A MIXED METHOD STUDY OF

HOW TRAINEE COUNSELLORS CHANGE

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In Britain formal counsellor training is regarded as an essential pre-requisite for practice but its impact on the personal and professional development of trainees remains largely unexplored in the research literature. A hierarchical nested research study design (*N*=64) was used to investigate trainee characteristics and change processes across three BACP accredited counsellor training programmes. This study used quantitative and qualitative methods to conduct two related studies: 'The Early Effects of Practitioner Training' and 'A Longitudinal Examination of Trainee Change'. The first was comprised of a cross sectional examination of trainee characteristics (*n*=63) and two qualitative studies: The Beginning of Training Study and a single subject Case Study of Margaret. The second consisted of one quantitative and two qualitative studies, these were: a paired sample investigation of the impact of training on one student cohort (*n*=20), the End of Training Qualitative Study of trainees (*n*=7)*,* and an Assimilation Model Analysis of Mandy. The research was conducted from a critical realist perspective.

The majority of trainees were white, female and middle aged but the experience of minority groups within cohorts was explored. Trainees had personal histories characterised by supportive relationships, loss, trauma, abuse and recovery. Practitioner training had a significant impact on personal and professional development but evidence of some negative effects, including Stressful Involvement, were found. Low levels of distress and increased emotional functioning were positively related to the completion of training. It is proposed that although the achievement of key competencies is the ultimate aim of practitioner counsellor training that it is the ability of trainees to assimilate problematic experiences and integrate different kinds of knowledge that is likely to result in therapeutic expertise.

Dedication

This thesis is dedicated to the memory of my brother Kevin

And to my parents John and Ivy Folkes with love and gratitude for

all they have taught me.

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I am sincerely grateful to Professors Robert Elliott and Sue Wheeler, my research supervisors, who have offered me guidance, critical reflection, and support throughout. It has been a privilege to work alongside Robert Elliott whose influence on me as a researcher and as a person will remain with me for the rest of my life. Without Sue Wheeler's help this research would not have been possible.

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Abbreviations

APA	American Psychological Association
BAC	British Association for Counselling (replaced by BACP)
BACP	British Association for Counselling and Psychotherapy
BABCP	British Association of Behavioural and Cognitive psychotherapies
BPC	British Psychoanalytic Council
BPS	British Psychological Society
CACREP	Council for Accreditation of Counseling and Related Educational Programs
CBT	Cognitive Behavioural Therapy
DipHE	Diploma of Higher Education
DOH	Department of Health
FE	Further Education
HE	Higher Education
HPC	Health Professions Council
HE	Higher Education
IAPT	Increasing Access to Psychological Therapy
NICE	National Institute for Health and Clinical Excellence
NIMHE	National Institute of Mental Health in England
NHS	The National Health Service
RCT	Randomised Controlled Trial
QAA	Quality Assurance Agency
UKCP	United Kingdom Council for Psychotherapy

Chapter 1: Introduction

An introduction to the thesis that includes: research rationale, statement of the research problem, research questions, aims and objectives, general statement of contribution, structure of the thesis and definition of terms used.

Research rationale: personal context

The research presented in this thesis has grown out of a personal and professional interest in counselling and psychotherapy training.

My first experience of therapy was as a client. It was only towards the end of my second year of person-centred therapy that I began to consider being in the 'other' chair. I applied to my local college to do a counselling skills course and from this went on to study, what was then, a BAC accredited course, at the University of Birmingham in psychodynamic counselling.

I completed my professional training in 1995 and since this time I have practiced in a variety of settings including voluntary agencies, secondary and further education, private practice and an NHS adult psychotherapy service. I began my work as a part-time counsellor trainer in 1997 at the University of Birmingham as a counselling skills tutor. Within a few years I began teaching and supervising on the professional counsellor training programme there. For most of my career I have combined working as a therapist and teaching trainee counsellors. Although in some ways quite separate, they also have had an on-going impact on each other. Teaching and supervising trainees has challenged my thinking, and my work with clients has grounded my teaching in practical experience.

Since 2004 I have been employed as a Lecturer in Psychodynamic Counselling at the University of Leicester. To begin with, I was the course director of an undergraduate diploma course, and for the past five years I have been the course director of the Postgraduate Diploma/MA in Psychodynamic Counselling. This course is accredited by the British Association for Counselling and Psychotherapy (BACP).

The students enrolled on this programme are typical of other such accredited courses in the UK, particularly those in Higher Education. It is taught on a part-time basis and incorporates theory, skills, supervision, a practice placement and personal development group work. Students are generally graduates who come with a wide variety of professional and personal experiences. Some have no experience of working with clients or even of being with people in distress in a helping role. The majority are white, middle class, female professionals. The syllabus has changed a great deal over the past ten years with greater emphasis on evidence based practice, professional competences, neuroscience, CBT and difference and diversity. However, the central aim remains the same: to help students to become effective, reflective practitioners and in so doing, to help and protect clients through upholding high professional standards.

The research that will be presented here has emerged from the context of my personal and professional life but it has also been influenced by major political and professional changes in the counselling and psychotherapy profession over the past twenty years.

Statement of the problem

Beutler, Malik, Alimohame, Harwood, Talebi, and Noble (2004) conducted a meta-analysis of the previous twenty years of research into counselling and psychotherapy training and they conclude that "overall findings tend to cast doubt . . . on the validity

of the suggestion that specific training may be related to therapeutic success or skill"
(p. 239). Rønnestad and Ladany (2006) state that empirical evidence that supports a
positive relationship between training and therapist effectiveness is both 'meagre' and
'inconsistent' (p.262). Beutler et al. (2004) conclude that interest in therapist variables
had declined over the previous twenty-five years because of the influence of
Randomised Controlled Trials (RCT's) which aim to exclude therapist variables such as
training. The paucity of research findings therefore, may be a consequence of an
emphasis on RCT research in recent decades but this type of research is also predicated
on a misconception of what therapy is.

Orlinsky and Rønnestad (2005) define therapy as a "professional-personal relationship"
(p.6) between the therapist and the client rather than a series of techniques or
procedures. The personality of the therapist therefore, is inevitably a key component of
therapy. Research is needed into the influence of training on the person of the therapist
and their professional development.

Psychological therapy has accrued a body of evidence that demonstrates it is effective,
and in the UK psychological treatment is recommended for most forms of depression
and anxiety (NICE, 2009). It is also clear that therapists vary in their effectiveness with
regards to treatment outcome and that those factors that are responsible for this are yet
to be identified (Okiishi,Lambert, Nielson, & Ogles, 2003).

The role that practitioner trainings play in the personal and professional development of
therapists is largely unknown in the research literature. Understanding how training
helps students to become therapists is the first step to understanding how training helps
therapists be effective. As will be shown in the literature review in Chapter 2 there are a

number of problems with the existing evidence base for training that is, evidence derived from empirical investigations. Research has focussed on discrete core elements of training rather than the impact of training as a whole. Despite the fact that practitioner training is predicated on a model of integrated learning and assumes that these elements are interdependent and mutually inclusive. Practitioner training aims to produce graduates who are capable of conceptualising client difficulties using different kinds of knowledge and skills that can be frequently modified and adapted to the needs of each client. There is some evidence that sophisticated conceptualisation is associated with expertise and may be related to improved outcomes for clients. Research is needed into how training enables trainees to develop this ability.

There is a consensus that practitioner training is stressful, particularly at the start of practice, as it demands personal change alongside the development of professional skill and academic achievement. Only a few studies have investigated levels of stress in trainees. Even fewer have examined how trainees prepare for practice and the impact of beginning work with clients. Most findings are derived from retrospective accounts or personal learning journals. The degree to which trainee 'stress' is helpful or harmful has rarely been investigated. Levels of distress in one student cohort at the beginning and the end of training, has not been measured.

Few studies have investigated the impact of practitioner training on British counsellor trainees. Most research comes from the US where training is full-time and post graduate; whilst in the UK it is largely part-time and trainees qualify with a variety of academic qualifications that range from NVQ to MA. There is a need to understand the extent to which, this British model of training impacts on trainee development and how

the experiences of British trainees compare with those of trainee therapists in other countries.

Few studies have tracked trainee change over the course of training. Research into how trainees change and what helps them to become competent practitioners is needed.

Study aims and objectives

The primary aim of this study was to examine how trainee counsellors change during their training. A distinction is made between learning and change. The concept of change, as exemplified by Change Process Research (CPR), is the focus of this research. Elliott (2010) defines CPR as:

> "…processes by which change occurs in psychotherapy, including both the in-therapy processes that bring about change and the unfolding sequence of client change (which changes occur first and lead to what subsequent client changes)" (p.123).

The aim of this study is to identify the processes by which change occurs in trainee counsellors using CPR methods, rather than to investigate how they acquire knowledge or skills which are part of that process.

Aim: to understand how trainee counsellors change and what helps them to change.

Objective: The purpose of the study was to identify how British professional counsellor training programmes help or hinder student trainees to become counsellors. Quantitative and qualitative methods were used to investigate: trainee characteristics, the early effects of training, therapeutic involvement and experienced professional growth,

helpful and unhelpful training experiences, and the impact of training on perceived therapist confidence.

General statement of contribution

The findings of this investigation positively contributed to the existing research in the following ways:

- Identified change processes that occur during practitioner training specifically in relation to professional growth and resourcefulness

- Specified training factors that contribute to trainee development or decline

- Identified how core elements of training are assimilated over time and how the level of assimilation may contribute to the development of therapist competence

- Enable trainers, course providers and regulators to better understand the changes trainees' experience and how training courses assist students in making the transition from trainee to therapist.

- Described the characteristics of British trainee counsellors

- Identified the influence of training in preparing trainees for work with clients

Structure of the Thesis

The review of the literature in Chapter 2 begins with an outline of the current context in which counselling training takes place and is followed by a review of the research literature that relates to counselling and psychotherapy training. Topic areas will include: an examination of professional and academic standards, the impact of training on the personal and professional development of trainees and a critical review of research methods that have been used in training research. Finally, the research questions, which will become the focus of this thesis, will be defined.

Chapter 3 begins with an account of researcher reflexivity. This is followed by an examination of the research methodology that underpins the thesis and this is followed by an overview of the research design. In Chapter 4 the methods and results of The Early Effects of Practitioner Training which is comprised of one quantitative and two qualitative investigations are described. In Chapter 5 the methods and results of the Longitudinal Examination of Trainee Change, which consists of three studies; one quantitative and two qualitative will then be presented. Each of these chapters will conclude with a discussion of the findings. The thesis conclusion, Chapter 6, will begin with a summary of the central thesis followed by a discussion of the findings from a critical realist perspective and is concluded with a theoretical integration of the findings.

Definitions of terms used.

The focus of the research is the impact of practitioner training on British counsellors. Practitioner training refers to those courses that meet the training requirements for either individual or course accreditation as defined by the BACP. The term trainee will be used to denote individuals engaged as students in practitioner training. The terms counsellor, therapist, practitioner and psychotherapist will be used interchangeably to refer to psychological therapists who provide "insight-oriented, exploratory therapy" (Gold & Hilsenroth, 2009, p.162). Such therapists aim to alleviate psychological distress rather than provide advice, guidance or helping skills support.

For this reason, this study will not focus on professional groups that exclusively practice models of therapy that do not depend on the development of insight through the use of the therapeutic relationship. This primarily relates to CBT practitioners whose training is likely to differ from that of other counsellors and psychotherapists in that the

emphasis is on achieving change through the application of specific techniques or procedures. In general, CBT offers a wide range of interventions including individual therapy and the therapist provides structure rather than space for exploration that leads to 'change [in] extreme thinking and unhelpful behaviour' (BACBP, 2011, homepage). For this reason the training standards of those organisations that accredit courses that exclusively train therapists in this model e.g. British Association for Behavioural and Cognitive Psychotherapies (BABCP), have not been included in this study.

The term researcher will be used throughout to refer to the author of this thesis.

Chapter 2: Literature Review

In this chapter the literature relating to the current context of professional counsellor training in the UK and its impact on the personal and professional development of trainee therapists is examined.

This chapter outlines the current context in which counselling training takes place in the UK. It charts developments in counsellor training over the past decade and examines current academic and professional standards. It then evaluates the research evidence in respect of its impact on trainees and the methodological challenges of undertaking research in this area. Finally, the research questions will be defined.

The literature review focuses on published empirical research with reference to professional documents and government reports. Central to the review is UK counsellor training but relevant research and professional standards from other countries is included. It is divided into three sections:

> Section one: The current context of counsellor training in the UK.
>
> Section two: A common factors approach to practitioner training: the acquisition of conceptual skills, therapeutic skills and self-knowledge.
>
> Section three: the impact of practitioner training on trainees

Searches were conducted in key electronic data bases via Athens that included Psych Info, Psych Articles and the Ethos dissertation data bases. Relevant peer reviewed journals and books were accessed via the University of Leicester Library Catalogue and digital library along with articles and books from the British Library. Conference abstracts and reports were downloaded from the websites of professional organisations

and government bodies such as the Society for Psychotherapy Research, Health

Professions Council and the British Association for Counselling and Psychotherapy.

