropriate for the client. This suggests that she is not a theoretical assimilationist (Arkowitz, 1992). In describing her philosophy of practice, this trainee’s emphasis was on understanding how to apply models of therapy, keeping the work discrete and focused, and remaining open to bringing in multiple theoretical approaches at different stages of treatment for a specific and clearly articulated purpose. Thus her philosophy might be described as multi-theoretical but narrowly eclectic in practice (Holleaders & McLeod, 1999).

These nuances demonstrated in these findings are consistent with those of Hollanders and McLeod (1999) who discovered that a majority of UK practitioners in their sample described their practice as broadly eclectic. Unfortunately, the data in the present study is insufficient to support an in-depth discussion of how and on what basis these eleven trainees are integrating theory. This could be an area for further research.

I have already discussed that understanding how trainees are integrating theory is important because: 1) counselling psychologists are expected to practice using multiple theoretical models and 2) therapeutic competence is often defined in the theoretical literature and research as technical knowledge and adherence to a model of practice (Sharpless & Barber, 2009; Barber et al., 2007). This suggests that theoretical integration could be considered a competence in its own right. For example, Draghi-Lorenz (2010) argues that counselling psychologists must be competent theorists in order to be competent practitioners. My findings indicate that trainees experience the task of theoretical integration as a challenge that influences their perceptions of their own competence. For example, trainees comment that when they are integrating an unfamiliar model into practice they feel less competent. The theoretical and research literature suggests that when therapists feel less competent
they may under perform (Melchert et al., 1996; Theriault, Gazzola and Richardson, 2009)

7. Supervision
Trainees comment that positive supervisory relationships have helped them to develop a sense of competence. This trend is confirmed elsewhere in the literature (Ronnestad & Skovholt, 1993). One trainee experienced her supervisor’s “anxious” style as unhelpful for developing her sense of competence because it made her constantly question her performance. Ronnestad & Skovholt (1993) assert that supervisor anxiety can inhibit growth in trainees. Stoltenberg (2005) suggests that supervisors can help trainees who are just beginning to develop their skills by offering supervision that is both structured and supportive. Trainees remark that experiences of individual clinical supervision and group supervision, including multidisciplinary meetings and case discussion groups, accelerate their understanding of how to put theory into practice.

Trainees reported that supervision was one of the ways they developed therapeutic competence. They commented on experiences of individual clinical supervision, group supervision, and peer supervision. My findings demonstrate that trainees have identified four functions of supervision that contribute to developing competence:

1. Safeguarding clients
2. Linking theory with practice
3. Providing feedback on competence
4. Developing confidence

Safeguarding Clients
Eight trainees remarked that one important function of supervision was to monitor their competence in order to safeguard clients. These comments indicate that trainees used supervision to help them manage clinical risk. Loganbill, Hardy, and Delworth (1982) confirm that clinical supervisors monitor trainees’ competence using live observation (e.g. audio recordings) or reviewing the details of sessions with their supervisees. Trainees reported that they contribute to safeguarding clients by sharing honestly their concerns with their supervisors. Those trainees who believed they had sufficient supervision (one trainee reported having insufficient supervision) were
satisfied that supervision was working and also confident that they were meeting the minimum threshold of competence.

**Building Therapeutic Skills**

My study revealed that some trainees aim to build their intervention skills in supervision and skills practice with colleagues. This skill-building element of learning through supervision is known as “supervised practice”, a method of instruction that can be helpful for developing competence (Holloway & Neufeldt, 1995, p. 209). The method of supervised practice provides trainees with immediate, corrective feedback. Skill building and structured supervision has been found to contribute to therapist adherence to an unfamiliar theory of practice (Weingardt et al., 2009). Trainees mention several experiences in training that can be considered examples of supervised practice. For example, two trainees mentioned that skill practice with colleagues was helpful for developing their competence. One trainee reported participating in group supervision sessions where she received immediate and helpful feedback on her therapy skills.

**Linking Theory with Practice**

Trainees comment that supervision helps them to link theory and practice within a theoretical framework of therapy. The supervision literature highlights that one of the ways supervisors help trainees link theory with practice is by developing their reflexive thinking skills (Falender & Shafranski, 2007; Loganbill, Hardy, & Delworth, 1982).

Supervisors instruct trainees by helping them to understand what is going on with clients and how to help them. This element of therapeutic competence is known as case conceptualization (Loganbill, Hardy, & Delworth, 1982). This ability to conceptualize clients and apply their concerns to a theoretical model of therapy is a complex skill that is central to therapeutic competence (Loganbill, Hardy, & Delworth, 1982; HCPC 2012b). Ericsson, Krampe, and Tesch-Romer (1993) argue that the context of supervisory relationship is most important for developing trainees’ skills for conceptualizing clients and linking theory with practice.

**Developing Trainee Confidence**

Helping trainees develop confidence in their clinical skills is an important supervisory function. This is particularly important in trainees’ early work when they most experience concerns about their competence that impact on their self-efficacy beliefs.
(Ronnestad & Skovholt, 2003). Heppner and Heesacker (1983) found that trainees are most satisfied with supervisors who exhibit a sense of trustworthiness. Supervisor and tutor empathy has also been highlighted as a factor for helping trainees to develop competence (Smith, 2011). The quality of the supervisory relationship may be linked to trainee competence. Holloway and Neufeldt (1995) suggest that supervisees who perceive their supervisors as trustworthy perform better as counsellors.

My findings indicate that the absence of a supervisor who functions as a secure base can have a negative impact on trainee confidence and contribute to doubts about their competence. One trainee reported that the supervisor at her first clinical placement used an unfamiliar orientation that she had not learned on her course. This trainee perceived that her supervisor was unable to help her link theory with practice, which made her feel incompetent and anxious in her work with clients. In this instance, supervision failed to achieve one of its primary functions: to give trainees a secure base (in the form of a theoretical anchor) on which to build a sense of confidence in their clinical decisions (Loganbill, Hardy, & Delworth, 1982). Thus my findings corroborate the notion that it is important for trainees in the early stages of their work to receive specific and supportive guidance from their supervisors (Ronnestad & Skovholt, 1993).

5.3 METHODOLOGICAL DISCUSSION

This section aims to provide a reflexive account of my method and the design of my research. I intend to reflect on my research to address the limitations and the potential of my methodology. Along the way I will discuss some of the tensions I experienced as a constructivist researcher.

Reflections on Theory Building

I used grounded theory techniques to analyze the data obtained from my eleven research participants and developed a number of theoretical categories to complete a grounded theory framework (Charmaz, 2006). I did not go on to develop substantive theory (Glaser, 2009; Glaser & Strauss, 1967). The procedure for developing substantive theory requires the researcher to engage in a process of theoretical sampling (Glaser, 2009; Scott, 2009). In my case, this would have meant recruiting additional research participants to follow my emerging theory (Scott, 2009). I chose
not to pursue that path because I am a lone researcher engaged in a time-limited project (Patton, 2002).

My decision to adopt an intermediate theoretical framework instead of developing substantive theory is not uncommon within the grounded theory tradition (Strauss & Corbin, 1990; Charmaz, 2006, Braun & Clarke, 2013). I have used two approaches to grounded theory to answer my research question, thus becoming a theoretical “bricoleur” (Morrow, 2007, p. 214). Two key criteria for quality control have been met within the design of my study: My sample size meets the criteria for a small-scale qualitative study; and my procedures for data analysis remain consistent within the prevailing research paradigm (Braun & Clarke, 2013; Lincoln & Guba, 2000).

**Strengths and Limitations of Grounded Theory**

Using grounded theory techniques, I developed categories and queried the research to demonstrate the relevance of the categories. The categories helped me to illuminate some of the key learning processes unique to this group of trainees. One advantage of a grounded theory study is that the inductive method (building theory from the ground up) demonstrates how trainees perceive their training experiences have influenced their process of developing competence (Bitar, Bean, & Bermudez, 2007). Illuminating trainees’ experiences of developing competence may provide guidance on practice in training and developing counselling psychologists. For example, understanding how trainees respond to challenges in practice may alert supervisors as to how they might enhance trainees’ self-efficacy. It may be that tutors can also make a contribution to the well-being of trainees. For example, Bennett-Levy and Beedie (2007) concluded that their participants felt they might have benefitted by being warned about some of the ups and downs in the training experience.

Tobin and Begley (2002) argue that the criterion for “goodness” in qualitative research is a high standard of academic rigour. One of the benefits of the grounded theory method is that it applies rigorous procedures for data analysis (Fassinger, 2005). One such method is Glaser’s (1978) procedure called line-by-line coding. In line-by-line coding each line is coded for action and meaning (Charmaz, 2006). One challenge to line-by-line coding is that it has the potential to fracture the data, resulting in some risk that the overall meaning will be lost (Rennie & Fergus, 2006). Charmaz (2006) makes the opposite argument; line-by-line coding keeps the
researcher close to the data so that all theoretical possibilities remain open for consideration. Glaser’s (1978) framework was appealing because it is designed to keep the researcher focused on the data. This is important in the beginning stages of an inductive process when the researcher should remain curious and open to emergent meaning. Glaser’s (1978) method of line-by-line coding seemed the best option for me as an insider researcher because it helped to be “rigorously subjective.” Glaser’s line-by-line coding procedure served as a kind of “bracketing” exercise and it prevented premature conclusions (Morrow, 2005, p. 54).

Pergert (2009) acknowledges that the grounded theory method is a complex method and too often learned while it is being applied. Because I am a novice researcher some rigour was inevitably lost, for example, I did not go on to produce substantive theory. Because I am novice researcher, during data collection and analysis I was not fully engaged in theoretical sampling, which is a prerequisite to creating substantive theory (Scott, 2009; Glaser, 2009). I documented this situation and my decisions about the data in Appendix H. It is fair to say that my own limitations as a researcher limited this study.

**Developing an Informative Study**
One of the tensions to balance was staying true to participants’ stories and building an abstract theoretical framework that would be both recognized by my research participants as representative of their views and potentially relevant to other contexts (Guba & Lincoln, 1994). This was handled by conducting member checks, questioning my own values and assumptions, and maintaining transparency.

In terms of producing knowledge that is generalizable to other contexts, one standard imposed by the grounded theory method is that of theoretical saturation (Glaser & Strauss, 1967). Since there was no theoretical sampling, it would be difficult to claim the saturation of categories (Glaser & Strauss, 1967; Glaser, 2009). Although Braun & Clarke (2013) suggest that my sample size is sufficient to qualify for a small-scale research study, I would be hesitant to claim that I have discovered knowledge that can be applied to other contexts. In some ways this limits the usefulness of the grounded theory. One could argue that I have been true to my aim as a constructivist researcher to uncover knowledge that is contextually relevant. The intention was to represent the perspective of a cross section of U.K. based trainees. Sufficient data was gathered to develop theoretical categories that were informed,
meaningful, and relevant. Thus I have laid a foundation for future researchers to study the specific context of training in the U.K.

**Theory Building**
One advantage of using the grounded theory method is that the theory is generated from the data (Glaser & Strauss, 1967). This inductive or “bottom up” approach to theory building allows the researcher to stay close to the meaning of the research participants’ experiences. The participants were represented using an unstructured interview to focus on trainees’ experiences in order to discover what was important to them. Thus this contribution to the literature that represents the voice of the trainee in training.

Once I defined what trainees were saying about therapeutic competence, theoretical categories were created to organize the data, and this process resulted in fracturing individual participants’ narratives and then reconstructing them in ever expanding layers of theoretical abstraction. This aspect of data analysis meant that some of the meaning within the original stories would be lost.

**Constant Comparative Analysis**
Constant comparative analysis helped balance this tension. Glaser and Strauss (1967) suggest using the participants’ own language during data analysis. This keeps the categories open long enough to allow for all theoretical possibilities to emerge from the data (Charmaz, 2006). Categories were derived from definitions of competence that were generated by trainees. So, for example, the competence that many trainees highlighted, “justifying and rationalizing the work,” was not changed to “developing formulation and case conceptualization skills” as those concepts began to trickle into the analysis. That concept was retained alongside the related concept “case conceptualization skills”. A researcher who was less focused on context might have combined those two related categories. But sensitization to the theoretical “weight” of those categories prevented this. (Charmaz, 2006). “Justifying and rationalizing the work” was a highly contextualized statement that made direct reference to trainees’ experience of working in their placement contexts. I was informed by Charmaz’s (2006) perspective, and I knew that category held promise for additional layers of contextual meaning, so I left it as a separate category. This was a helpful strategy and it strengthened the study. Leaving trainees’ own language in that category lead to exploring certain aspects of trainees’ experiences that may not have surfaced.
otherwise. Several meanings were derived from that category that helped inform the influence of placement context on competence, including “developing competence by gaining experience of working in a professional role”, “developing skills in communicating with colleagues”, and “receiving affirmation from colleagues for the quality of one’s formulations”. It may be that the above example provides an illustration of what Glaser (1978) calls “theoretical sensitivity”.

Operating as a constructivist researcher allowed me to adopt an active interviewing style. Being an active participant in the conversation helped to strengthen the potential of the grounded theory method. Active interviewing led to a rich expression of ideas that more fully defined the theoretical categories, strengthening the study. My active participation in the process of defining the category “Making Progress” with one of my interviewees was one example of this. During one interview I gained an experiential understanding of that category while engaged in conversation with a trainee who was reflecting on her experience of competence. During the interview I participated in her process of trying to make sense of her experience of competence. I felt prompted to ask her how she felt about making progress. She acknowledged her progress in a way she had not previously. This communication benefitted her, and it enhanced an understanding of why reflection on practice is so important for trainees’ process of developing competence.

**Data Collection**

One critical issue that needs to be addressed is whether meaningful data was obtained with my data collection instrument. The data gathered through qualitative interviews is subject to a number of challenges (Kvale, 1994; Polkinghorne, 2005). One has to accept that interviews provide useful data that is worthy of academic study. This data can be challenged on any number of points – is the information worth knowing? Does it represent mutually agreed truth? Does it have the potential to inform other contexts? Intersubjective knowledge is acceptable within the qualitative paradigm, and constructivists agree that the researcher can access truth, even with the constraints imposed by language (Kvale, 1994; Polkinghorne, 2005). There are problems with self-reports. For example, the details can be inaccurate due to lapses of memory, and the act of recalling an experience changes it (Polkinghorne, 2005). One thing that strengthens the study is that the themes it discovered are not dissimilar to other relevant studies that have been identified in the literature.
Usefulness of the Data
Qualitative research is subjective and context dependent. Morrow (2005) argues that if these limitations are properly understood, qualitative research provides an opportunity to advance knowledge. The knowledge obtained through this study is “ideographic” or “emic”, which means that it focuses on a few individuals and derives categories of meaning from them (Morrow, 2005). I am happy that I applied the grounded theory procedures for data analysis in the proper way and I have clearly defined my intellectual territory. This study should be accepted as a potentially useful piece of research that can inform training and supervision as it is practiced in the U.K. Although these findings may not be generalizable to other contexts, they may be considered transferable (Morrow, 2005, p. 252). The degree to which the findings are transferable to another context depends on whether the theoretical categories resonate with the reader, and whether they are credible and sensible to those outside this specific context (Morrow, 2005).

Procedures for data trustworthiness have been addressed in the methodology chapter and details of these procedures (including member checks) have been included in the appendices. Member checks strengthen this study by allowing verification of categories. Coding practices made some sense to my research participants. I participated in a bracketing interview (See Appendix F) that helped me to identify my values and assumptions as a researcher. Thus I have tried to adopt a reflexive stance (recognizing there is no such thing as a neutral stance) to this data, and this strengthened the study (Etherington, 1994).

5.4 RESEARCH IMPLICATIONS AND RECOMMENDATIONS
The trainees who took part in this study identified seventeen competencies in counselling and psychotherapy (see Figure 4.10). Trainees also identified several methods by which they perceive that they acquire a sense of competence. This research used trainees’ definitions and processes to develop a theoretical framework for understanding competence. The findings were critically evaluated in relation to practice and research, and related to the wider literature that was reviewed in Chapter 2.

In my concluding remarks I will highlight several themes gleaned from the study which might be considered most pertinent to advancing our understanding of
competence. I will make tentative reflections and observations about the implications of these themes for counselling psychology research and practice. I will draw on these implications to offer recommendations for training practice. I will then add my own personal reflections about this research and suggest areas of inquiry that researchers might follow up to build on this research to develop our understanding of competence.

**Implications of This Research for Understanding Competence**

The first theme is a reflection on the foundations of counselling psychology practice. This study has identified that the philosophy and ethics play a formative role in shaping trainees’ perceptions and definitions of competence. The findings suggest that this group of trainees would define evidence-based practitioners who are informed and motivated by humanistic ethics in practice as competent. This reflection has several implications for training and practice.

*Defining Competence in Counselling Psychology Practice*

One way that trainees define competent practice is by its humanistic ethical and theoretical principles including high regard for the client and respect for his or her agency, a commitment to pluralistic practice, and knowledge of the science and research behind empirically supported treatments. This study illustrates that trainees are trying to form a practical understanding of how to develop skills such as formulation and assessment that are associated with evidence based practice. On the strength of these findings, it appears safe to assume that at least some trainees are struggling to integrate the principles of pluralism into practice within NHS placement contexts that identify, as a standard of competence, strict adherence to a CBT protocol.