The Current Context of UK Counsellor Training

"According to the law a quack is anyone who treats patients without possessing a diploma ... I should prefer another definition: a quack is anyone who undertakes a treatment without possessing the knowledge and capacities necessary for it" (Freud, 1926, p.47-48).

In the absence of the statutory regulation for most counsellors and psychotherapists in

the UK, standards that define necessary knowledge and capacity for practitioners are set

by training institutions and professional bodies. The only exceptions to this are

counselling psychologists who are regulated by statute through the Health Professions

Council (HPC) and who train on courses that are approved by the HPC and

professionally accredited by the British Psychological Society (BPS). For the majority

of counsellors and psychotherapists in the UK there is currently no minimum level of

qualification and no requirement to undertake training in order to practice. There is no

agreement between the two lead professional bodies; The British Association for

Counselling and Psychotherapy (BACP) and The United Kingdom Council for

Psychotherapy (UKCP) on a definition of counselling or psychotherapy. BACP have

maintained that the practice of counselling and psychotherapy are the same. The UKCP

hold a position that psychotherapy is distinct from counselling. Eighty-one per cent of

individuals and 56% of organisations who responded to the Health Professions Council

(2009b) consultation on the statutory regulation of counselling and psychotherapy

disagreed with the proposal that counselling and psychotherapy should be differentiated (Health Professions Council, 2009a; Health Professions Council, 2009b). Despite this response the HPC announced its intention to define counsellors and psychotherapists as separate professions on the grounds that their training is significantly different i.e. that psychotherapists qualify at a postgraduate level and counsellors with Higher Education diplomas.

Training level has been used to denote psychotherapists as specialists with post-graduate qualifications and counsellors as semi-skilled generalists who are not graduates. This is despite contrary evidence that many counsellors are graduates with a significant proportion holding postgraduate degrees or that most psychotherapists do not have post graduate qualifications that have been awarded by academic institutions (Aldridge & Pollard, 2005). There is also little empirical evidence that level of training is related to therapeutic skill.

 Stein and Lambert's (1995) meta-analysis of the findings of over 30 studies that investigated the relationship between training level and therapy outcome conclude that higher training level i.e. stage of training, academic level and/or experience has an impact on client outcome. The strongest effect related to client satisfaction followed by client change. However, other investigations have failed to establish a positive relationship between training level and therapist effectiveness (Boswell, Castonguay, & Wasserman, 2010; Norcross, 2002; Norcross & Wampold, 2011; Okiishi, Lambert, Nielson, & Ogles, 2003). Okiishi et al. (2003) measured the client outcomes of ninety-one therapists who saw 1,841 clients over two and a half years and conclude that effectiveness is not related to any therapist variable including training. There is evidence that it is how therapists are with their clients that makes them more effective

(Norcross, 2002). These common factors, rather than specific ones such as qualification, are most likely to distinguish expert therapists from the semi-skilled or inept. Neither the UKCP nor HPC proposals were supported by the empirical or demographic evidence.

Recent developments indicate that the statutory regulation of counsellors and psychotherapists will not take place in the near future. A government command paper: Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care, was published in February 2011 (Department of Health, 2011). Its intention is to introduce an enhanced system of voluntary regulation for health care and social care workers, including counsellors and psychotherapists in 2012. Whatever the outcome, the conflation of academic qualifications with expertise is likely to continue, for although erroneous, it is a confusion that is typical of all professions (Abbott, 1988).

Freud's (1926) hope for a laissez-faire approach to the training of therapists rather than one that is tightly controlled by governments is only partly realised in Britain. Professional freedom alongside the absence of agreed training standards has resulted in on-going disputes between different factions within psychotherapy (Jacobs, 2000) and a fragmented counselling profession (Aldridge & Pollard, 2005). Longstanding professional rivalries have been exacerbated by two initiatives through which government has increased its control of psychological therapy (Mace, Rowland, Evans, Schroder, & Halstead, 2009). These are: the Increasing Access to Psychological Therapy (IAPT) programme; and the National Institute for Health and Clinical Excellence (NICE).

The overriding principle of evidence based practice i.e. the development of services and treatments based on the best available scientific evidence, has threatened to restrict treatment choices for NHS patients. The gold standard for evidence based practice adopted by NICE is that derived from Randomised Controlled Trials (RCT's). Based on this evidence, Cognitive Behavioural Therapy (CBT) is the only recommended psychological treatment for depression and anxiety (NICE, 2009). NICE guidance that identifies CBT as the best treatment for patients with depression, anxiety and post-traumatic stress disorder (PSTD) has resulted in shortages in the provision of psychological therapy (Mace et al., 2009). These shortages led to government investment in IAPT community based services and this was instigated by a government report.

The Centre for Mental Health Performance's Policy Group's report led by Lord Layard (The Centre for Economic Performance's Mental Health Policy Group, 2006) put the economic cost of depression and anxiety at £12 billion per year and highlighted the chronic shortage of CBT therapists. The report stated that as a consequence, NICE treatment recommendations could not be implemented and that this left many of those with anxiety and depression out of work and reliant on state benefits. The training of 10,000 CBT therapists was proposed through increasing the number of training places for clinical psychologists to produce 5,000 extra therapists. The remainder were to be found from the existing NHS workforce of 60,000 nurses, social workers and counsellors who would be given part-time training in order to make them "fully professional therapists" (The Centre for Economic Performance's Mental Health Policy Group, 2006, p.12). The report made no reference to existing qualified and experienced members of professional associations, in particular BACP.

There is however, little empirical evidence to support the view that CBT therapists are more effective than those trained in other modalities. NICE treatment guidance (NICE, 2009) recommends CBT for depression and anxiety on the basis that it is the only psychological therapy with sufficient RCT evidence that demonstrates its effectiveness. NICE are not suggesting that CBT is superior to other psychological therapies. Studies that have compared the efficacy of different approaches have consistently revealed no difference in the outcomes for clients.

This research has come to be known as the Dodo bird verdict. This originates from 'Alice in Wonderland' when at the end of a race the Dodo pronounces that "everybody has won, so all shall have prizes" (Carroll, 1865/2008, p.17). The findings from this body of research indicate that although therapists vary in their effectiveness this is not related to their model or approach. For example, Luborsky et al. (2002) examined the findings of 17 meta-analyses and conclude that there is no evidence to support the view that approaches differ in respect of outcome. Stiles, Barkham, Mellor-Clark, and Connell (2007) investigated the therapy outcomes of 5,613 patients being seen in routine practice in the NHS. Outcomes were compared by modality: CBT (n=1,045), person centred therapy (PCT) (n=1,033) and psychodynamic therapy (PDT) (n=530). The authors conclude that outcomes for clients are equivalent across different approaches. The study had some limitations and these are acknowledged by the authors. Clients were not assigned to therapists on a random basis and the data set was incomplete as many clients did not complete the end of therapy outcome measure. Clark, Fairburn and Wessely (2008) criticise the research in respect of the deficient nature of the data and the failure of the authors to control for the influence of natural recovery or concurrent medication on the outcome of therapy.

This failure, it is suggested, inflated the benefits of psychological treatment regardless of approach. Their final criticism is that no evidence was presented regarding the equivalency of caseloads i.e. that therapists from different modalities were working with clients with similar levels of distress. They state that as consequence the findings of the study are unreliable. Stiles, Barkham, Mellor-Clark, and Connell (2008a, 2008b) responded to these comments and emphasised the value of practice based evidence and this sparked a debate that is on-going.

The debate focuses on the reliability of evidence produced from practice based studies such as those conducted by Okiishi et al. (2003) and Okiishi et al. (2006), and the limited value of evidence produced from RCT's for routine practice. The latter may prove to explain the lower than expected performance of CBT in IAPT services (Glover, Webb, & Evison, 2010). In essence, the Stiles et al. (2007) study was criticised for not being a clinical trial despite its explicit intention of conducting a naturalistic investigation. That treatment outcome is not related to therapist modality has been found to be typical of many studies that have been conducted on routine practice (Norcross, 2002). This has also been the case in some trials. For example, Shea, Elkin, Imber, and Sotsky (1992) reported similar rates of improvement regardless of treatment condition in their RCT. Clients with depression were assigned to CBT, Interpersonal Therapy, medication or medication plus placebo. At follow up, the rate of improvement was the same across all groups which suggest that not only was modality not related to outcome, it is also possible that client recovery may have had little to do with any of the treatments provided.

Despite evidence that efficacy is not related to modality; NICE guidance has contributed to a culture where psychotherapeutic approaches are regarded as different

treatments. Each one is expected to develop its own RCT evidence base, for it to become a recommended treatment. The promotion of Cognitive Behavioural Therapy (CBT) through NICE and IAPT has created deeper divisions between allied professions. For example the NICE depression guideline consultation document which was published in 2009 recommends CBT for most clients. It stated that other psychological approaches, such as counselling, should only to be offered to patients when essentially all else had failed and that clients should be told that there was no evidence that it would help (NICE, 2009). Professional groups have exerted pressure on NICE and NHS service providers to recognise the value of different psychological therapies and of different kinds of research evidence. The most influential pressure group is the Savoy Partnership, formerly known as the Savoy Group.

The Savoy Partnership contributed to the New Ways of Working Report which was published by National Institute for Mental Health in England (NIMHE) in 2010. They propose a new career framework for NHS psychological therapists. This report, if implemented, will result in greater plurality in the provision of psychological therapy and professional parity across psychological professions.

Summary

Therapists in the UK who have been left to their own devices with regards to training standards and practices for most of their history; have been subjected to greater government control over the past decade. This has resulted in attempts to demarcate counsellors and psychotherapists based on the incorrect notion that they provide different levels of therapeutic expertise signified by level of qualification (Health Professions Council, 2009a; Health Professions Council, 2009b).

CBT has been the treatment of choice (NICE 2012) for the treatment of anxiety and depression since 2006 and this had resulted in shortages in treatment provision within the NHS (The Centre for Economic Performance's Mental Health Policy Group, 2006; Mace et al., 2009; NICE). This has contributed to widening the division between counsellors and psychotherapists as evidenced by the HPC's attempts to introduce statutory regulation (HPC 2009a; HPC, 2009b).

The empirical evidence does not support the view that specific factors such as level of qualification or orientation influence therapist effectiveness (Boswell, Castonguay, & Wasserman, (2010); 2010; Norcross, 2002; Norcross & Wampold, 2011; Okiishi et al., 2003). With the exception of Stein and Lambert's (1995) study however, there is no evidence to support the view that stage of training, academic level and/or experience, is related to better client outcome. There is a body of evidence that common therapy factors e.g. empathy, therapeutic alliance etc. have a greater influence on therapy outcome than specific factors such as training level or modality (Norcross, 2002). The APA task force has recommended that approved programmes deliver training based on this research, specifically "the demonstrably and probably effective elements of the therapy relationship" (Norcross & Wampold, 2011, p.99). This evidence has been largely disregarded by statutory and professional organisations in the UK. Pressure has been exerted on government to recognise evidence that supports greater plurality of provision by groups such as the Savoy Partnership (NIMHE, 2010) but it is too early to judge what the outcome of this will be for therapists and clients.

There is a danger that evidence based approaches, identified by NICE will become the focus of practitioner training rather than evidence based practices, such as those described by Norcross and Wampold (2011). The limited resources available to fund a

sufficient number of RCT's, which are the gold standard in the NICE hierarchy of evidence, are likely to lead to the dominance of a limited range of recommended treatment modalities, such as CBT. There is a danger therefore that practitioner training in the UK will become narrower and fail to provide the greater plurality of approaches identified by the Savoy Partnership as a necessary development within NHS services.

Practice patterns

Orlinsky (2009) defines psychotherapy as something that is practiced throughout the world by a variety of professionals including counsellors.

> "It is a commonplace to note that while there are many professional psychotherapists, there is no profession of psychotherapy – no single profession in which all psychotherapists are trained, to which all belong, and for which all are accountable. There are, instead, several different professions... most prominent among the secular professions in which psychotherapy is practiced are medicine and psychology, joined by a somewhat variable set of other professions in different countries (e.g. social work in the US, counselling in the UK)" (p.183).

The training of therapists and their qualifications vary throughout the world. The National Health Service (NHS) is the largest provider of psychological services in the UK but the full extent of provision can only be estimated because of the wide variety of professionals who practice therapy such as nurses, social workers etc.

Mace et al. (2009), state that psychotherapy is a recognised medical speciality for psychiatrists but that they represent a fraction of practitioners. The only other group of psychotherapists that have similar recognition in the NHS are child psychotherapists. NHS adult psychotherapy has no differentiated route for lay therapists and no national employment standards. Orlinsky (2009) states that, unlike their US counterparts, a

minority of clinical psychologists practice psychotherapy. Counselling psychologists have the same employment rights as clinical psychologists but do not share funded training or a career structure and the same is true of art psychotherapists (Mace et al., 2009).