*Counselling Psychology Values and Ethics*

Another conclusion is based on the assumption that trainees are maintaining their values and finding their own individual ways of implementing them in their practice within their placement contexts. This remains an assumption because although trainees verbalized a commitment to humanistic psychology values, it was more difficult to identify how trainees were implementing these values and ethics in practice. Trainees experienced challenges to their sense of competence in placements and especially in certain NHS contexts that did not support a pluralistic value base.
This is understandable because the expectation that the trainee would conform to a strict CBT protocol could potentially create a conflict between how trainees are educated and how they are expected to work.

Trainees reported challenges to competence but because trainees’ perceived that they practiced differently in different contexts it was difficult to ascertain whether the competence was to justify their practice to fit the demands of the context or to use different competencies (such as being more persuasive to elicit the client’s participation in a CBT intervention). The question remains whether trainees had to step outside of their value system to practice in a certain way and if they did, what kind of experience did that create? In other words, were they feeling challenged because of their lack of experience adhering to a CBT protocol or were they experiencing a sense of discomfort from having to contravene their ethical principles and beliefs about therapy?

This discussion of values in the context of this research is relevant because trainees identified that a commitment to ethics formed part of their definitions of competence. The transmission of values and attitudes towards competence has been identified to be part of graduate training professional psychology (Barnett & Youngrenn, 2007). Trainees’ comments about their education suggested they had become acculturated into a profession that is identified with humanistic values and ethics (Cooper, 2009; Handelsman, Gottlieb & Knapp, 2005). The notion that trainees articulate a commitment to humanistic values is worth highlighting. A tentative conclusion is that trainees are beginning to form an emergent professional identity as counselling psychologists, a process that continues to develop post qualification (Mantica, 2011).

On the basis of these research findings it can be said that the prospective clash between trainees’ values (e.g. a commitment to pluralistic practice) and the way they are expected to work is a contextual issue and a potential professional challenge for some trainees. Bearing in mind that there are gaps in the data, I have tentatively concluded that trainees are handling this issue on a case-by-case basis and they are working out value frameworks for practice that are appropriate to their individual placement contexts. More research is needed on the way that trainees are working out their values in practice. Further exploration of this issue could potentially broaden our understanding of competence and/or professional identity.
Challenges to Competent Practice in Counselling Psychology

The second implication is related to the expectation that counselling psychologists are competent to apply at least two models of therapy in practice. The data reflects that the majority of the individual trainees in this study described their practice as integrative or pluralistic. They commented that working in a multi-theoretical way was necessary to provide a good standard of practice. The two therapeutic models most widely discussed, humanistic psychology and science-based practice (mostly CBT protocols) emphasizing empirically supported treatments for specific diagnoses, are not subject to integration (Persons & Silbershatz, 1998). The data suggests, however, that many trainees indicate science-based practice and humanistic approaches can sit alongside each other within a personal framework for practice. The findings reflect that trainees are developing a framework or a personal philosophy of practice for working in a multi-theoretical way. It appears that some trainees approached the issue of theoretical integration by drawing on common factors research and were more or less eclectic practitioners (Arkowitz, 1992; Hollanders & McLeod, 1999). Because trainees are expected to become competent evidence-based practitioners who are informed by a humanistic value base, they are developing a personal philosophy of practice that includes at least two separate and different models of therapy, which is difficult. Trainees reported that they sometimes felt uncertain about competence in the face of that challenge. One implication of these findings is that challenges to trainees’ sense of competence are a predictable consequence of undertaking training because it is an academically and professionally demanding task. Research in counsellor and therapist development identify that beginning students and novice therapists struggle with their perceptions of competence as they begin their work with clients (Ronnestad & Skovholt, 2003). Empirical research also demonstrates that integrative counsellors find it difficult to develop a philosophy of practice in the absence of a home theory or single theoretical model (Lowndes & Hanley, 2010).

A Theory of Practice in Counselling Psychology

The third consideration is whether the evidence suggests that we are developing theoretical coherence in practice. This study does not imply the existence of a monolithic approach to practice. Gillon (2007) recognizes that counselling psychology has its roots in person-centred practice he dispels the idea that one can be
a “person-centred counselling psychologist”. The findings reflect nuances in the philosophies of individual trainees. For example, it appears that some trainees feel most comfortable with a CBT-oriented practice because it has a strong evidence base and it fits within the NICE guidelines. Some trainees are oriented towards humanistic and/or psychodynamic approaches and they feel most comfortable using their relational skills. Trainees’ narratives indicate that at least some trainees who have a more humanistic focus may struggle to adapt their practice (and their values) to suit an NHS placement where they are expected to use structured CBT interventions. Boucher’s (2010) example of working flexibly within a CBT framework offers an approach that provides promise for reconciling some of the conflicts and challenges that may arise within practice in certain contexts.

Counselling Psychology Practice in Context

Another observation is that trainees are making choices and flexibly applying competencies according to their situations. Trainees’ narratives reflect that they vary their approach to practice in order to suit a professional culture and a context. This is a cautionary and tentative observation based on a limited amount of evidence but the implication of this research is that trainee participants choose to approach practice differently in different contexts and presumably for different reasons. Only one trainee offered that she used NICE guidelines to determine the relevant competencies. It might help to improve our understanding of competence if more data was available.

This study has flagged up contextual influences on trainees’ decision making but it has left out individual differences such as the personal values, personality and individual style of the trainee (such as whether they prefer to work from an intuitive or a scientific framework). We have already discussed that trainees were not clear about what competencies they were using and why. Filling in those gaps might help us to better understand how trainees use their perceptions and definitions of competence to guide their practice.

Contextual Influences on Practice

This research highlights the relevance of context within which trainees perceive, define and acquire a sense of their own therapeutic competence. Contextual influences are relevant because constructivist grounded researchers acknowledge that individuals construct meaning in a social context (Charmaz, 2006).

This discussion has emphasized two professional issues related to context. This research has found that trainees’ work with clients and their experiences of
supervision in the context of their clinical placements significantly impacted their learning and development. This highlights the importance of clinical placements to the professional development of trainees who are in the midst of developing their competence and identifying their emergent professional trajectories (Kamen et al., 2010).

The findings also reflect that supervision influences trainee’ perceptions and definitions of competence. This influence of supervision is also reflected in the wider literature. Ronnestad, Helge and Skovholt (1993) point out that the culture of an organization influences the nature of supervision and that conflicting values between the culture of the organization and the trainee have an impact on their supervisory experiences. Calhoun et al. (1998) and Woody et al. (2005) argue that internship opportunities are extremely important aspects of training. *Hatcher and Lassiter (2004) maintain that practicum training and coursework should reinforce one another and they argue that links between coursework and placements are important for developing trainees’ competence to deliver evidence-based practice.

**Recommendations for Practice**

The above discussion about contextual influences provides a background for the following recommendations for training practice which include: 1) Establishing formal links with a network of clinical placement providers 2) Improving trainees’ access to supervisors who are embedded within their placement contexts.

**Clinical Placements**

Trainees report that their university coursework does not always dovetail with their clinical work. For example, one trainee described learning one model of practice at university and using a different model in her placement. The difficulty is that placements can be hard to come by, and trainees may feel they must “take what they can get” whether or not the philosophy of their placement context is aligned with their training programmes, values, or personal styles.

This is an unfortunate situation and it highlights that counselling psychology educators should play an active role in establishing links with appropriate placement providers to facilitate greater cohesion between theory, coursework and clinical practice. One strategy might be for programmes to have a placement provider network to ensure that trainees have the best possible chance of being positioned in contexts
where they can develop their practice on the basis of their coursework. So, for example in an integrative programme trainees who are learning one model of practice should not feel forced to take up a placement where they will be expected to practice in a different model.

A second recommendation is based on trainees’ reports that they struggle with their perceptions of competence. One role for educators might be to consider how to help trainees adjust to a working environment that is not naturally oriented to a counselling psychology perspective. Educators might address this issue during classroom training to help them trainees address these challenges (Bennett-Levy & Beedie, 2007). Work done by Josefowitz and Myran (2005) on the integration of Person-Centred therapy and CBT, and Boucher’s (2010) flexible approach to using CBT help to identify some of the theoretical and practical issues that lie beneath the surface of this challenging work.

_Counselling Psychology Supervision_

Trainees commented that external feedback from their supervisors, tutors and senior colleagues was a major resource for developing their skills and abilities as therapists. They identified issues with supervision in their placements citing insufficient, over controlling and at times, unhelpful supervision. In some cases trainees reported that negative experiences of supervision adversely impacted their sense of competence. From this discussion of the findings, and for other reasons that have already been mentioned (such as the power imbalance between supervisors and trainees) it can be inferred that trainees place a high value on appropriate supervision and they desire empathic and trusting supervisory relationships (Smith, 2011).

There seems to be little evidence to suggest that trainees highlighted the absence of counselling psychologists serving as supervisors in their clinical placements as a problem. Nevertheless, I suggest that training would be improved by providing trainees greater access to supervisors who are counselling psychologists employed within their placement contexts. I offer this recommendation based primarily on my perceptions as a researcher who is influenced by my own experience. It is my interpretive conclusion (and a personal reflection) that supervision can contribute to competence because counselling psychologists who are supervisors have a shared experience of education and professional identity with trainees and, perhaps most importantly, they share experience of a specific professional context.
Clinical supervision is widely reported to be a critical element of graduate training in counselling and psychotherapy. Sadler’s (1989) model of how students use feedback to direct their learning suggests that supervisors play a major role in facilitating trainees’ learning. Stoltenberg (2005) and Falender and Shafranske (2007) argue that supervision helps trainees develop higher order clinical skills because supervisors facilitate guided reflections on practice that help trainees sharpen their reflexive skills. Given their shared experience of education with supervisees, supervisors understand that theoretical integration is a key issue for trainees who are working in NHS placement contexts. In terms of how NHS contexts may pose particular challenges to trainees, supervisors might want to emphasize that nobody can hold two models in equal proportion – one model is going to be stronger than another, and trainees may need additional guidance in accepting these differences so they gain confidence in their skills and abilities.

The profession recognizes that there is an inconsistency between humanistic values and the predominant professional culture that is driving models of service delivery within the NHS (Orlans & Van Scoyoc, 2009). Trainees in the early stages of developing competence have to balance these tensions because they affect the way that competence is defined and determine what is deemed to be competent practice. It is my opinion that supervisors who are embedded in a professional context may help trainees to bridge the gap between theory and practice. Supervisors working in clinical placements serve two important functions of supervision: the role of the supervisor as both teacher and mentor (Loganbill, Hardy and Delworth, 1982).

5.5 PERSONAL REFLECTIONS

McLeod (2001) argues that reflecting on practice leads to new ideas and innovations because it puts practitioners in charge of research. My participation in this project has empowered me to use my research to explore how I am developing as a practitioner and what competence means to me.

I have developed an awareness of the unique way that counselling psychology has developed in the UK. This awareness has made me feel more determined to hold on to humanistic traditions (based on my research). I would rather not see these humanistic traditions become de-emphasized in the U.K. Counselling psychology is a distinct profession that has much to offer because of the unique mix of its commitment to science-based practice combined with humanistic values and ethics.
that emphasize pluralism and client autonomy, and it seeks to preserve the viability of personal choice for mental health services in the UK.

One major challenge to preserving counselling psychology practice in the U.K is to address the issue of how psychologists preserve their professional identities in NHS contexts. The potential of values between education and practice could potentially result in a sense of dissonance in some trainees. A therapist who subscribes to humanistic values but is being asked to work in a directive way, to a timescale, may become disillusioned over time. He or she may also feel incompetent. For example, one research participant said that her client-centred philosophy of practice means that she only feels truly competent when her clients are working from a position of equality with her in the client-therapist relationship. The medical model of practice that drives practice in the NHS militates against the preservation of that identity. The profession would benefit from more research on how counselling psychologists view their professional identity in NHS contexts. Mantica (2011) is already doing some of this work. Further contributions can be made through research that explores how trainees are developing a sense of professional identity.

I have been fortunate to receive supervision from both a counsellor and counselling psychologists that were embedded in my placements. The guidance they were able to offer based on our shared experience of education was invaluable for helping me link theory with practice. It may be that none of my research participants were that fortunate which is why they did not notice the absence of supervision as a contribution to their learning. This research has helped to strengthen my resolve to join my local BPS network and my intention to offer supervision throughout my career.

One of the central challenges to competence faced by trainees is that of developing a research-informed practice that includes scientific rigour and knowledge of “what works” but continues to emphasize the relational competencies that are at the heart of counselling and psychotherapy and common factors research (Lambert & Barley, 2001; McLeod, 2001a; Polkinghorne, 1999). The BPS and the HCPC’s definition of competent practice includes knowledge of evidence-based interventions and practical understanding of how to apply that knowledge in the service of clients, while remaining sensitive to the cultural and spiritual traditions of counselling psychology. This research has helped me think about why that distinction is so important.
**Influences of this research my practice**

One effect this research has had on my practice is that I have begun to conceptualize the work with my clients differently. Clients who are presenting with low mood and low self-esteem have their perceptions of competence influenced by negative feedback. My assessments have been revised to include questions designed to elicit this information. Insights discovered by conducting this research have helped me to understand that clients may experience an underlying sense of incompetence that contributes to their difficulties.

This new awareness has helped identify an ending to my work with a client (Mearns & Thorne, 2007). When a client identifies an area of competence and begins to receive positive feedback outside of the therapy room, it signals that the client may be ready to end the therapy. Exploring this with the client may be significant and potentially empowering for those clients.

The recommendations I have made for training are applicable to my own personal circumstances. I have experienced feelings of anxiety about my competence; I have needed to be reassured. I have needed more time to read theory and more space for reflecting on practice. I have needed to be able to assess my own competence to improve my own performance as a therapist. Therefore, it is appropriate to note at the conclusion of this research that I include myself in these reflections.

5.6 FUTURE RESEARCH

This research could be extended in several ways to broaden our understanding of competence. Some suggestions include further research on how trainees are integrating theory, how they are implementing values in practice, individual differences that influence clinical decisions, and how trainees perceive the development of science-based competencies.

*Theoretical Integration*

This research identified that trainees were developing a way of working with disparate theoretical orientations. This study has identified that most trainees were using a broadly eclectic approach but as a researcher I am aware that there are significant gaps in the data and terms could have been more clearly defined. I think, for example, it would have been worth exploring trainees’ understanding of what they meant by the terms “integrative” and “pluralistic.” This may have yielded more
information about how trainees were applying theory in practice. I think more qualitative research could be done to explore trainees’ perspectives on theoretical integration.

**Counselling Psychology Values**
This study found that ethics and values shaped trainees’ definitions of competence. What was less identifiable was how trainees were implementing these values in practice. Humanistic values are an integrative part of how the profession defines itself and this is reflected in trainees’ definitions (Cooper, 2009). In practice, however, it appears that some trainees may have been feeling forced to choose between their values for practice and the demands of their placement contexts. It is unclear how many trainees actually felt this way and the extent to which it affected their practice.

In some contexts (particularly in IAPT settings) certain trainees felt challenged by the expectation to work in a more directive way with clients but the question remains – what is the nature of that challenge to trainees’ competence? Is it simply a lack of experience with a certain model of therapy or is there something deeper, such as a sense of dissonance between their values and the philosophy of their context? The philosophy of counselling psychology maintains that competence lies both in the values and attitudes of the practitioner and the way that they behave in practice. A qualitative study designed to further explore trainees’ attitudes could extend our understanding of competence.

**Personal Style and Therapeutic Competence**
This study was not designed to explore individual differences in trainees’ definitions of competence and their philosophies of practice. Instead it identified similarities in the way trainees perceived and defined competence and linked them to context. Other factors such as trainees’ individual differences, including their personal styles and preferences were not explored. The question may be asked, is there any one style or preference (such as an intuitive or a scientific) that contributes to competence? It may be that these individual differences are highly relevant and could extend our understanding of competence.

**Science-Based Competencies**
Research into how trainees integrate science based competencies is topical (Nicholson & Madson, 2015). The data developed here is related to practice. It could prove interesting and beneficial to the profession for research to be done on trainees’
perceptions of developing science-based competence. Such a study would provide the potential to open up themes related to competence in engaging with research.

**5.7 CHAPTER SUMMARY**

This chapter addressed the research question by discussing the methods by which trainees perceive, acquire, and define therapeutic competence. Key learning processes discussed include reflective practice and the development of skills and knowledge through training. Also identified were some surprising results including a lack of evidence to suggest that trainees were thinking about the influence of pharmacology on treatment.

Some of the vehicles for developing competence that were identified by trainees included learning from coursework, feedback, self-reflection, clinical experiences with clients, skills in reflexive thinking/self-awareness, knowledge about theoretical models of therapy and developing skills and knowledge through supervision.

This chapter discussed the implications of these findings for understanding competence in counselling psychology. It went on to explore how this research has influenced my opinions and my practice. This chapter concluded with some suggestions to extend this research by following up on some of the competencies identified including theoretical integration, investigating the effect of therapist held values and ethics in practice, looking at the relationship between personal style and competence, and exploring trainees’ perceptions of science-based competencies such as conducting research and engaging with the scientific literature to inform practice.
REFERENCES


Cooper, M. (2009). Welcoming the Other: Actualising the Humanistic Ethic at the Core of Counselling Psychology Practice. Counselling Psychology Review, 24(3 & 4), 119-229.