The exact number of therapists that fall outside the above groups, which includes counsellors, is unknown. Mace et al. (2009) are not able to give a precise figure for two reasons. First, many counsellors practice outside of the NHS for example in education and social work, and second others practice psychotherapy as part of another profession e.g. occupational therapists, nurses etc. Current estimates of qualified therapists who are members of discrete professional organisations such as BACP and UKCP indicate that there are around 33,000 counsellors and 7,000 psychotherapists in the UK (NIMHE, 2010).

Aldridge and Pollard (2005) in their survey of members of professional counselling and psychotherapy organisations found that one third of counsellors and psychotherapists worked in the NHS, with a higher proportion of counsellors working in primary care. Twenty per cent were employed in the education sector. They state that based on their study, counsellors tend to work in agencies and psychotherapists in private practice. IAPT services, which were intended to expand existing provision of counselling and psychotherapy, have increased employment opportunities for therapists, particularly those trained in CBT. Two recent reports: the Glover report (Glover, Webb, & Evison, 2010) Improving access to psychological therapies: A review of the progress made by sites in the first rollout year and the New Ways of Working for Psychological Therapists (NIMHE, 2010) depict the current and future employment patterns of therapists in NHS services.

The IAPT programme is regarded as the most ambitious attempt to implement evidence based psychological treatment in the UK. The Glover report describes the impact of the first year of operation on clients. The majority of patients (56.6%) who completed therapy improved with most patients being seen for high intensity therapy i.e. for up to twenty sessions with a qualified therapist. The attrition rate from first referral to first appointment was very high and some data were excluded from the study due to imprecise use of diagnostic categories at assessment. There is little in the report regarding therapists' qualifications other than to state that therapists practiced the approach in which they had trained (Glover et al., 2010).

The largest professional group employed in the first year of IAPT were counsellors and 30% of these were offering high intensity therapy. Less than half of the therapists identified as CBT therapists and fewer than 5% of the workforce were psychotherapists. The number of counsellors working in IAPT services decreased a little in its second year of operation, but they were still the second largest professional group next to clinical psychologists. The Glover report (2010) acknowledges that there was an emphasis on the delivery of CBT therapy but, it makes clear that the aim will be to increase the range of therapies available to patients and to move towards more diverse provision. It makes a commitment to increasing access to IAPT approved courses by developing part-time programmes alongside the existing full-time courses. The authors' also acknowledge the importance of developing a more ethnically diverse workforce given that 80% of IAPT employees described themselves as white.

Summary

In the UK there is no one profession of psychotherapy but many practitioners of it. Counsellors are likely to form the majority of the work force, although this is difficult to

judge accurately as psychotherapy is offered as part of other professional roles. IAPT is largely comprised of qualified counsellors offering CBT but this is likely to change in the future with plans to incorporate other approaches into existing provision. Standards of training and employment vary. Counsellors and psychotherapists work in a variety of organisations offering a range of interventions. Standards for training will be examined in more detail in the next section.

Current Training Standards for UK Therapists

The Oxford English Dictionary defines a standard as "A required or agreed level of quality or attainment" (Oxford University Press, 2011, para.1). The Health Professions Council (HPC) has developed both specific and generic standards of proficiency for each of the fifteen professions that it currently regulates. These standards are comprised of professional and academic criteria. The HPC provide one nationally agreed standard for registration and practice for each of their registered professions. These standards provide clear criteria for the investigation of misconduct and a single complaints procedure through one regulator; the HPC (Health Professions Council, 2011b).

Counselling and psychotherapy are regulated on a voluntary basis through membership of a number of professional bodies such as the UKCP and BACP. Professional standards are set by a variety of institutions and qualifications are awarded at different academic levels by statutory and voluntary organisations. Academic standards are set for Higher Education through the Quality Assurance Agency (QAA) who provide clear criteria for qualifications, but as yet have not produced specific benchmarks for counselling and psychotherapy training courses (Aldridge & Pollard, 2005; Mace et al., 2008). It could therefore be argued that in the UK there are no training standards for counsellors and psychotherapists but a range of professional and academic criteria that

relate to training. However, in the absence of statutory regulation professional and academic standards for counselling and psychotherapy have evolved and are widely accepted. The integration of academic and professional standards has occurred despite the absence of specific academic benchmarks for counselling and psychotherapy. The popularity of training amongst therapists and employers denote the existence of commonly agreed training standards (Aldridge & Pollard, 2005). The term training standard will therefore be used to refer to the existence of academic qualifications and professional criteria. These exist in the absence of an agreed national standard for counselling and psychotherapy and outside of the system currently operated by the HPC.

Five main professional organisations represent counselling psychotherapy in the UK each with their own training standards and mechanisms for practitioner and course accreditation: the BACP, the UKCP, the British Psychoanalytic Council (BPC) (formerly the British Confederation of Psychotherapists), British Psychological Society (BPS) and the British Association of Behavioural and Cognitive Psychotherapies (BABCP). The latter being the only body which has training standards that are recognised by IAPT (Mace et al., 2009). Psychology practitioners, including counselling psychologists have been regulated by statute through the HPC since 2009.

The previous government made clear their intention to introduce statutory regulation for psychotherapists and counsellors in 2007 in their White paper 'Trust, assurance and safety - the regulation of health professionals in the 21st century' (Secretary for Health, 2007). It outlined plans for the regulation of health professionals stating that "This will be the first priority for future regulation" (p.85). The Department of Health had commissioned an initial mapping project of the counselling and psychotherapy

profession in 2005 in preparation for statutory regulation. The project co-ordinators and authors were Sally Aldridge from the BACP and James Pollard from UKCP (Aldridge & Pollard, 2005). This report is significant in that it provides details, previously unknown, of the extent of training provision and existing standards of training for counselling and psychotherapy in the UK.

Aldridge and Pollard (2005) found that the absence of a minimum level of qualification had little impact on the importance placed on training by practitioners. Ninety-seven per cent of the 4,126 respondents had completed professional training and the majority practiced within the parameters of that training. Five hundred and seventy professional counselling and psychotherapy training courses were identified by the study. Of these three hundred and fifty-one were counselling courses (61.6%). One hundred and sixty-eight (48%) were in Further Education (FE), seventy-five (21%) in Higher Education (HE), and eighty-nine (25%) in private organisations. Sixty-three per cent of courses were not recognised by any professional body. The report included 79 BACP accredited courses, the largest number of professionally recognised programmes in the study. These were distributed across four sectors FE (19), HE (29), Private (29) and Health (2).

The authors conclude that there is no one route into training and no agreed standard across different sectors. Since its publication, as discussed above, efforts to agree training and practice standards for counselling and psychotherapy, in preparation for statutory regulation through the (HPC), has been thwarted by conflict over what counsellors and psychotherapists have been trained to do.

The value of the Aldridge and Pollard (2005) report is limited in that detailed information about the courses was not collected. Therefore, it is not possible to

determine which of the 63% of courses that were not professionally accredited were offering practitioner training. Professionally accredited courses are the only courses that offer quality assurance to prospective trainees and clients. Academic standards alone do not necessarily reflect the quality of the training provided.

BACP has the largest membership of any existing professional body representing counsellors and psychotherapists in the UK i.e. 33, 334 (BACP, 2011). Nine thousands of these are accredited members i.e. individual practitioners who have met training and professional requirements for accreditation. Accreditation is maintained through evidence of continuing professional development (British Association for Counselling and Psychotherapy, 2010).

The UKCP has a smaller membership of 6,600 practitioners but, unlike the BACP, most members are accredited. They currently accredit seventy-five courses (UKCP, 2011). These membership figures are regularly used in government documents, most recently in Command Paper concerning voluntary regulation (Department of Health, 2011), to describe the size of the counselling and psychotherapy provision. Therefore, by implication, UKCP and BACP may be regarded as representing legitimate practitioners who have either met explicit professional training standards or aspire to do so.

Counselling psychologists

The British Psychological Society defines counselling psychologists as:

> "A relatively new breed of professional applied psychologists concerned with the integration of psychological theory and research with therapeutic practice. The practice of counselling psychology requires a high level of self-awareness and competence in relating the skills and knowledge of personal and interpersonal dynamics to the therapeutic context" (British Psychological Society, 2011b, para.1).

In February 2011 there were 17,051 practitioner psychologists registered with the HPC (Health Professions Council, 2011a). Practitioner psychologists include seven different modalities these are clinical, counselling, occupational and educational psychologists. There are currently fourteen counselling psychology courses that are accredited by the BPS and approved by HPC. All approved practitioner courses are full-time, lead to either a professional or clinical doctorate and are based in universities. For counselling a psychologist, unlike all other UK counsellors, there exists one agreed training standard and one entry point into the profession.

Academic standards

The relationship between academic and professional standards is problematic. The United Kingdom Council for Psychotherapy (UKCP, 2008) have maintained that its members are trained to Masters' level despite the fact that the mapping report commissioned by the DOH identified a substantial number of psychotherapy training courses that had been designated as post graduate but were not validated by a higher education institution (Aldridge & Pollard, 2005). UKCP has taken the view that a post graduate academic level for practitioners signifies specialist status for psychotherapists and that this clearly differentiates them from counsellors. Their commitment to post graduate qualifications is problematic in that the majority of UKCP accredited courses exist outside of academic institutions in private organisations. Therapist training in the UK is unusual as in most countries professional training takes place in universities where academic and professional standards are integrated (Orlinsky, 2009). The integration of professional and academic standards may be more difficult in independent institutions where the academic validation of qualifications is likely to be peripheral to the training process, if it occurs.

BACP's course accreditation scheme has focussed on practitioners achieving competence and places no emphasis on academic level. This has widened access to the profession, attracting more non-traditional students (Coldridge & Mickelborough, 2003) but unfortunately, as described above, lower academic levels of qualification for practitioners has been equated with lower standards of training and professional status by the HPC (HPC, 2009b). The separation of academic qualifications from standards of professional competence by BACP is therefore out of step with other professions and the process of professionalization (Abbott, 1988).

Over the past twenty years there has been an expansion of Higher Education in the UK. The highest numbers of students in its history, 1.033 million, were enrolled on full and part-time University courses in January 2011 (Coleman & Bekhradnia, 2011). A significant proportion, 19.6%, of UK adults had a first degree or above at the last UK Census (Office for National Statisics, 2001) and this number is likely to be higher once the results of the 2011 census are published. Helping professions in the UK are moving to a position where a degree is the minimum qualification for registration. For example, nursing diploma courses will be phased out and from 2013 only graduates will be able to register to practice (NHS Careers, 2011). In social work a degree has been the minimum qualification for registration since 2003 (General Social Care Council, 2010). These developments indicate a greater integration of professional and academic standards in these helping professions and an increase in entry level qualifications.

In the US psychologists qualify at doctoral level (American Psychological Association, 2008) and counsellors with a Master's degree (Buser, 2008). This has occurred despite the lack of empirical evidence that supports the view that there is a direct relationship between academic achievement and therapeutic skill (Okiishi et al., 2003). Higher

academic awards are strongly related to the establishment of professional status (Abbott, 1988). For example the minimum qualifying standard for psychology practitioners in the UK is a clinical or professional doctorate (British Psychological Society, 2011a).

The development of specific academic subject benchmarks may present an opportunity to combine professional and academic standards. There are no Quality Assurance Agency (QAA) subject benchmarks for counselling and psychotherapy but an initial proposal has been accepted by QAA and a development group meeting was planned for May 2011. If this meeting is successful, then a consultation process will begin. In March 2011, there were 2,380 registered students enrolled on counselling courses and 280 on psychotherapy programmes in HE; this may result in subject benchmarks being developed by QAA for counselling but not psychotherapy (BACP, 2011c).

Summary of professional standards

The current model of training for counselling and psychotherapy can be summarised thus. Standards for professional training courses are either those set by professional associations, in particular BACP, BPS and UKCP, through their accreditation of specific programmes or through the individual accreditation or registration of individual members or both. (BPS is the exception in that its course accreditation relies upon HPC approval).

For BACP and UKCP, academic standards for counsellor and psychotherapy training are set by colleges of FE and HE and independent training institutions and lead to awards that range from NVQ's and undergraduate diplomas to a Master's degree. Psychotherapy training claims to be at a postgraduate level of study but few courses

take place in universities and not all courses are validated by an academic institution. Counsellor qualifications are awarded at a number of academic levels. Most counselling courses are based in colleges of FE and HE but a significant proportion is offered by private training organisations (Aldridge & Pollard, 2005).

Practitioner counselling courses are taught mostly on a part-time basis and take between two to four years to complete. BACP professional practitioner accreditation takes place a few years following the completion of formal training and so does not coincide with the award of the final qualification. This is not the case for the majority of UKCP courses (UKCP, 2011). Counselling psychology courses are full-time. Most counselling courses also recruit mature students i.e. over the age of 21 years (BACP, 2011b).