APPENDICES

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APPENDIX A
CODING EXAMPLE

Initial Codes Leading To The Focused Code “Ethics”

Part 1: Excerpt of Interview with Harry with comparative notes in the margin (Lines 119-135)

P: “I had this discussion with my supervisor because in our first session I said ‘I am confident’ and I left it there. I knew I should have continued my sentence because she’d picked up on it and I knew what she’d picked up on was is that a cockiness type of confidence? And in the end I went back to her and said “no, what I mean is I’m confident working with these clients now.” I probably said “base level of competence” is in a place that I feel I can work with clients, I’ll do no harm and I can bring benefit, or any harm that I would do would be therapeutic, like harm in the sense of challenging somebody.

1. Good quote for the way this participant defines therapeutic competence. Demonstrates a developmental perspective (Base Level of Competence).

But then actually saying that out loud, theoretically I don’t think I could ever … I’m into Freudian and defence mechanisms … and I feel like again I would never break someone’s defence mechanisms, so I’m aware of that knowledge, I’m aware that I can work with somebody in a way, in a psycho-dynamic way, and I believe I’ve got loads to learn with it.

2. Trainee feels capable of challenging a client without breaking their defense mechanisms. Trainee demonstrates confidence knowing how to work safely within the psychodynamic model. Open code: a. competence in practice b. competence within the psychodynamic model

So that’s where my confidence is. I’ve got self-belief that I can be a positive thing for a client, and not be detrimental. But I’m confident that if there’s learning to be had, I’m also not in a place where I’ll ignore that – “I don’t need to learn” – I don’t think I’ll every profess, I don’t think … I’ll be 90 on my death bed and I’ll think there’s more to learn. And I think that gives me self-confidence.

3. Confidence is self-belief that he will not cause harm. Feeling self-confident because he will always think there is more to learn. Open code: a. confidence is self-belief b. competence is not cockiness or over confidence.

I think I would have it in a … voice concern if I was saying “I know what I’m doing”, so it’s almost like the inner voice, it feels at one, it feels at harmony within the body, because I know that inner voice is right, to say we don’t know it all but we’re on a level where we can go and work with clients and we can continue learning.
4. Competence involves awareness of the “inner voice” that is in harmony with what he knows to be true. Open codes: a. competence requires inner trust or confidence b. inner trust is experienced as a sense of harmony within the body c. Being competent requires an awareness that you “don’t know it all”.

And the mistakes that I make will be mistakes that I can learn from for future but won’t be detrimental at this point. I think that’s the biggest thing for me starting therapy”.

5. Trainee has fulfilled his own requirements for having a “base level of competence”. Focused code level 1: Having a base level of competence, being safe. Focused code level 2: Ethics. He knows his mistakes won’t be detrimental. He believes this because he understands psychodynamic theory and feels he is capable to work within that model. He knows he will make mistakes. This reassures him because he knows that he is not over confident e.g. he has more to learn.

Part 2: Coding Memo for Harry – This data was assigned to the focused code “Ethics.”

How does Harry experience a sense of competence when working therapeutically with clients?

Definitions of competence and process of acquiring competence:

“A base level of competence is a place that I feel I can work with clients: I’ll do no harm and I can bring benefit.” Harry also refers to this as “baseline competence.” Baseline competence is different from competence in being able to work within a model of therapy. It involves attitudes like self-belief and trusting his process of learning.

1. Trainee trusts that part of learning is that he will bring the right things to supervision. Trainee calls this “supervising competence” which is knowing (believing) that he will know when to bring something to supervision. He will know what to bring even if he doesn’t know that he knows what to bring. (Associated with critical incident of learning about transference in supervision.)

2. Trainee believes he is “unconsciously competent”. Trainee has faith in his inner process of learning to develop competence. He believes he’ll get what he needs when he needs it. (Associated with critical incident of finding a book that contained information he needed to know to improve his knowledge.) Unconscious competence example quote: “I don’t need to know that I know it, I know it and it’s just there, it’s part of my being... I think my inner voice would lead me to where I need to go to find out what I need to know. It’s [acquiring competence] about making that process more conscious”.

2. Trainee has learned to trust his inner process because of his experience of reflecting on learning experiences. Open code: a. developing faith in the inner process of learning b. reflecting on learning to acquire competence
Unconscious competence means, “not needing to know that I know something”. Open code: a. experiencing a feeling of competence b. trusting in his inner voice c. knowing (believing) that he has knowledge in his being d. developing faith in this learning process.

3. Trainee defines incompetence as “feelings of doubt that lead to learning

4. Trainee defines self-confidence as “knowing the[inner] voice

5. Trainee defines competence as self-awareness. (Associated with a critical incident of acquiring competence by gaining self-awareness while on a counselling course). Example quote: “Once I did that course it was like I opened a tapestry ... began to really look into myself. So that understanding of myself gives me a grounding, and the fact that I feel I know myself, I feel that’s one of the competencies required to be a Therapist”.

Focused code level 1 self-awareness/ self-development Open code: a. looking into myself b. developing self-knowledge c. feeling competent because he knows himself d. feeling ready to become a practitioner
APPENDIX B
MEMBER CHECK

Email 1: Harry

Introduction

This email transcript includes Harry’s response to my request to verify the codes. I sent him a copy of his transcript and my coding memo with my notes in the margin (also shown in Appendix A) to ask him for feedback on whether he thought I’d captured the themes. In this same email I also included a follow up question to help me clarify the category Reflexive Thinking/Self-Awareness. His response is located in the text. His response verifies that he feels that self-awareness is a key competence for a counselling psychologist.

Transcript:

Hi Lorie

I'm happy with everything.

The first quote about doing harm is challenging, I was a bit nervous of how that read, but when I read it in the context of the whole quote in the transcript, I knew what I meant then.

Interesting to read and see your thought process, looks like it will be a really interesting piece of work. Good luck!

In answer to your question:

"I am interested in why you were drawn to counselling psychology? You talked about "wanting to study counselling psychology because of a parallel experience." Were you referring to the counselling course you were talking about in the interview?"

My response:

One of the big things that drew me to counselling psychology was that I saw the importance placed on therapist self-development, in order to enhance therapist competency. I am fascinated in understanding myself, and I am fascinated in being able to understand others and help them as a therapist. So for me, the parallel experience is that I can do both. Counselling psychology teaches me methods such as reflexive diaries and encourages therapist self-awareness (personal therapy etc.), while at the same time, it teaches me therapeutic skills to employ with clients, so it's the best of both worlds. There's also some factors around the humanistic nature and the freedom to be a therapist as well as a psychologist. I perhaps have a clinical brain and a humanistic heart (although my clinical brain points out that the humanistic heart still belongs to my brain function!).
Hope that helps, feel free to ask any other questions, good luck!

Member checks were done to confirm some of the key findings which included 1. A list of trainees’ definitions of competence and 2. A list of influences on trainees’ sense of competence. These emails were sent to all of the participants on two different occasions. They have been reproduced below:

Member Check Email 2 (all participants)

I. Please can you take a few moments to look at the definitions of therapeutic competence that I've collated and indicate whether the categories make sense to you?

Please indicate 1. The categories make no sense 2. The categories make some sense 3. The categories make good sense.

Many Thanks,
Lorie

<table>
<thead>
<tr>
<th>Trainees’ Definitions of Competence:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Working with the therapeutic relationship/therapeutic process</td>
</tr>
<tr>
<td>2. Awareness of self in the therapeutic process</td>
</tr>
<tr>
<td>3. Facilitating a working relationship with clients</td>
</tr>
<tr>
<td>4. Modelling a sense of confidence in the work</td>
</tr>
<tr>
<td>5. Applying psychological theory and knowledge of client presentations to practice</td>
</tr>
<tr>
<td>6. Understanding the science/research behind evidence-based treatment</td>
</tr>
<tr>
<td>7. Capability to conduct research</td>
</tr>
<tr>
<td>8. Understanding and applying models of therapy</td>
</tr>
<tr>
<td>9. Skills in assessment and formulation</td>
</tr>
<tr>
<td>10. The ability to adapt models of therapy to suit clients’ needs</td>
</tr>
<tr>
<td>11. Using supervision to reflect on practice</td>
</tr>
<tr>
<td>12. Explaining counselling contract/obtaining informed consent</td>
</tr>
<tr>
<td>13. Working within the boundaries of confidentiality</td>
</tr>
<tr>
<td>14. Following procedures for statutory reporting</td>
</tr>
<tr>
<td>15. Having a base level of competence/Being safe</td>
</tr>
<tr>
<td>16. Developing a framework for ethical decision making</td>
</tr>
<tr>
<td>17. Contributing to a professional context</td>
</tr>
<tr>
<td>18. Justifying/rationalizing the work</td>
</tr>
</tbody>
</table>

II. 8 trainees replied to the above email. The results are as follows:

6 trainees gave the categories a score of 3 (categories make good sense)
2 trainees gave the categories a score of 2 (categories make some sense)

Member Check Email 3 (all participants)
1. I have identified a list of factors that influence trainees’ sense of competence. Please can you take a few moments to look at the list that I’ve collated and indicate whether the categories make sense to you?

Please indicate 1. The categories make no sense 2. The categories make some sense 3. The categories make good sense.

Factors that Influence Trainees’ Sense of Competence

<table>
<thead>
<tr>
<th>Influencing Factors</th>
<th>Number of trainees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowing Theory</td>
<td>7</td>
</tr>
<tr>
<td>Having a Philosophy for practice</td>
<td>5</td>
</tr>
<tr>
<td>Receiving positive/negative feedback (supervisors, tutors)</td>
<td>5</td>
</tr>
<tr>
<td>Affirmation from colleagues</td>
<td>5</td>
</tr>
<tr>
<td>Qualitative/quantitative outcome measures</td>
<td>3</td>
</tr>
<tr>
<td>Receiving positive/negative feedback (clients)</td>
<td>5</td>
</tr>
<tr>
<td>Having a sense of making progress</td>
<td>5</td>
</tr>
<tr>
<td>Experiencing positive/negative emotions about the therapy</td>
<td>5</td>
</tr>
<tr>
<td>Self-Confidence</td>
<td>5</td>
</tr>
<tr>
<td>Experiencing a sense of resonance with a professional context</td>
<td>6</td>
</tr>
</tbody>
</table>

II. This email was mailed out to all of the research participants. Four trainees responded to this email. All four trainees said the categories make good sense.
APPENDIX C
INTERVIEW SCHEDULES

I. Pilot Interview Schedule

Introduction to the interview:

I am interested to hear about your experience of training as a Counselling Psychologist. Please feel free to voice your true opinions and feelings about your training experience. If you are unclear about any question, please let me know. Everything you say is relevant to this research.

Prompts:

What aspects of your training experience (positive and negative) have influenced the development of your sense of competence when working therapeutically with clients?

In what ways has your view of what it means to a competent practitioner been influenced by your training experience?

In what ways have you used (or do you expect to use) your training experience to develop your therapeutic practice?

II. Revised Interview Schedule

Introduction to the Interview:

I am interested to hear about your experience of training as a Counselling Psychologist. Please feel free to voice your true opinions and feelings about your training experience. If you are unclear about any question, please let me know. Everything you say is relevant to this research.

2. Demographic Questions

   Age/gender/ethnicity?

   What is your training route?

   How long have you been in training?

   What kind of placement are you in?

   How much clinical experience did you have prior to enrolling on the programme?

3. Interview Question
What does it mean to you to have a sense of competence when working therapeutically with clients?

4. Prompts

· In terms of your training programme, what experiences have you had that have influenced your sense of competence/incompetence in your therapeutic work with clients?

· Is there any experience that really stands out for you?

· How do you define competence?

· When do you feel you have a sense of competence/incompetence in your work?

· What have you completed within your training programme that your tutors or assessors would consider indicates your level of competence?

· Is there anything within your training programme that you consider to be helpful or unhelpful to your current practice?

· Can you briefly summarize the qualities of a competent counselling psychologist?
Call for research participants: Counselling Psychology Trainees’ Perspectives of Developing Therapeutic Competence

Dear Counselling Psychology Trainees,

I am a third year Counselling Psychology trainee at the University of Manchester. I am researching Trainee Counselling Psychologists’ experience of developing therapeutic competence in their clinical work with clients. I would like to recruit research participants who are counseling psychology enrolled on taught doctorate courses and those on the independent route. I will be conducting semi-structured individual interviews which will last about 45 minutes. You will only be expected to participate in one interview. I am planning to hold these interviews at the University of Manchester (I can offer a range of available appointments to suit your convenience).

CALL FOR RESEARCH PARTICIPANTS: Counselling Psychology Trainees’ Perspectives of Developing Therapeutic Competence

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Research participant information sheet – Lorie.doc

Like ♦ Comment ♦ Follow ♦ Post
APPENDIX E

PARTICIPANT INFORMATION AND CONSENT FORMS

Title of Research
Counselling Psychology Trainees’ Perspectives of Developing Therapeutic Competence

Participant Information Sheet
You are being invited to take part in a study that is being conducted as part of my work as a student undertaking a professional doctorate in Counselling Psychology. Before you decide whether to participate, it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

Who will conduct the study?
The study will be conducted by Lorie Muellenbach, a trainee Counselling Psychologist from the School of Education, Ellen Wilkinson Building, The University of Manchester, Oxford Road, Manchester M13 9PL

What is the aim of the study?
The purpose of the research is to explore the perspectives of trainee Counselling Psychologists on the subject of developing a sense of competence in their clinical work. The researcher wants to find out what factors have contributed to (or hindered) their sense of developing competence when working therapeutically with clients.

Why have I been chosen?
You have been chosen because you are a trainee undergoing a professional doctorate in Counselling Psychology. If you choose to take part, you will be one of between 8 and 12 participants contributing to this study.

What would I be asked to do if I took part?
If you decide to take part, you will be asked to take part in an individual interview with the researcher. The interviews will last approximately 45 minutes. You would be asked to contribute your thoughts, feelings and experiences of developing a sense of competence when working therapeutically with clients. The discussion will be audio recorded on a digital recorder.

What happens to the data collected?
The audio recording of the discussion will be transcribed by the researcher. The audio recording of the interview will be deleted after transcription and the electronic document containing the transcription will be kept in a password protected file. Only
the researcher will have access to the transcription. Some quotations may be used in the write-up of the research, but these will not be attributed to anyone in any identifiable way.

**How is confidentiality maintained?**
All efforts will be made to ensure that confidentiality is maintained. As mentioned above, the electronic data will be kept in password protected files and there will be no identifiable information contained within the write-up of the report. You will be referred to as a participant in any written reports and any quotes used will be non-identifiable. These safeguards are in compliance with the University of Manchester regulations on data protection.

**What happens if I do not want to take part or if I change my mind?**
It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time without giving a reason and this will not be viewed negatively by the researcher. If you have any questions or concerns do not hesitate to contact the researcher using the details at the end of this sheet.

**What is the duration of the study?**
You will only be required to attend one interview lasting approximately 45 minutes.

**Where will the study be conducted?**
The interview will be conducted at the University of Manchester (or another agreed location) at a mutually convenient time.

**Will the outcomes of the study be published?**
The outcomes of the study will form part of a University thesis, and there may be further publications in academic journals.

**Contact for further information**
Researcher: Lorie Muellenbach
Email: muellenbachlorie@gmail.com

**Supervisor:**
Terry Hanley, Lecturer in Counselling Psychology, at the University of Manchester
Email: terry.hanley@manchester.ac.uk
Phone: 0161 275 8815

If there are any issues regarding this research that you would prefer not to discuss with the researcher or her supervisor, please contact the Research Practice and Governance Co-ordinator by either writing to 'The Research Practice and Governance Co-ordinator, Research Office, Christie Building, The University of Manchester, Oxford Road, Manchester M13 9PL', by emailing: Research-Governance@manchester.ac.uk, or by telephoning 0161 275 7583 or 275 8093
Consent for Participation: Research Study
Trainee Counselling Psychologists’ Perceptions of Competency

If you are happy to participate please complete and sign the consent form below:

1) I confirm that I have read the attached information sheet on the above research study investigating trainee counselling psychologists’ perceptions of competence and have had the opportunity to consider the information, ask any questions and have had these questions answered satisfactorily.

2. I understand that my participation in this research study is voluntary and that I am free to withdraw at any time without giving a reason and that withdrawing from the research will have no negative effect on my training as a counselling psychologist.

3. I understand that the interview will be audio recorded and transcribed and held securely in line with data protection legislation.

4. I agree that the use of anonymous verbatim extracts within my interview may be used within the researcher’s Professional Doctorate in Counselling Psychology thesis and within journal articles, other professional publications (e.g. books) and conference presentations.

5. I understand this research study is being conducted following ethical approval by The University of Manchester and in line with The British Psychological Society (BPS) Code of Human Research Ethics (2010).

6. I understand my identity will be protected throughout (I will choose a pseudonym to be known by in the study); the identities of others talked about e.g. clients, colleagues, friends, family will be protected and details of geographical locations withheld.

I agree to take part in the above project

Name of participant ____________________________  Date ____________________________  Signature ____________________________

Name of person taking consent ____________________________  Date ____________________________  Signature ____________________________

Lorie Muellenbach
APPENDIX F

RESEARCHER’S BRACKETING INTERVIEW TRANSCRIPT

R: Tell me about your career path so far.
P: Before I came on the course I was working for the council. Sort of doing support work for kids who were using drugs and alcohol. So I’ve been working with adolescents, um, kind of solution focused, quasi CBT-type work. But it wasn’t a therapeutic relationship; it was more of an educational advisory kind of relationship. So my job was to sort of, be there for the kids but also have an eye to the staff because I was also kind of an ambassador for the service so I had to kind of, I suppose, keep an eye on training and things like that and offer them stuff like advice and information.

R: Um-hm so it sounds like you had a variety of experience and different kinds of skills in your previous work.