Training standards

BACP, BPS and UKCP accredited counselling and psychotherapy courses require trainees to acquire competence in, and a working knowledge of, three main topic areas:

- Theory: a core theoretical model, contextual and professional issues, research etc.
- Therapeutic skill: work with clients via a placement, skills training, and supervision.
- Self-awareness: personal development work and or personal therapy.

This tripartite model was devised by Max Eitingon in Berlin at the beginning of the twentieth century and was well established by the time Freud refers to it in: A question of Lay Analysis, which was published in 1926. It became the template for the International Training Committee in 1927 (Schröter, 2002). This model emphasises personal therapy or training analysis but the length of training was far shorter than current psycho-analytic training programmes at around two years (Freud, 1926). The

UKCP, BPS and the BACP have established professional standards for psychotherapy and counselling through their accredited courses schemes. Their course accreditation criteria are similar, but differ in some respects. Given the importance of these standards they will be described in detail in Table 1 below.

Table 1 *Similarities Between Course Accreditation Criteria*

UKCP-Guiding Principles (UKCP 2008)	BACP – Core Curriculum (BACP 2009)	BPS – Key Aims (BPS 2010
a) A model of the person and mind.	B) Understanding the client C) The therapeutic process D) The social, professional and organisational context for therapy	2. Value the imaginative, interpretative, personal and intimate aspects of the practice of counselling psychology 4. Understand, develop and apply models of psychological inquiry for the creation of new knowledge which is appropriate to the multi-dimensional nature of relationships between people
b) A model of gendered and culturally influenced human development	B) Understanding the client C) The therapeutic process D) The social, professional and organisational context for therapy	3. Commit themselves to on-going personal and professional development and inquiry; 5. Appreciate the significance of wider social, cultural and political domains within which counselling psychology operates
c) A model of human change and ways in which change can be facilitated.	B) Understanding the client C) The therapeutic process	2. Value the imaginative, interpretative, personal and intimate aspects of the practice of counselling psychology
d) A set of clinical concepts to relate theory to practice.	A) The professional role and responsibility of the therapist B) Understanding the client C) The therapeutic process	1. Be competent, reflective, ethically sound, resourceful and informed practitioners of counselling psychology able to in therapeutic and non-therapeutic contexts; 3. Commit themselves to on-going personal and professional development and inquiry
e) An extensive literature which includes a critique of the model.	C) The therapeutic process	6. Adopt a questioning and evaluative approach to the philosophy, practice, research and theory which constitutes counselling psychology

Criteria for counsellor training courses were first introduced by BACP then known as BAC, in 1988 under the Recognition of Counsellor Training Courses Scheme. The scheme has been revised a number of times over the past twenty years and the "Accreditation of Training Courses Gold Book" (British Association for Counselling & Psychotherapy, 2009) is the fifth edition. The "Accreditation through partnership handbook: guidance for counselling psychology programmes" was published by the BPS in September 2010 but an accreditation scheme for counselling psychologists was first established by BPS in the 1970's (British Psychological Society, 2010). UKCP first published its training standards in 1993 in "Training Requirements of UKCP" (United Kingdom Council of Psychotherapists, 1993). Its current training standards are contained in "UKCP Standards of Education and Training: The Minimum Core Criteria Psychotherapy with Adults" (United Kingdom Council of Psychotherapists, 2008).

The curriculums for practitioner training are similar for BPS, UKCP and BACP accredited courses. They each require students to develop an understanding of themselves, of theoretical models and to develop the ability to apply those models in practice. They each emphasise the importance of therapists developing an understanding of relevant research and the ability to use this knowledge in practice. Good supervision and practice placements are emphasised in all schemes, as is the importance of each trainee's fitness to practice. Each scheme stresses training in assessment and mental health for practitioners. The schemes all specify standards relating to administrative procedures, student selection, and pastoral care and support along with transparency with regard to course information and student progress. They each require all training agencies to abide by a published code of ethics and have formal policies in relation to equal opportunities and complaints.

As shown in Table 2 below, the accreditation schemes differ in a number of respects.

These differences, in relation to UKCP and BACP, relate to the use of training to

enforce differentiation. UKCP place a greater emphasis on supervision and academic

level and BACP focus more on professional competence, skills training and face to face

contact between trainers and trainees. BACP make no mention of academic level in

their criteria except to state that all accredited courses should lead to a recognised

award. Despite the fact that counselling psychologists qualify with a clinical or

practitioner doctorate degree there are few differences between the course accreditation

schemes other than length of training and entry criteria. The exception being,

counselling psychologists who need to have worked with clients prior to beginning

training. The different criteria also describe the dissimilar contexts in which counsellors

and psychotherapists practice with counsellors working in agencies. In the case of

counselling psychologists placements are usually in the NHS, and psychotherapists

work largely in private practice (Aldridge & Pollard, 2005).

Table 2   *Differences Between Course Accreditation Criteria*

UKCP Course Accreditation Scheme (UKCP 2008)	BACP Course Accreditation Scheme (BACP 2009)	BPS Accredited Counselling Psychology Programmes (2010)
Training Minimum of 4 years	400 hours of face to face teaching and 50 hours of guided study (120 hours of face to face practice)	Full-time clinical doctorate (3 years full-time) 450 hours of supervised practice
Psychotherapy courses lead to master level or equivalent award (PGDip for Psychotherapeutic Counsellors) but these do not have to take place in a University or be validated by a University	Level of award not specified – lead to a formal award of an academic qualification. Training can take place in academic or private institutions	Doctorate in Counselling psychology. Training takes place on 15 BPS accredited and HPC approved courses. All courses are offered by universities
Trainee Placements – usually in private practice	Trainee placements- usually in agency setting	Trainee placements usually in NHS in years one, two and three
Not included	Work based learning and development of team working skills	Graduates need to have an understanding of the management of professional relationships, including appropriate liaison; have knowledge of organisational policies and contextual and legal frameworks within which they practice
No requirement for formal skills training outside of supervision	Formal skills training to be included in course in addition to supervision during training	Trainees have participated in counselling skills training and have substantial experience with face-to-face counselling work (usually one year minimum) prior to beginning training
Final qualification coincides with UKCP Practitioner registration	Final qualification does not coincide with BACP practitioner accreditation which can be applied following 3 years of practice and 450 hours of face to face work with clients	Final qualification entitles graduate to apply for & Chartered Psychologist, HPC registration & protected title

Unlike most UKCP or BPS Counselling Psychology courses, the successful completion of BACP accredited training does not coincide with professional accreditation. In the case of BPS the completion of an accredited course gives graduates the right to apply for chartered psychology status as well as HPC registration. The accomplishment of training for those students on BACP accredited courses signifies the end of basic training whilst professional accreditation can only be obtained by those who have completed at least 450 hours of supervised work with clients over a minimum of three years. Professional accreditation is granted to those who can demonstrate that they are mature rather than beginner practitioners. UKCP require all accredited courses to be at least four years (part-time) long whereas the length of BACP courses can be shorter, but the total training from initial training to professional accreditation is likely to be equivalent to if not longer than UKCP courses.

Summary of current training standards

The absence of a minimum qualification for counsellors or psychotherapists, (counselling psychologists excepted), has had little impact on the importance placed on training by those who wish to become practitioners (Aldridge & Pollard, 2005; Mace et al., 2008). Counselling training for the most part is fragmented and distributed across FE, HE, and private providers. Most courses are currently not professionally accredited. A wide range of qualifications are offered. Academic standards and/or professional standards set by BACP, BPS and UKCP provide benchmarks for training standards (Aldridge & Pollard, 2005; BACP, 2011a; British Psychological Society, 2011a; Mace et al., 2008; UKCP, 2008).

Counselling psychologists are the only counsellors who operate in the UK under a protected title and who are regulated by statute through the HPC. The training standard for counselling psychologists is tightly controlled by both government and the British Psychological Society (British Psychological Society, 2011a; Health Professions Council, 2011a; Health Professions Council, 2011b). This is not the case for the majority of counsellors and psychotherapists in the UK.

BACP's accreditation scheme has focussed on practitioners achieving competence and has placed less emphasis on academic achievement (British Association for Counselling and Psychotherapy, 2009). UKCP have taken the view that a post graduate academic level for practitioners not only signifies specialist status for psychotherapists but also clearly differentiates them from counsellors (UKCP, 2008). BACP and UKCP, in the absence of statutory regulation provide professional training standards for counsellors and psychotherapists in the UK. They probably represent the majority of professional practitioners and set high professional standards for training. The course accreditation schemes for counsellors, psychotherapists and counselling psychologists are similar with differences largely relating to level of qualification, the delivery of training and the timescale for professional accreditation.

Professionalization

> "Many professions have gone from rags to riches, not a few the other way... Beyond this diversity, these examples show how the development of the formal attributes of a profession is bound up with the pursuit of jurisdiction and the besting of rival professions. The organisational formalities of professions are meaningless unless we understand this context" (Abbott, 1988, p.30).

Training is a means of establishing professional jurisdiction. UKCP's attempts to gain superiority through claiming that psychotherapy is a post graduate specialism, is an example of what Abbott refers to above as besting counselling, a rival profession in order to establish its jurisdiction. This theory of professionalization explains how two groups that share professional aims and standards and ostensibly do the same work, become differentiated through competition. Professions succeed through control of: membership, academic qualifications and training, and the establishment of specialist knowledge but also through competition and rivalry (Abbott, 1988;Timmermans, 2008). Professional status therefore is not conferred but won at the cost of allied professional groups. The HPC's (2009b) support for UKCP's proposition that psychotherapists were more highly qualified and specialised than counsellors is also an example of besting. The need to present BACP as inferior to psychotherapy was necessary in order for UKCP to establish Psychotherapy's professional credentials. BPS's standard of a practitioner or clinical doctorate for all psychologists is another example of besting given that there is little evidence to support the view that level of training has any bearing on expertise or therapeutic skill (Boswell et al., 2010; Okiishi et al., 2003; Okiishi, Lambert, Eggett, Nielsen, Dayton, & Vermeersch, et al., 2006).

In the US counselling is an established profession. It has been legally regulated in all states for over twenty years and is characterised not only by Masters' level training but by increased specialisation. Unlike the UK, there are few practitioner counsellor training programmes that offer a generic training in the US. Professional training generally leads to specific qualifications that enable practitioners to work in settings such as colleges or community services or with specific client groups such as gerontological or marital, couple and family therapy (Council for Accreditation of Counselling and Related Educational Programs, 2011). It is increased specialisation

along with higher academic qualifications that have established counselling as a profession in the US. It is a profession that has a lower entry threshold for practitioners than psychology where a doctorate is required, but nonetheless, its professional status is established. Professional training is therefore likely to determine the future course of the professions of counselling and psychotherapy in the UK.

Section One: Conclusion

Training, despite the failure of statutory regulation, will continue to be used by therapy organisations for the purpose of establishing a competing hierarchy of counsellors and psychotherapists, regardless of the evidence. The absence of statutory regulation or of even a minimum qualification for practice for the majority of counsellors and psychotherapists has had little impact on legitimate practitioners i.e. those who belong to recognised professional organisations, who have, with few exceptions, completed professional training. The large number of training courses is an indication of the appetite that exists for formal training in counselling and psychotherapy in the UK.

Common factors research (Norcross, 2002) consistently demonstrates that skilful therapists build strong therapeutic alliances with clients and manage impasses and ruptures. They respond empathically to clients and manage their counter-transference well. These skills and attitudes are likely to have been acquired, or at least influenced, during formal training. Therefore, in order to understand the impact training has on clients it is first necessary to understand its impact on trainees. The next section of this chapter will focus on an examination of the findings of empirical studies, which have investigated the impact of different aspects of practitioner training on the professional development of trainees.

A common factors approach to practitioner training

This section of the literature review will focus on an examination of the existing empirical evidence. Studies that have investigated the impact of different aspects of practitioner training on the professional development of trainees will be explored. First, it is necessary to define what is meant by practitioner training.

> "Who is and who is not a psychotherapist? Unfortunately, the population of psychotherapists at large is difficult to define precisely, even within a single country, and is all the more difficult to define in an international context" (Orlinsky & Rønnestad, 2005, p.20).

Anyone attempting to review research into the training of therapists needs first to define what constitutes practitioner training in counselling and psychotherapy i.e. training that provides a route of entry to practice. This is challenging because there is no one profession of psychotherapy and many practitioners of it. In Britain, practitioner training takes place in a variety of institutions, often in universities and colleges but also in private organisations (Aldridge & Pollard, 2005). The length of training is variable as is the final qualification which can range from a National Vocational Qualification (NVQ) for counsellors, and a doctoral degree for counselling psychologists.

Generality and a common factors approach to training research.

The Society for Psychotherapy Research's (SPR) Collaborative Research Network (CRN) was faced with the same problem when a group of therapist/researchers from around the world met to design an international study in 1989 (Orlinsky & Rønnestad, 2005). The instrument that the group produced, The Development of Psychotherapists

Common Core Questionnaire (DPCCQ) has been used, with some modifications, over the past 15 years to study the characteristics of over 10,000 psychotherapists. The group employed two sampling strategies to overcome this problem. First, they asked colleagues in different countries to distribute questionnaires to people who were regarded locally as professionals engaged in psychotherapy. Second, they distributed questionnaires to a range of psychotherapy associations i.e. organisations which had a significant proportion of members who were identified as counselling or psychotherapy practitioners. This broad sampling approach was used in their study of nearly 5,000 therapists (Orlinsky & Rønnestad, 2005). The majority of the people in the sample worked in psychology (57%) and medicine (28%). The next largest group was social work (5.7%). Informants came from Germany (21.7%), the US (17.3%), Norway (16.5%), and South Korea (11%). The remainder were employed as therapists in seven European countries, but not the UK, and they accounted for between 2-5% of the sample. Other data was contributed by Russian (2.3%) and Israeli (2%) therapists.

The authors acknowledge such a heterogeneous sample creates problems for the application of findings. The aim of their study was therefore, to present an overview of therapist characteristics and practice patterns i.e. the aim being generality rather than generalisability. Another possible solution to this problem is to take a common factors approach to training research.

This theory proposes that different approaches to psychotherapy and counselling have common components and that these make a greater contribution to therapy outcome than unique factors (Imel & Wampold, 2008). The aim of common factors research is "to identify robust mechanisms of change that cut across different orientations in order

eventually to develop more effective treatments based on these" (Castonguay, 2000, p.263).

Changes to practitioner training programmes are increasingly recommended in response to research findings e.g. (Boswell et al., 2010; Castonguay, 2000; Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010; Roth, Pilling, & Turner, 2010). These findings, as in the case of Evidence Based Training (EBT), originate from therapy outcome research (Norcross & Wampold, 2011), or research that concludes that practitioner training needs to become demonstrably more successful in producing effective therapists (Fauth, Gates, Vinca, Boles, & Hayes, 2007). Despite this emphasis on empirical evidence, the core components of counselling and psychotherapy training courses are essentially the same as those established in the 1920's by Max Eitingon (Schröter, 2002). These are: theory and/or self-knowledge, clinical practice and supervision.

Boswell and Castonguay (2007) propose that trainees be exposed to: (a) classical theoretical works e.g. Freud, Rogers, b) to research: applied (process and outcome research) c) experiential training rather than didactic methods, d) self-reflection, and e) multi-cultural competence. Fauth et al. (2007) state that therapist training should be structured around three 'big ideas' these are: 1) the development of meta-cognitive skills e.g. pattern recognition and mindfulness, the ability to identify key in-session moments and respond effectively, 2) supervision that attends to organisational or treatment culture and group supervision with peers and 3) applied research.

Each of these models emphasise elements that are consistent with the Eitingon model and the criteria of the UKCP, BPS and BACP counselling and psychotherapy course

accreditation schemes which have been described above. The core components of

practitioner training can be summarised thus:

1. Conceptual skills and knowledge.
2. Therapeutic skill.
3. Self-knowledge.

These core components are factors common to the process of training of therapists in

'...insight orientated, exploratory therapy' (Gold & Hilsenroth, 2009, p.162). The aim of

this review is to examine first; the extent to which practitioner training contributes to

the development of competence in each of these common factors, and second; how

these common factors impact on the personal and professional development of trainees.

Literature review structure

In this section of the review, research into the impact of each of these common training

factors on the professional development of trainees will be examined. Relevant studies

will be selected on the basis that what is presented is consistent with psychotherapy

practice in the broad terms described by Orlinsky and Rønnestad (2005). The evidence

regarding the impact of practitioner training courses as a whole will then be presented

followed by a conclusion for this section of the review.

The acquisition of conceptual skills and knowledge

Trainees are required to incorporate different kinds of knowledge into a core theoretical model that can then be applied to work with clients. The breadth of knowledge trainees are expected to acquire for example, the BACP's Core Curriculum for accredited courses (British Association for Counselling and Psychotherapy, 2009) reflects the fact that psychotherapy is a complex process. It requires some talent and ability on the part of the practitioner to synthesise different types of knowledge and apply them accurately to a variety of clients (Skovholt & Starkey, 2010; Fauth et al., 2007).

All professionally accredited counsellor and psychotherapy programmes in the UK are constructed around a core theoretical model. A core theoretical model provides trainees with a cogent theory which can be used to understand themselves, their clients and the contexts in which they live and work. It creates a "framework in which learning can take place [and] a secure base to which the counsellor can return" (Wheeler, 1999, p. 203).

As Wheeler's comment suggests, a trainee's attachment to a core-theoretical model exceeds the intellectual or practical benefits of the approach. As evident in many first-hand accounts (Castonguay, 2006; Harding-Davies, Hunt, & Alred, 2004; Karter, 2002) therapists' choice of theoretical orientation is often personal. The importance of 'fit' between the trainee's personality and the modality is made explicit in some approaches. Rogers (1949) for example, describes the process of training as more straightforward for those trainees that have an operational philosophy i.e. the way one is in relation to others, that is closer to the client-centred approach. In this and other therapy orientations, training assists the trainee in becoming the approach rather than by teaching them about it. A few published studies (Arthur, 2001; Boswell, Castonguay,

& Pincus, 2009; Orlinsky & Rønnestad, 2005) have investigated the relationship between personality and orientation.

Arthur's (2001) review of the literature relating to therapist orientation initially identified 45 publications but, only 14 of these were empirical studies. Arthur concludes that the existing empirical evidence "strongly suggests" (p.61) that personality differences exist between therapists. The informants in these studies were qualified therapists and so it is not possible to determine how far their personalities were influenced by their training or vice versa. Orlinsky and Rønnestad (2005) report that the core theoretical model of experienced practitioners changes over time and that they become more integrative later in their careers. Therefore, choice of orientation may be related to personality but it may also change in response to professional experience.

Boswell and Castonguay et al. (2009) investigated the relationship between theoretical orientation and personality. Their sample was comprised of forty-six post-doctoral clinical and counselling psychology trainees enrolled on four APA approved integrative programmes, and at different stages of their training. They conclude that choice of orientation predicts, not only the way trainees will think about therapy processes, but also the kind of therapy they offer. The trainees were enrolled on programmes where a variety of approaches were taught. Six items from the Development of Psychotherapists Common Core Questionnaire (DPCCQ) that related to the influence of different theoretical approaches on current practice were used to identify the core theoretical models of informants (Orlinsky & Rønnestad, 2005). Trainee personality traits were measured using the Revised NEO Personality Inventory (Costa & McCrae, 1992), a measure that uses a five-factor model of personality. A two stage cluster analysis was

conducted on the DPCCQ data to identify the combination of models that were being utilised by the trainees. These clusters were then compared to the personality scores.

Boswell et al. (2009) found clear divisions between approaches within each cluster. Psychodynamic or humanistic orientated therapists were less likely to identify with CBT and this was also the case for the CBT orientated trainees who were less likely to relate to humanistic or psychodynamic approaches. These differences were also found between the two types of training i.e. counselling psychology and clinical psychology. The CBT cluster was largely comprised of clinical psychology students and the humanistic/systems/dynamic cluster of counselling psychology trainees. This is despite the fact that both training programmes were very similar: each subscribed to the scientific-practitioner approach and offered training in an integrative model. Despite this the counselling psychologists were more inclined towards humanistic and psychodynamic approaches and the clinical psychologists towards a CBT orientated model.

Boswell et al. (2009) found a significant relationship between theory clusters and particular facets of the five personality traits. The trainees in the CBT cluster scored lower on the angry hostility and the impulsiveness dimensions than those in the humanistic/systems/dynamic and psychodynamic clusters. This indicates that the CBT cluster of trainees had greater difficulty with the expression of emotion. The authors state that given the increasing importance placed on the therapist's ability to engage in emotional processing with clients, that CBT trainees may require specific help in expressing and processing emotion.

This study provides evidence to support the view that there is a relationship between trainee personality type and choice of orientation. The findings indicate that choice of

professional group also plays a part in choice of orientation. The study did not examine how different approaches were integrated or how each model was used in practice. The use of a core theoretical model, along with other kinds of knowledge, to conceptualise client difficulties is a key skill and the evidence for this will be examined next.

Conceptualisation

There is a consensus in the literature that trainees are able to acquire different sorts of knowledge during training (Buser, 2008; Kivlighan & Kivlighan, 2009), particularly when this learning is targeted at a specific task, such as skills acquisition (Hilsenroth, Defife, Blagys, & Ackerman, 2006; Hilsenroth, Ackerman, Clemence, Strassle, & Handler, 2002; Urbani et al., 2002) or specific topics such as scientific knowledge (Buser, 2008; Stedman & Schoenfeld, 2011). What is less clear is how types of knowledge are combined by trainees during training to conceptualise client difficulties.

Reed, Kihlstrom, and Messer (2006) in their investigation found that, on average, there were 1,089 possible topic areas that a therapist could respond to in during a therapy session. One of the main aims of practitioner training is to help trainees to become effective in conceptualising client difficulties so that they make apposite and timely therapeutic interventions. Betan and Binder (2010) in their study of expert therapists conclude that effective therapy is born of the therapist's ability to metabolize these different elements and to then apply them routinely, but often differently, to each client.

> "Metabolization is the process of bringing ideas and concepts to live inside one's mind and psyche so they become part of self and identity. As a result, the therapist's way of seeing the world and thinking about psychological phenomena changes, as does the therapist's way of being with a patient" (Betan & Binder, 2010, p.144).

This ability, they propose, is the mark of the seasoned practitioner and therefore could reasonably be regarded as an unrealistic goal for trainees. Eells et al. (2011) in their research on case formulations found that expert therapists consistently demonstrated greater skill in this area than novices and that a key feature of expert formulation, was the depth and range of knowledge that was utilised as a basis for treatment planning.

It is both the complexity of the task, as evidenced by many studies that have investigated therapy processes Elliott (2010), and the ambiguity of the process of therapy that makes training particularly stressful for the trainee. As described by Skovholt and Rønnestad in their paper The Struggles of the Novice Therapist (2003), trainees inevitably struggle because they have "inadequate conceptual maps" (p. 45). The greatest source of stress, they propose, is the requirement to make clinical decisions based on limited understanding. This situation only changes with experience but how experience gives therapists the ability to conceptualise or for that matter, the role that training plays in this process is not explained.

Tracy Eells has conducted a number of studies that have compared novice and expert case formulations (Eells, Kendjelic, & Lucas, 1998; Eells & Lombart, 2003; Eells, Lombart, Kendjelic, Turner, & Lucas, 2005; Eells, 2010; Kendjelic & Eells, 2007; Eells et al., 2011). Case formulations in these investigations were analysed using a coding manual (Eells et.al, 1998). Level of experience has consistently been found to be related to conceptual skills, with novices producing less complex case formulations or formulations of a lower quality (Eells & Lombart, 2003; Eells et.al, 2005)

The Eells et al. (2005) study analysed 390 formulations of 6 client vignettes. They found that expert therapists produced more sophisticated client treatment plans that were consistent with the original formulation, than trainees. The novice therapists were

less concerned with the psychiatric history of clients or the limited nature of the case history material that was provided, than the experienced therapists. This finding indicates that they were likely to be less adept at risk assessment. Reeves, Wheeler, Bowl and Guthrie (2004) found that course providers assumed that risk assessment was being taught to trainees in supervision. They conclude that when it is not an explicit part of the course syllabus trainees are less likely to respond to clients who are at risk from committing suicide or inflicting self-harm (Reeves et al. 2004).

Kendjelic and Eells (2007) examined the impact of specific training in assessment. Seventy-seven per cent of the 43 informants were trainees. Half of the sample acted as a control. Those trainees who had taken part in a two hour training session produced significantly more complex and accurate client assessments than those who had not. These findings support those of Skovholt and Rønnestad (2003) and Betan and Binder (2010) that suggest that without help, trainees struggle to metabolize the knowledge they have learned or to use knowledge to conceptualize client difficulties without help. The fact that experienced or expert therapists are able to do this implies that this skill is something that develops with experience. Given that the ability to formulate client difficulties has been linked to improved client outcomes (Crits-Christoph, Cooper, & Luborsky, 1988; Luborsky, 1993; Silberschatz & Curtis, 1993; Eells et al., 2011) there is considerable impetus to speed up this process to ensure that newly qualified therapists have this ability. The findings of Kivlighan and Kivlighan's (2009) investigation indicate that intensive experiential training, that incorporates supervision, may provide a means of achieving this.

Kivlighan and Kivlighan (2009) used a three stage model of knowledge acquisition to describe the development of knowledge structures. Knowledge structures describe how

an individual mentally organises knowledge according to perception or stimuli. Individual knowledge structures are likely to have both shared and unique features even where trainees are exposed to the same learning experience. They state that measures of "knowledge structures are superior predictors of skill performance than measures of knowledge acquisition" (p.176*).*

Kivlighan and Kivlighan (2009) measured changes in the knowledge structures of nine female doctoral psychology trainees who were enrolled on a group therapy programme. The trainees took turns to co-lead a weekly open ended therapy group. The trainees observed group sessions they did not participate in, and a discussion group of experienced therapists which followed each session. The group leader could join the therapy group at any time to make suggestions to trainees about how they might intervene. Trainees could join a group leaders meeting to make suggestions or ask questions.