P: Yes

R: So what brought you into this programme?

P: Well I did, um, a long time ago I had a masters in psychology. Um, I was planning to go on to do a clinical doctorate but I changed my mind. I didn’t do it. I ended up getting married and having kids at the time or shortly after I got that masters anyway. I was also working with adolescents over there…actually I was working with primary school kids on this issue and I think that’s a bit odd too to be honest, now that I’m looking back on it. Yeah so we did this with primary school kids but I did other things too, I worked on conflict management, conflict resolution stuff with them and I also did a little bit of parenting too and stuff like that. So, I never really used my psychology and I thought, well, I should have done this a long time ago, so, I mean it’s just, I mean how much longer can I go, really? I think I got a bit sick of the job with the council I mean it was a good role and I enjoyed it but it wasn’t really enough to keep me happy I don’t think in terms of a role and there was nowhere to go with it.

R: So why counseling and not clinical?

P: Well actually it was between counseling and educational psychology I applied to the Edpsych programme but didn’t get on it. And I just sort of said to myself well, if it’s not educational psychology then I would think counseling. And then I googled counseling and psychology together and found a course on counseling psychology which I didn’t even know existed and I thought that was a bit of intuition or synchronicity or something so I just called them up and went down there. And that was it you know, here I am.

R: All right, so what is your understanding of what it means to be competent in your therapeutic work with your client?

P: Um for me it means being fully myself in the therapy session.

R: Can you say more about that?

P: Well I was thinking about an instance in the therapy room recently where, a girl, one of my clients, said something and there was a little part of me that wanted to follow up what she said indicated some risk that really I should have followed up (based on my intuition) because she said something that made me feel suspicious. I knew her well enough to know that she might be thinking about suicide. I really didn’t think “she’s going to end her life” but I did think “I’ll bet she’s thinking about suicide.” And she was. I checked with my supervisor and followed up my intuition but I should have followed it up on the spot. The question I asked myself is ‘Why
didn’t I ask that question then and there?” I think I didn’t go there because I didn’t trust myself to go there partly because the question is well “what are you going to do with that question? Are you going to cause a negative issue where one doesn’t exist?” So I didn’t go there. Now I think, “I should have gone there I think it was a mistake. I don’t pick this as an issue of competence or incompetence (well now maybe it is….) The question is, “What if I were feeling more competent? Would have gone there because I would have trusted myself and I would have been there so fully in the relationship that I wouldn’t have hesitated to take that next step?” So there’s something about being aware enough, having enough experience to know when to speak and when to not speak and um to follow those threads and also, yeah, when to speak and when to not speak and being very, I suppose, in the moment with a client. Following them and attending to that relationship but I’m aware that there are other areas of competence and I’m aware of that but for this stage of my training, and I think that’s very important thing to say - its about getting the relationship right.

R: Ok do you want to say more about getting the relationship right?
P: Well I think that really it’s about establishing that rapport all the time, really getting to know the person and getting to know who I am as a therapist what I can offer in the context of that relationship and considering my state of development which isn’t very far. So getting the relationship right is just getting them to trust me having an open dialogue with them and not being afraid to push a little bit.

R: OK well it sounds as if you have mentioned a couple of areas of how you want and being in the moment, immediacy, or being confident. But as a trainee what qualities do you think one should have in order to have this competence

P: Well I think self awareness is the most important thing obviously a caring attitude certainly being able to put aside your town thoughts and feelings about a subject and just really focus on the person so something around being attentive and caring and also I think there is a certain logic to this work that comes with experience and so but I think you need to be someone who can wrap your head around that so there’s cognitive ability too you need to be able to understand where it is you need to go so you need to be somewhat analytical because you know there is so much, I mean when it comes to competence in psychology there is so much I couldn’t believe I mean a thousand lifetimes and I could never achieve that goal - what I really need to be is to be focused and analytical about whatever piece I break off at the time. Yeah so that’s around knowing my limitations and being attentive to where my path or my process is taking me so its very much knowledge that’s kind of intuitive and maybe spiritual in some ways more so than any knowledge that’s out there as real knowledge, um theory, practice those are aspects of competency that I really can’t hope to approach right now.

R: Ok so do you want to add anything?
P: No

R: So what aspects of your training programme do you feel have facilitated your sense of competence when working therapeutically with clients?
P: Ok the training I think believe it or not the assignments have been very useful. I think I learned the most from the assignments. And that’s both that’s in so many ways, that’s the writing, that’s in the literature I’ve had to review for them um it’s developing a certain way of thinking I think as a researcher that has been very helpful in my feelings well its helped me gain some knowledge or maybe a perspective as a sense of identity as a trainee that maybe something more than I had before. And I presume it’s a platform to be built upon so I think the assignments have been really helpful. The taught aspect of the course - not so helpful. I haven’t had enough
practice in class. If I had more practice I would say, yes, it’s been more helpful. But also I haven’t even had 30 hours of clinical practice in my placement yet so that may be part of the problem. You are supposed to have more by this point. I can definitively see how meeting with clients, even one or two clients, I mean I’ve only met with three clients so far, um, that makes a big difference. I suppose I’m doing ok because I feel like I’ve established a relationship with them all but I don’t feel like I’ve concluded anything I honestly think I don’t have that much to offer them in terms of specific interventions that can help them (which I could have gotten from practice in class) so I suppose it depends on my definition of what I think is being competent. The assignments have helped me think about the relationship they’ve helped me think about immediacy they’ve got all the sort of the counseling stuff that I’ve had to learn in order to do the assignments which I think I could see myself carrying out. The supervision is also just underdeveloped. I mean I’ve only had a few sessions. So the order is first the most helpful has been the assignments probably followed by the case discussions in class because I really did learn a lot from other people in that environment, I mean I learned something about what I’m needing to achieve by hearing what other people bring so just listening to the stories has been really helpful.

R: So it sounds like you’re in the very beginning of like exposing yourself to all these different areas to kind of fit in in your clinical practice but for now it appears that assignments and your case discussions are beginning to feed into your clinical practice.

P: Yeah and to see that to see those two things gelling even when I make a mistake when I see theory and practice kind of gelling it gives me hope (laugh) maybe not competence but hope that might be achieved.

R: Is there anything you would like to add?

P: I don’t think so

R: Ok so the final question is what aspects of your training experience has hindered your sense of developing therapeutic competence when working with clients.

P: Hmm I don’t think I’ve got enough information I think that I don’t know doodley squat about what I need to know to become a psychologist. I know a little about where I might be heading.

R: Ok so it sounds like lack of information lack of knowledge

P: Yeah lack of knowledge and information (long pause) yeah I think all the way around it’s a lack of knowledge about how to put theory into practice and not knowing where I want to go as a practitioner. I don’t think I’ve had enough of a mentor I haven’t had anyone really sit down and say ok now what do you really want to do? And help me figure out where I want to go and that’s been a serious lack of…

R: So like guidance

P: Yeah. Very little guidance and not enough information

R: Can you tell me more about that feeling of not having very much guidance and not having enough information in your clinical practice? What is that feeling like?

P: I feel like I’ve got a lot of guinea pigs around. The guinea pigs are my clients I mean, well, it feels a little bit unethical because my clients aren’t really getting very much.

R: So how does that feel your clients are not getting very much from you?

P: A little bit sorry for them because this is probably all they’ll get. This is as good as it gets for them. I mean they don’t have many options. It’s not like they are going to go to a proper CBT therapist and spend £50 per session to get help. So I feel like I’m letting them down a little bit. But at the same time I am there and I do care so my intentions are good but oh, and that’s the other thing. I said the assignments are good
but I’m just too busy there are too many of them. So it gets in the way of my ability to be competent because I don’t have the time to look up all of these traumas that my clients are going through which could possibly prove to be helpful because I could look at theory and try and use it in the counseling so if I had the theory maybe I’d be able to give a slightly better service. But I don’t know, maybe I’m not convinced about that but it would make me feel as if I were doing something (laugh). I’m sure I probably would be doing something more. Oh, yeah. One more thing is that I haven’t had enough training hours but that’s not the fault of the programme. The actual placement hours are too I mean I should have had more by now but it’s not the fault of the training. If I were going by the training standards I would have had at least 100 or 150 hours by now and I don’t even have 50 so it’s very difficult to assess.

R: How does that make you feel just to have under 50 hours?
P: Out of synch. Very much out of synch and a little bit unsteady because I’m a little bit worried about I just I look at everyone else’s competence and I start to compare and I think oh my god, I don’t know anything. Everybody else knows far more than I do and so when it comes to me getting a job its gonna be like I don’t know oh, who is this woman and who cares? She doesn’t really know that much she doesn’t have that much to offer. So there’s a little bit, there’s a little bit of doubt about the future but is that competency getting a job? Yeah I don’t feel I’ve achieved enough competency to be able to go out there at the end and get a job.