The trainees and the experienced group leader were measured at two points during their group work training: after session 4 and session 16. They were asked to indicate how similar each client was to every other group member. They found that as predicted, the experienced group leader had a more complex conceptual view of group members than trainees at the beginning of the course which was consistent with a sophisticated knowledge structure. The trainees' knowledge structures changed over time. By session 16 the trainees had knowledge structures that were more similar to those of the experienced group leader which indicated that they had moved from a basic level of knowledge to that usually associated with expert understanding.

Knowledge structures, as shown in the above study, are most clearly expressed through case conceptualisations. They offer a way to measure the acquisition of knowledge and

the presence of conceptual skills. This study provides evidence for the value of supervision in developing conceptual skills and the building of complex knowledge structures. Yet, surprisingly no other studies were identified that have investigated the way in which supervision influences the development of this skill in trainees.

Summary: the acquisition of conceptual knowledge

Professionally accredited courses, as evidenced by the publication of the BACP's core curriculum (British Association for Counselling and Psychotherapy, 2009), places a great deal of emphasis on knowledge acquisition. The core-theoretical model provides both a personal foundation for trainee development and a conceptual framework into which other sources of knowledge can be assimilated. The personality of the trainee is likely to influence their choice of training and its core theoretical model.

The metabolization of different kinds of knowledge is associated with expert therapists whilst inadequate conceptual maps are likely to be typical of trainees. Given that the ability to conceptualise may be a better predictor of client outcome than knowledge alone, there is a need to improve training in this area. Counselling and psychotherapy programmes are expected to cover a wide variety of topics (BACP, 2009) but the findings indicate that time may be better spent teaching trainees how to think rather than focussing on what they need to know. The Kivlighan and Kivlighan (2009) study demonstrates that it is possible to help trainees to develop case formulation skills to a higher level. The extent to which the method described could be applied to practitioner training in the UK, which is largely part-time and where most institutions do not have their own therapy services is questionable. There is a need for a follow-up study that would measure the extent to which the informants retained their more complex knowledge structures before the overall benefit of such training can be evaluated.

The findings presented above mostly come from quantitative studies. The use of qualitative or mixed methods may reveal not only how trainees learn, but also the obstacles to learning that exist. Experiential learning rather than didactic teaching, as demonstrated in a number of studies for example Kendjelic and Eells, 2007, Orlinsky and Rønnestad (2005), is likely to be the most helpful way for trainees to learn. The research literature that relates to the acquisition of therapeutic skill will be examined in the next section.

The acquisition of therapeutic skill

Therapists consistently report that their work with clients has had the greatest influence on their professional development (Orlinsky & Rønnestad, 2005). For trainee therapists, early work with clients is likely to be stressful (Howard, Inman, & Altman, 2006; Skovholt & Rønnestad, 2003) but is also characterised by growth in therapeutic confidence (Bischoff, 1997; Bischoff & Barton, 2002; Hill, Sullivan, Knox, & Schlosser, 2007).

Counselling skills training is usually a pre-requisite for entry to practitioner programmes. Counselling skills are relatively easy to learn as demonstrated by many studies e.g. Brewster, 1979; Hill and Lent, 2006; Hilsenroth et al., 2006; Kivlighan, 2010; Levy, 1994; Nelson-Jones and Toner, 1978; Truax, 1971; and Urbani et al., 2002. Given that counselling skills training provides a foundation for professional training, a brief overview of relevant research will be presented below.

Hill and Lent (2006) introduce their meta-analysis of 15 meta-analytical studies by stating that research into helping skills training has declined since the late1980's for two reasons. First, early research established a clear evidence base for skills training

and so further study was not required. Second, researchers have shifted their attention to investigating practitioner training and supervision. They conclude that helping skills training, in particular Micro Counselling and Human Relations Training, substantially outperforms the no training condition in the studies they investigated.

Ladany (2007) states that helping skills proficiency amongst trainee psychologists varies. He proposes that helping skills training should be regarded as one of the most important aspects of practitioner training, rather than as just a pre-requisite, and that it should continue to be taught, alongside supervision, to all trainees throughout training.

The impact of helping skills training on students is relatively easy to detect whilst the benefits of practitioner training are in general are harder to identify. This is not as contradictory as it might first appear. Helping skills training is a simplified version of psychotherapy and this may account for the success of its impact. Psychotherapy is a complex process that requires practitioners to develop a sophisticated range of knowledge that can then be used to conceptualise client difficulties. So, although it is assumed that skills acquired at a basic skills level are directly transferable to work with real clients this may not be the case.

The impact of work with clients

Orlinsky and Rønnestad (2005) recommend that trainees begin work with clients as early as possible in their training. In their study, clinical work was rated by experienced therapists as the most influential aspect of therapist development, despite the fact that beginning work with clients is likely to be emotionally demanding and stressful.

Trainees tend to blame themselves when things go wrong with clients or when they are unsure of what to do. The findings of De Stefano, D'Iuso, Blake, Fitzpatrick, Drapeau, and Chamodraka's (2007) qualitative investigation indicate that trainees experience impasses in their work with clients as a personal failure. Thériault, Gazzola, and Richardson (2009) interviewed trainees enrolled on three Canadian, graduate counsellor training programmes about feelings of incompetence. A thematic analysis identified three sub-themes: goodness of fit, the fraud factor, and client issues. The two greatest sources of anxiety were working with clients and meeting course expectations. Trainees described feeling incompetent and inauthentic. The majority of informants had experienced both cognitive and physical problems in relation to anxiety. The authors propose that feelings of incompetence are a central feature of novice therapists and that this is a product of practitioner training.

Mallinckrodt and Nelson (1991) compared the development of the therapeutic alliance with clients across training levels. Key components of the therapeutic alliance were rated by trainees and their clients. They found that the ability to form effective therapeutic alliances occurred at more advanced stages of training. The greatest statistically significant difference between the novice and advanced trainees was the superior ability of the latter to identify and agree therapeutic goals with clients. However, the advanced trainees i.e. students engaged in their second practice placement rated their level of skill lower than their clients. Mallinckrodt and Nelson (1991) conclude that trainees experience a loss of confidence at this intermediate stage of their development. Piper et al. (1999) also found that advanced trainees rated their ability to form therapeutic alliances significantly lower than either the novice or experienced therapists. Bischoff proposes that the main aim of training is growth in clinical self-

confidence and that work with clients is where this is developed and tested (Bischoff, 1997; Bischoff & Barton, 2002; Bischoff, Barton, Thober, & Hawley, 2002) .

Bischoff (1997) studied the development of therapeutic confidence in thirteen trainee family therapists enrolled on a Master's programme. They each completed a monthly log during their first three months of practice. They were asked to describe their experiences of clinical work. A grounded theory analysis of their entries produced the core category of: the development of clinical confidence. Bischoff concludes that the primary task of early practice is the development of clinical confidence.

In two later studies, (Bischoff & Barton, 2002; Bischoff et al., 2002) 39 recent graduates of the same student cohort of family therapists took part in telephone interviews. They were asked to describe the development of their clinical self-confidence over the past year. From their findings the authors constructed a three stage model. Both studies propose that although training is associated with the development of therapeutic confidence in recent graduates it is still under developed. Skovholt and Rønnestad (1992) in their model of therapist development conclude that it takes many years for therapists to become established as competent, confident practitioners.

One of the few studies of British trainees was conducted by Truell (2001). He examined the impact of counsellor training on 6 trainee counsellors. The trainees each took part in a qualitative interview at the end of their Diploma of Higher Education (DipHE) in person centred counselling. Trainees had high expectations regarding their performance as therapists. They believed that they should be able to solve client problems, practice therapeutic skills easily and to the highest possible level. Comparing their skills to those of their tutors, who were idealised as perfect therapists, fed feelings of inadequacy. Some of the trainees in the study felt guilty that they were practising on their clients and

were fearful of causing them harm. They were also concerned that their clients were not being given the best possible care because they were being seen by a trainee.

The trainees in Bennetts's (2003) study of British counsellors voiced similar concerns about their work with clients. Bennetts investigated the experience of recent graduates of an undergraduate DipHE in person centred counselling programme. Informants were worried that whilst in training their clients were getting help that had a lower value because they were trainees and unpaid. Despite this, they reported increased levels of authenticity with clients as the course progressed and higher levels of confidence at its end. How these findings were arrived at is not clearly described. Bennetts's does not present core categories or central themes so it is not possible to evaluate what was common to the experience of these trainees. As a result, the evidence presented although narrative in style, falls short of the standards of systematic qualitative inquiry defined by Elliott and Timulak (2005).

Orlinsky and Rønnestad (2005) investigated the practice patterns of therapists by career cohort. They found differences between cohorts in relation to patterns of practice that were defined as: Effective, Challenging, Distressing and Disengaged. Effective practice is characterised by therapists who are personally invested in their work, have healing involvement styles with clients and positive coping strategies. Challenging practice differs from Effective practice in only one respect, the presence of 'more than a little' (Orlinsky & Rønnestad, 2005, p.84) stressful involvement that is, therapists report markedly less satisfaction in their work. Those therapists who can be classified as engaged in distressing practice patterns report more stressful involvement than healing involvement styles. Typical of disengaged practice are therapists who have little healing

or stressful involvement, no personal investment and no sense of making any difference to the lives of their clients. Their findings are summarised in Table 3 below.

Table 3 *Patterns of Therapeutic Experience by Career Cohort*
         (Orlinsky & Rønnestad 2005 pp. 88-89)

	Effective	Challenging	Disengaged	Distressing
Novice Therapists (n=330) < 1.5 yrs. Experience	39.4%	21.8%	19.4%	19.4%
Apprentice Therapists (n=372) 1.5 to 3.5 yrs. Experience	38.2%	22.8%	22.8%	16.1%
Graduate Therapist (n=627) 3.5 to 7 yrs. experience	43.7%	23%	19.6%	13.7%
Senior Therapists (n=237) 25+ yrs. experience	60.3%	20.7%	12.7%	6.3%

The Orlinsky and Rønnestad (2005) findings indicate that therapeutic experience is positively related to higher levels of Effective Practice and lower levels of Distressing Practice with clients. Novice and apprentice therapists reported similar levels of Effective, Challenging and Disengaged practice but novices, experienced the highest levels of Distressing Practice. The level of Distressing Practice reported by novice therapists was the highest in the sample. The senior career cohort, i.e. those therapists with the most experience of work with clients, reported the highest level of Effective Practice and the lowest levels of Distressing Practice in the study.

These therapists' experienced most difficulty in relation to client work at the beginning of their careers. The highest levels of Distressing Practice occurred in the first eighteen months and slightly less Effective Practice during the second and third year of work

with clients. The apprentice therapists had the highest level of Disengaged Practice but the proportion of Challenging Practice was similar for apprentice and graduate therapists at around 22%. The decline in Effective Practice and the increase in Disengaged Practice difficulties are unlikely to be related to having more difficult clients. Orlinsky and Rønnestad (2005) conclude that it is the lack of Cumulative Professional Experience that makes trainees vulnerable. They recommend that trainees begin practice with clients with whom they can achieve early success in order to provide them with positive experiences which they can then draw on when faced with more challenging clients.

Howard et al. (2006) investigated critical incidents identified by 9 novice counsellors in their first year of practice. They found 157 critical incidents that related to five major categories: professional identity, personal reactions, competence, supervision, and philosophy of counselling. They state that training requires considerable "intra-psychic and outward practical adaption" (p.98) on the part of the trainee, and that it is this process that makes trainees vulnerable.

> "A lack of professional experience, particularly with regard to clinical issues, may lead one to feel overwhelmed by ambiguous situations and may indicate that the individual has an insufficient cognitive framework for understanding his or her experiences" (Howard et al., 2006, p.99).

Impact of supervision on skills acquisition

As evidenced in the research presented above, most trainees have inadequate conceptual maps or basic knowledge structures that make thinking about clients and their treatment particularly challenging. This may explain why supervision is so influential on trainee

development, (Eells, Lombart, Kendjelic, Turner, & Lucas, 2005; Kivlighan, 2010; Skovholt & Rønnestad, 2003).

There are many definitions of supervision (Wheeler & Richards, 2007). Milne, Reiser, Aylott, Dunkerley, Fitzpatrick, and Wharton (2010) conducted a systematic review of the literature in order to produce an empirically supported definition of CBT supervision that could be applied to group or individual supervision and to practitioners at different stages of their training or development. They used the findings of 24 empirical studies to improve and refine a commonly used definition. Their final definition is:

> "The formal provision by senior/qualified health practitioners of an intensive relationship-based education and training, (regular and on-going), that is case-focused and which supports, directs and guides the work of colleagues (supervisees). Functions of Supervision: quality control (ethical practice), maintaining and facilitating the supervisees competence and capability; helping supervisees to work effectively" (Milne et al., 2010, p.440).

Definitions relating to trainee supervision are similar, but supervision for trainees differs according to Ladany, Walker, Pate-Corolan and Evans (2008) in that, "Psychotherapy supervision is the primary educational way in which people learn to become therapists" (p.10). Despite its importance Ögren and Jonsson state that "very little is known about what actually happens" (2003, p.375). Fortunately for the purpose of this review most supervision research is concerned with trainees rather than experienced practitioners. This is largely to do with the fact that supervision is regarded, particularly in the US, as an integral part of therapist training rather than an on-going professional requirement as is the case in the UK (Wheeler & Richards, 2007).

There have been a number of systematic reviews of the supervision research literature. In the introduction to their review Wheeler and Richards (2007) cite six that were conducted between 1998 and 2002. They used EPPI-Reviewer software to organise their systematic search. They identified 18 articles that met the inclusion criteria they set, which were published between 1981 and 2005. These mostly concerned trainee supervision. Three studies were rated as poor, two as very good and the rest as average. Only four studies were European and these were evenly divided between the UK and Sweden. They conclude that supervision has a positive influence on supervisees particularly in relation to the development of therapeutic skill, and that these changes are measurable. Relevant studies from this review will be used as a starting point for investigating the relationship between supervision and the acquisition of therapeutic skill.

Borders (1990) measured the impact of supervision on 44 trainees at the beginning and end of their first practice placement using the Supervisee Levels Questionnaire (SLQ). The analysis identified a significant increase in trainee ethical knowledge and therapeutic skill. This study investigated the short term impact of supervision on trainees at the beginning of practice, when the impact of supervision on therapeutic skill is likely to most evident.

Patton and Kivlighan (1997) examined the impact of supervision on skills acquisition in students. They set out to explore the impact of the supervisory alliance on the therapeutic relationship and adherence to the taught model. The 44 trainees in the study were not enrolled on a practitioner programme and so this was their first experience of working with clients therapeutically. Their findings indicate that positive supervisory alliances impact on trainee skills acquisition and support adherence to treatment

methods. This study is similar in both design and outcome to one recently published by Kivlighan (2010) which examines skills acquisition. They both fall short of Milne et al.'s (2010) definition of supervision and for this reason the value of these findings is limited. The supervisee and the supervisor were not in a professional relationship as they were both students. The work of supervision was not formerly contracted in these terms and was temporary rather than on-going. The nature of the therapy offered was short-term and delivered by students who had undertaken a limited amount of skills based training. Helping skills training consistently has a positive effect on participants (Hill & Lent, 2006) and this may be because what is being studied is a simplified form of therapy. Therefore, Kivlighan's (2010) have no relevance to trainee therapists working with real clients who are being supervised by experienced supervisors in a formerly contracted professional relationship.

Raichelson, Herron, Primavera, and Ramirez (1997) in their study of 150 supervisors and 150 supervisees, found that supervisees found the exploration of the parallel process helpful i.e. where aspects of the therapeutic relationship are repeated, often unconsciously, in supervision. The importance of working with process with regards to the learning of trainees was also found to beneficial by Worthen and McNeill (1996). In their qualitative study they interviewed eight intermediate level trainees with the aim of investigating good supervision events. The data analysis revealed that good events increased the supervisees' ability to conceptualise client difficulties. These events were experienced as supportive and instructive and the supervisees felt better able to carry on with the struggle of clinical practice following them. The exploration of parallel processes and good supervision events are influenced by the quality of the supervisory relationship.

The importance of the supervision environment is stressed in two Swedish studies: Ögren and Jonsson (2003) and Ögren, Jonsson and Sundin (2005). Ögren et al. (2005) investigated the effect of supervisor style and group climate on the perceived skills acquisition of 184 trainee psychologists who were supervised in 78 supervision groups. They found a significant relationship between supervisor style and each supervisee's skill attainment. Trainees reported higher levels of skill attainment when supervisors concentrated on exploring psychodynamic processes and lower levels when theory was the primary focus of sessions.

The Ögren and Jonsson (2003) study was rated as very good in Wheeler and Richard's (2005) review. It investigated the relationship between supervision and perceived therapeutic skill. The participants were 162 trainee psychologists and 28 group supervisors enrolled at three universities. The trainees rated how they would manage their next session of therapy after supervision. Their supervisors also rated changes in their supervisees' level of skill using MSES (a Swedish version of the Self Evaluation Scale), following each supervision session. Supervisees felt more skilful following supervision. For example, differences in their "ability to contain and deal with emotionally loaded issues" (p.382) was found to be very significant ($p = 0.000$). In general, both supervisors and supervisees reported changes that were highly significant. Supervisors consistently rated their supervisees' level of skill higher than the supervisees themselves. The authors conclude that supervision has a direct impact on perceived skill development in trainees.

Milne, Pilkington, Gracie, and James (2003) investigated the attainment of skills in supervision but, unlike Ögren and Jonsson (2003), they went one step further and identified the degree to which learning was transferred to practice. The study used

mixed methods. The authors investigated the learning acquired from ten supervision sessions to a trainee's work with one client, over the course of ten weeks of therapy. Both the supervision and the therapy sessions were video recorded. Ten supervision tapes and ten therapy sessions were analysed. The supervision recordings were analysed using grounded theory and fourteen themes were identified. Therapy sessions were then independently rated using these themes, to evaluate the extent to which what had been learned in supervision was transferred to the therapy.

The movement of supervision themes to therapy sessions occurred more frequently than anticipated; with between four and nine themes were transferred at each meeting. The use of themes was rated as either appropriate or inappropriate in relation to the trainees and supervisors adherence to the CBT model. The study did not collect any other data, including outcome data, and so the transfer of themes was not investigated in relation to client progress or outcome. The themes identified in supervision were very general e.g. goal setting, summarising, reflection, modelling etc. and so this may account for the high rate of transfer.

The themes also reflected the model the trainee was learning i.e. CBT. What is not examined in this study is the extent to which the transfer of themes came from other sources e.g. personal study, taught sessions etc. The findings demonstrate that learning in supervision is likely to be transferred to work with clients but reveal little of the process by which this occurred. Like the Ögren and Jonsson (2003) study the impact these interventions had on clients was not explored.

Ladany et al. (2008) investigated the impact of supervision on both the development and practice of one trainee therapist, Lydia. In this study Lydia's supervision was observed through video and audio recordings. Both the supervisor and the therapist

completed measures after each meeting and attended a qualitative interview to review the session with a researcher. Lydia's clients were video and audio recorded and levels of distress, alliance, arousal, positivity and impact of therapy were measured. They also attended a post session interview with a researcher to review the session. Lydia did the same, attending post session interviews and completing therapist versions of all measures with the exception of the client distress questionnaire.

This case study is unique in that in not only tracks Lydia's development over the first eight months of practice but also examines the impact of supervision on her practice. Lydia saw five clients for between 3 and 17 sessions. Her first supervisory relationship had a largely negative impact in that the supervisor's didactic style was both disempowering and unreliable. Ladany et al. (2008) propose that there was some evidence of parallel process. For example, when something important was not explored in supervision in particular Lydia's feelings, this was repeated in her work with clients i.e. she did not explore their feelings. The therapist's anxieties regarding endings and abandonment were repeated in supervision when there was a mix up about the timing of an appointment and the supervisor was absent. This was later repeated when the therapist missed a client session.

What is clear from their findings is that Lydia's development as a therapist was hampered by her first supervisor, Tricia, who tried to help by telling her what to do. This supervisor also avoided exploring difficulties in the supervisory relationship and the supervisee's feelings. The accounts of early therapy included some problems with boundary issues and twice Lydia overran with a client, first by twenty minutes and then by 30 i.e. sessions lasted between 70 and 90 minutes rather than the planned 50. In

supervision during this time Lydia is observed switching off from the process and this is directly related to the supervisor attempts to educate her.

Lydia's second supervisory relationship was very different. Her supervisor allowed space for her to explore her experience and thoughts about clients and encouraged her to set the agenda for each supervision session. Lydia became more exploratory and empathic with her clients and grew in confidence as a therapist. Feeling more contained and supported by her supervisor may have helped Lydia to do this for her clients.

The authors conclude however, that a supervisor who can do both i.e. offer practical guidance and provide space for processing aspects of both the therapy and supervisory relationship is probably the most appropriate style for a trainee. Lydia agreed that she needed different kinds of supervision at different stages of her development.

> "When I first started I was like, how do I do a first session, what do I say, very structured and Tricia was very good at that. I needed to know what to do...but now the question is how to be more empathic" (Ladany et al., 2008, p.174).

These findings indicate that positive supervisory relationships are collaborative; they focus on deeper exploration of supervisee and client processes and help trainees to acquire therapeutic skills and deepen their understanding of therapy. The opposite is therefore also likely to be true, as shown in the case of Lydia, that poor supervisory relationships undermine trainee development and has a negative impact on their work with clients.

Impact of poor supervision

There is some evidence that the supervisory relationship can be negative. Ladany, (2007) states that experience of very good supervision is likely to occur for only a third

of the time. The negative impact of poor supervision on trainees cannot be underestimated. Orlinsky and Rønnestad (2005) suggest that when things go wrong for trainees in supervision, it can result in "double traumatisation" (p.189). This is when trainees become caught in a negative cycle of self-criticism and experience decreasing levels of both self and therapeutic confidence.

Ladany and Lehrman-Waterman (1999) examined the ethical practice of the supervisors. One hundred and fifty-one trainees completed a questionnaire on the ethical behaviour of their supervisors. Fifty-one per cent reported at least one ethical violation. The most common violations related to trainee performance evaluation and confidentiality. Non-adherence to ethical standards was positively related to a reduction in the strength of the supervisory alliance. Poor supervisory relationships may contribute to higher levels of anxiety in trainees who are reluctant to disclose negative supervisory experiences (Mehr, Ladany, & Caskie, 2010).

Trainees with negative supervisory relationships avoid disclosure of difficulties relating to their practice. Hess et al.'s (2008) qualitative study found that non-disclosure related to the power imbalance between trainees and supervisors. This was most clearly expressed through the fact that the supervisor was assessing their performance. Webb and Wheeler (1998) found that supervisees felt more able to disclose to a supervisor they had chosen themselves than to one they had been allocated. Supervisees, in this study, were also more likely to disclose difficulties in individual supervision than in a group. Having some control of supervision and feeling in a more powerful position may be related to supervisee disclosure. Non-disclosure not only limits the usefulness of supervision but may also be related to lower standards of ethical practice. The exploration of difficult issues is one of the responsibilities of being a supervisor

(Wheeler, 2007) but this requires a degree of collaboration between the supervisor and the supervisee to do this. Shapiro (1995) humorously refers to disorders that commonly affect beginning therapists as Supervisoraphobia. He concludes that helping supervisees who are suffering from such a disorder is likely to be demanding for supervisors. Given that trainees are required to make clinic judgements based on a limited understanding of the work they have undertaken, have fluctuating levels of therapeutic confidence and the inevitable power imbalance that exists between supervisors and trainees, this observation is rather understated.

De Stefano et al. (2007) interviewed eight trainee counselling psychologists who had experienced an impasse with a client which they had then discussed in group supervision. The qualitative analysis revealed that trainees experienced difficulties with clients as a personal failure. They sought supervision for support and validation i.e. that they were OK as therapists. The supervisor's faith in them, alongside the encouragement of peers, helped them to gain a new perspective on their experience and increased their self-awareness. Supervisees who explored impasses in supervision felt this helped them to continue with their work with clients. The findings also revealed some anxieties about whether supervision was a safe place to talk about problems and some dissatisfaction with group dynamics. This study is valuable in that it gives details of how problems can be processed in supervision and identifies factors that enable and prevent trainee disclosure.

Summary: impact of training on skills acquisition Section

Work with clients has the greatest impact on therapist development (Orlinsky & Rønnestad, 2005). The findings of the investigations cited above reveal that early work with clients is stressful and demanding. Trainees struggle during the early years of

practice because they experience working with clients as complex and know that they are beginners. Inadequate conceptual maps coupled with self-blame and high expectations make them vulnerable. Levels of therapeutic confidence fluctuate but this is also a time of growth.   There is little evidence to support the view that trainees are less effective with clients than more experienced therapists (Okiishi et al., 2003) but they can feel that they do not measure up to the demands of the role.

Supervision is as influential on trainee development as work with clients (Orlinsky and Rønnestad, 2005). The findings demonstrate how supervision helps novice therapists to learn skills and supports them in their work with clients. Good supervision, which is collaborative and supportive, focuses on the exploration of processes rather theory. In doing so it supports and instigates trainee professional growth. Poor supervision erodes therapeutic confidence and can result in double traumatisation. Non-disclosure of negative aspects of practice is difficult for all trainees but impossible for those with poor supervisory relationships. However, the impact of non-disclosure on clients is not clear as no studies were found that have investigated this. The theory of double traumatisation is based on the findings of quantitative research. No qualitative studies were found that have investigated this phenomenon. Research into the characteristics of students who struggle during training and those trainees, who do not complete is also needed.