R: So you have been describing all these things could you describe in a short sentence what is the feeling? What would that feeling be?
P: Disappointment
R: Disappointment?
P: Yeah
R: OK right. Are you happy to end the interview?
P: Yep.
APPENDIX G
REFINING THE FOCUSED CODES

KEY
1. Red Boxes indicate focused codes that were collapsed.
2. Red Arrows indicate where the data was reassigned.
APPENDIX H

REFLEXIVE MEMO ON DEVELOPING THE GROUNDED THEORY

Introduction

In this memo I explain my thinking about developing an overarching theoretical category (Developing Competence) and why I didn’t do it. The memo consists of several excerpts from my reflexive journal during data collection, analysis, and write up. It also contains excerpts from an early theoretical memo on the proposed theoretical category “Developing Competence.” I have given the excerpts titles to help the reader follow my thinking and my process of decision making.

The decision not to develop theory influenced the course of the study because in the latter stages of my analysis that decision meant that I had to focus on enhancing my theoretical categories using an intermediate coding framework instead of going on to develop substantive theory (Glaser, 2009). Once I realized I did not have sufficient data to develop substantive theory, I decided that the focused codes Philosophy, Challenges, Ethics, Progress, and Feedback had to be refined. This is because the writing up process was becoming hopelessly stalled. I needed to develop subcategories to accommodate the data. I consider now that the subcategories that were eventually developed (Coursework, Observer Feedback, Self Reflection on Competence, Clinical Experience, Reflexive Thinking/Self Awareness, Theories and Models, and Supervision - see Figure 4.9 in the findings chapter) enhanced the data that was originally organised under the focused codes. I think the process of refining the data into categories and subcategories helped to enhance the theory because they gave me a more coherent structure for integrating a list of competences developed by trainees and it allowed me incorporate the factors that influence trainees’ perceptions of competence. The intermediate coding framework (Birks & Mills, 2011) helped me to further enhance my theoretical categories and define my theory.

Reflexive Journal Excerpts

Part 1: Why Developing Competence?

March 2014

I am thinking about theoretical codes. I have been thinking about the effect of where people are being trained and what model they are using. Trainees are communicating with me about their experiences of competence. I am asking about their experiences but other things are coming up. Trainees are defining competence and they are also telling me about specific instances where they have felt competent – influences on competence? I am feeling some emotions. I am feeling inspired and I sense that trainees are expressing commitment to be ethical and to be competent (of course being competent is part of being ethical). I think developing competence is where most of the energy is being expressed. I think this is the process of the interviews. I think developing competence is an emergent theme. This is not a million miles away from my thinking when I first started the analysis. I remember one of the first things I
noticed about the data was that there was this strong theme about “being” - being ethical, being competent, being a counselling psychologist, being “called” into this vocation, feeling it was right for them because of who they are. It makes sense that trainees are concerned about developing competence (after all it is what we are doing) – even if I did not specifically ask about this – trainees could not help but offer this perception.

**Part 2: Developing Competence**

**Excerpts from Theoretical Memo: Developing Competence (June 2014)**

Glaser (2009) asks: What are trainees main concerns in developing competence?

List of Trainees’ Concerns

1. Time challenges coursework and time for reading theory (2 participants).
2. Lack of confidence due to gaps in training – (1 participant), dealing with negative emotions brought up by challenges in practice (1 participant) not feeling rehearsed enough in certain interventions (1 participant) not knowing the boundaries of right and wrong action (1 participant).
3. Being judged (most if not all participants); most participants referred to stress of being observed/assessed. Some reported these as learning experiences even though they were sometimes negative (except 1 trainee who felt the negativity persisted in her self evaluation of practice).
4. Dealing with negative self-awareness during sessions. Getting distracted from clients’ narrative, making negative self-evaluations of practice. (several participants)
5. Ethical concerns around uncertainty of competence – Trainees are indicating their concerns e.g. Am I up to this challenge of doing clinical work? How do I manage those concerns?

They’ve answered their own questions. “I do this by learning more, getting better, asking, checking to discern limits of my competence. Am I feeling like a safe practitioner? Am I honest with my supervisor? Am I comfortable with that relationship?”

“I do this by developing a strategy for practice: Knowing the theory, applying the philosophy, gaining knowledge of the evidence base, and acquiring experience in practice.”

“I do this by making a commitment to improve my practice. I do this by being an ethical practitioner. Setting high standards for myself.” (Being an ethical practitioner and becoming more competent)

**Phase 3 Intermediate Coding Framework**

Reflexive Journal Excerpt
August 2014

Data on incompetence: Feelings of incompetence were identified in many interviews but only one trainee discussed her experience of them and how that impacted her sense of competence. One other trainee told me about having been seriously challenged by a supervisor she immediately framed that experience as a positive experience of learning. Was this because she was unwilling to discuss it? Was this
and example of impression management? If I had followed that theme more closely then I might have been able to flesh this “Developing Competence” theoretical code out but seriously, who knows whether people would have been willing to talk about this – who wants to talk about this stuff? How many volunteers am I going to get when they know I am asking the question, “So could you tell me all about the last time you were feeling really inadequate?” I did note that both of these trainees who talked about experiences of incompetence were in IAPT placements and I think that is going to affect some of my conclusions about the influence of context. It makes sense because if you feel unable to make a contribution to a professional environment then that’s got to affect your sense of your own competence.

Reflexive Journal Excerpt
September 2014

My conclusion about theoretical sampling (Glaser, 2009 - not having enough data on incompetence which is part of the larger concern of developing competence) affects the way I am going to finish this thesis. Building a theoretical code (I would have chosen “developing competence”) can’t be done without this missing data. I can’t go back to the data collection phase now. There is insufficient data to draw conclusions about trainees’ experiences of incompetence. If I’d had more experience as a researcher, I would have seen where the data was heading before I finished in May. I was focused on trainees’ years of experience, their models and their training contexts right from the beginning and that was fine because it’s part of the picture but I was missing a main point. I should have altered my interview schedule a second time in order to pursue trainees’ feelings of incompetence. I could have worked with that theoretical code to see where to take off of this. Trainees’ feelings of incompetence are too important to ignore because it is a well-established finding that trainees feel incompetent (Ronnestad & Skovholt, 2003). I knew about this but I forgot. This critical concern on the part of trainees was left virtually unexplored – so now I’m in the later phases of the analysis and I realize I did not meet Glaser’s (2009) criteria for theoretical sampling. I needed to explore experiences of incompetence to develop the theoretical code most relevant to this study, developing competence. Further interviews are not possible.

October 2014

What is left in the data?

How trainees perceive (or experience) define and develop (or acquire) competence. Middle range theory. Theory lite study.

Part 2 Why Not A Substantive Theory?

April, 2015

People didn’t talk much about their experiences of incompetence. Only one trainee gave me a glimpse into that journey. I should have probed for that – at least a little. Too much the therapist following the client instead of the interviewer following the theory! If I’m going to build substantive theory around developing competence, then I
need to make sure I’ve got enough data on experiences of being incompetent – and looking back on these interviews - I don’t.

Part 3 Where do I go from here?

April 2015

I really like the five focused codes but they are too broad to develop this theory if I’m not going after the third level of coding. I keep driving myself crazy trying to write this up! I don’t think I’ve got the skills to figure out how Charmaz would handle this roadblock. I wonder if I she’s still at Sonoma State University? I wonder if she’d take my phone call? Haha. I wouldn’t even know what to ask. Terry (my research supervisor) says, “Are you sure you know what your findings are?” Not a good sign.
APPENDIX I
SUBSUMING THE FOCUSED CODES
INTO THE THEORETICAL FRAMEWORK

Tables J.1-J.5 list how the data from the focused codes in Part 1 of the analysis were subsumed into the categories and sub categories developed in Part 2. The data from each focused code was assigned to one core category and one or more subcategories. Refer to the coding hierarchy in Figure 4.8 for a full listing of the categories and sub categories that constitute the theoretical framework.

**Table J.1 Philosophy**

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<tr>
<td>I. Core Category: Defining Competence</td>
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<tr>
<td>II. Sub Categories:</td>
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<tr>
<td>• Coursework</td>
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<tr>
<td>• Reflexive Thinking/Self Awareness</td>
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<td>• Theories and Models</td>
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**Table J.2 Ethics**

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<td>II. Sub Categories:</td>
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<td>• Reflexive Thinking/Self Awareness</td>
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<td>• Theories and Models</td>
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**Table J.3 Feedback**

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<td>I. Core Category: Perceptions of Competence</td>
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<td>II. Sub Category:</td>
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<td>• Observer Feedback</td>
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**Table J.4 Challenges**

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<td>• Supervision</td>
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**Table J.5 Making Progress**

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<td>I. Core Category: Perceptions of Competence</td>
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<td>II. Sub Category:</td>
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<tr>
<td>• Self-Reflections on Competence</td>
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