The acquisition of self- knowledge

Wheeler (2002) states that "...candidates must be able to use the training process to mature; to learn about themselves and others and ... to take in what is offered" (p.439). Practitioner training is emotionally demanding and trainees need to be self-aware and

resilient enough to not only survive the process but to benefit from it (Bischoff &
Barton, 2002; Howard et al., 2006; Orlinsky & Rønnestad, 2005; Skovholt &
Rønnestad, 1992; Skovholt & Rønnestad, 2003). Trainee resilience alongside self-
awareness is likely to be evaluated first during the selection process. For example,
unconscious motivations to train i.e. to get one's emotional needs met vicariously or to
seek reparation for childhood deprivations; need to be identified by selectors if they are
to exclude candidates for whom training may be harmful (Mander, 2004).

There is a consensus that candidates for practitioner training need to be selected
carefully; "The selection of candidates for training is the first and most crucial step
towards counselling competence" (Wheeler, 1996, p.42). Cook (2010) refers to the
"Historic struggle" (p.1) that has taken place within counsellor education in the US to
evaluate the emotional suitability of candidates. He warns against the harm that can
result to therapists, clients and the profession by selecting "unsuitable or unprepared
people" (p.1). The problem, as stated by Szecsödy (2003), is that identifying therapeutic
talent or potential in candidates is an imprecise process. Roth and Leiper (1995) found
that the twenty clinical psychology courses they studied lacked transparency in their
decision making processes regarding the offer of places. They also did not utilise any
scientific measures to assist them in the selection of trainees, despite being proponents
of the scientist practitioner model.

Little is known about the relationship styles and characteristics of those trainees who
are selected for training. Fifty-seven per cent of the 534 Novices i.e. those with less
than eighteen months of practice experience, in the Orlinsky and Rønnestad (2005)
study were married or living with a partner. The majority of Novices in the sample were
in a professional role: 34% psychology, 38% medicine, 20.9% social work. Most were

female, 57.5% and 12.8% described themselves as belonging to a minority group. The mean age of Novices was 32.9 years. The characteristics of this sample are quite different to those students who train on part-time practitioner programmes in the UK.

Coldridge and Mickelborough (2003) investigated the demographic characteristics of trainees enrolled on four practitioner training courses in further and higher education colleges. There were seventy-five trainees in the sample. They did not ask students about their current relationship status but the study did reveal other characteristics. Less than half of these UK trainees (42%) were in a professional role. Ninety per cent were female; almost double those in the Orlinsky and Rønnestad (2005) study, and the HE students were older, aged between 41 and 50 years. Ninety-five per cent of HE, and 87% of FE trainees described themselves as white.

Coldridge and Mickelborough (2003) conclude that the differences that exist between students training in HE or FE colleges are a consequence of economics and social class. Cheaper courses are offered at local FE colleges and these provide greater access to training to those students from poorer or more disadvantaged backgrounds.

There are many recommendations regarding selection criteria (Cook, 2010; Mander, 2004; Orlinsky & Rønnestad, 2005; Purton, 1991; Wheeler, 1996; Wheeler, 2002). Yet, there is little empirical evidence regarding either selection criteria or the process of selection. The criteria recommended by Orlinsky and Rønnestad (2005) are unusual in that they are based on evidence i.e. findings from their international study of therapist development. These are based on the healing involvement styles of effective psychotherapists. The most important criterion, according to Orlinsky and Rønnestad (2005), is that candidates should have a "well-developed basic interpersonal skills and a warm manner in their close personal relationships" (p.182).

The ability to sustain close personal relationships is regarded as crucial, given that effective psychotherapy is predicated on the establishment of a "professional-personal relationship" (Orlinsky & Rønnestad, 2005, p.6) rather than the ability to implement procedures or techniques. Their other criteria for selection are summarised below:

- high level of social maturity,
- composed responsive personal presence,
- capacity for empathising with a broad range of human experiences,
- ability to communicate genuine concern for others,
- keen intellectual curiosity,
- intellectual strength and flexibility,
- reflective disposition,
- an absence of serious psychopathology (pp.182-183).

Orlinsky and Rønnestad (2005) urge that these criteria be employed sensitively, taking into account cultural and gender differences. As will be shown in the next section self-awareness is regarded as the key to the personal and professional development of therapists, there is surprisingly little emphasis on the self-awareness of candidates in the Orlinsky and Rønnestad (2005) criteria other than the requirement that candidates have a reflective disposition.

Personal and professional development and self-awareness

Donati and Watts (2000) and Donati and Watts (2005) reviewed the literature relating to the personal development of therapists. They emphasise the increasing importance placed on this aspect of therapist development by professional bodies such as BACP and BPS, in both practitioner training and the continuing professional development of therapists. Self-knowledge is not only an important foundation for practice but it defines the limits of therapist competence and therefore, the extent to which they are able to help clients. Donati and Watts (2005) highlight the absence of agreed definitions

for concepts such as self-awareness and personal and professional development. What follows is an attempt to define these terms and an assessment of their meaning in the context of practitioner training.

Self-awareness

Therapist self-awareness is regarded as a means of understanding and protecting clients. Faith in therapist self-awareness is prevalent across different therapy approaches. Sufficient self-awareness ensures that however emotionally demanding the client, the therapist is still able to focus on his or her needs rather than their own (Guy, 1987). The ability to differentiate between feelings and thoughts that arise in therapy as belonging to either the therapist or the client is essential.

> "Only in this way can there be any hope of the avoidance of therapy that is adapted to the needs of the therapist rather than to the needs of the patient" (Winnicott, 1949, p.69).

Having sufficient emotional resources and satisfactory personal relationships helps therapists to avoid abusing their clients through meeting their own needs (Guy, 1987). Greater self-awareness also assists the therapist in the management of countertransference. This skill is one that is recognised as essential across most therapy modalities (Cooper, 2008; Norcross, 2002; Symons, 2008).

Therapist self-awareness alone does not guarantee beneficence. As shown above, evidence derived from empirical studies that supports the view that therapist self-knowledge limits harmful effects, is slim. However, Castonguay et al. (2010) propose that practitioner training should include explicit training in the harmful effects of

therapy e.g. poorly timed interventions or therapist rigidity etc. and state that such responses are often a consequence of limited self-awareness. The authors' evidence for harmful effects comes from outcome and process research studies and so their focus on trainees is preventative, rather than an indication that trainees do more harm than experienced therapists. Limited self-awareness and poor or harmful therapy has not been found to be associated with experience or training level (Okiishi et al., 2003) and as the Thorne (1987) case study of his work with his client Sally illustrates, self-awareness can lead even experienced therapists astray.

Changes in self-awareness, for trainee therapists, take place with the purpose of understanding the client rather than self-knowledge for its own sake (Irving & Williams, 1999). Mearns (1997) proposes a three-stage model of trainee counsellor change: greater self-awareness, self-understanding, and self-experimentation. The final stage, he states, is crucial in that it is through this process that trainees overcome their defences and thereby, through growth in 'fearlessness', become better able to meet clients at relational depth. In the context of practitioner training therefore, personal development is always, to some extent, professional.

Negative effects

Ralph (1980) found that having greater access to their emotions as a result of personal therapy was not entirely positive. Trainees recognised that there was a personal cost to putting themselves at the service of clients in this way i.e. that they would also suffer. The trainees in the Macaskill and Macaskill (1992) study identified personal therapy as the cause of psychological distress and of marital or family stress. Moller et al. (2009) also found that personal therapy brought with it a personal cost. Therapy "opened a can of worms" (p.379), and there was some concern amongst the trainees that if a serious

psychological problem emerged that this might disrupt or even end their training. The financial cost also put additional pressure on some trainees and informants described this as, "a burden [and] a nightmare" (p.379). These trainees also reported that they were concerned that mandatory therapy may be less helpful than voluntary therapy. This was a source of some resentment in that it assumed that all trainees needed therapy when they may not.

Professional Development

 The gap between what is known, (self-awareness), and what trainees are required to be, (professional), results in a loss of self- confidence and a degree of emotional instability during training. Self-reflective activities such as personal therapy and personal development group work provide opportunities for the synthesis of the personal and the professional. However, as demonstrated by Skovholt and Rønnestad (2003) and Orlinsky and Rønnestad (2005), therapists' professional identities takes some years to become fully established.

Irving and Williams (1999) define personal development as holistic and concerned with self-realisation rather than professional attainment. Professional development is purposeful, in that it seeks the development of professional skills and/or qualities. They state that this difference is not just a matter of semantics but that clarity is vital as counsellor training needs to focus on the professional development of trainees, rather than get side tracked into only facilitating personal growth.

Personal and professional development groups

Mandatory personal therapy is a requirement for accredited Counselling Psychology programmes in the UK (British Psychological Society, 2011a) and personal development group work is stipulated for accredited counselling courses (CACREP, 2011) in the US. BACP are less prescriptive. Their accredited course providers have the option of meeting the requirement for personal and professional development through either, personal therapy, personal development groups, or both. APA approved counselling and clinical psychology courses in the US must ensure that students develop competence in reflective practice and self-assessment. How this is to be achieved is not specified (Rodolfa et al., 2005). Personal development groups, particularly in a British context, are regarded as beneficial (Dryden, Horton, & Mearns, 1995; Mearns, 1997; Wheeler, 1996; Wilkins, 1997; Yalom & Leszcz, 2005). But what constitutes personal or professional group work varies.

A review of the literature reveals that courses use different names to describe personal development group work. For example, most US studies refer to Personal Growth Groups (Anderson & Price, 2001; Ieva, Ohrt, Swank, & Young, 2009; Luke & Kiweewa, 2010) whilst some British counselling courses use the term Personal Development Groups (Lennie, 2007). Clinical psychology courses in the UK refer to them as Reflective Practice Groups (Knight, Sperlinger, & Maltby, 2010). Regardless of the name, these groups share characteristics, aims and modes of operation. The size of groups in the studies reviewed varied from 6 to 13 participants. All had a group facilitator and each lasted for an hour and a half. The amount of time trainees spent in groups differed. In the UK study, trainees met weekly for two years i.e. for 90 hours

(Lennie, 2007) whereas in the US trainee counsellors attend for one semester which was around 20 hours (Anderson & Price, 2001; Ieva et al., 2009).

Moller, Alilovic, and Mundra (2008), following their survey of British counselling psychology course providers, conclude that there is no agreed format for personal development group work. They found that the amount of time trainees spent in such groups varied and no standard practices with regard to group facilitators i.e. whether groups were run by course staff or by independent therapists, exist. Clinical psychology courses in the UK are also required to facilitate the development of reflective practice in trainees but the way this is achieved is not specified. A recent survey found that personal development groups were the most popular medium for teaching personal and professional development to trainee clinical psychologists. Knight et al. (2010) investigated the experiences of 124 clinical psychologists who qualified between 1986 and 2007 and attended Reflective Practice Groups in their first year of training. The groups met fortnightly and for a total of around 23 hours.

The findings of studies that have investigated the impact of personal development groups on trainees need to be considered in the light of these differences. However, these groups share some similar aims even if the format differs. In all studies trainees took part in "unstructured group encounters that facilitate reflective inquiry in the context of professional development (Kline, Falbaum, Pope, Hargraves, & Hundley, 1997, p.158). To avoid confusion, such groups will be referred to as professional development groups (PDG's) from this point on.

Based on the following findings it is possible to conclude that personal development groups have a positive impact on the personal and professional development of trainees (Anderson & Price, 2001; Ieva et al., 2009; Kline et al., 1997; Knight et al., 2010; Luke

& Kiweewa, 2010). These studies, with the exception of Anderson and Price (2001) and Knight et al. (2010) who conducted surveys, employed qualitative methods. Methods included the analysis of trainee personal development journals (Luke & Kiweewa, 2010), semi-structured interviews (Ieva et al., 2009) and open ended questionnaires (Kline et al., 1997). All qualitative data were analysed using grounded theory.

The majority, (over 77%) of the ninety-nine respondents who had recently completed training felt their experience of personal development group work was valuable (Anderson & Price, 2001). Nearly 75% of the 124 participants in Knight et al.'s (2010) study had a positive experience of personal development groups and valued the influence they had on their personal and professional development. The trainees in the Lennie's (2007) study felt that PDG's were supportive and provided them with an emotional safety net.

Anderson and Price (2001) found that personal development groups were an effective way to learn and resulted in increased levels of self-awareness and improvement in interpersonal skills. The twenty-three trainees in Kline et al.'s investigation (1997) reported that personal development groups had helped them to develop more positive attitudes towards open communication. The fifteen informants in Ieva et al.'s (2009) investigation felt that their participation in personal development groups had resulted in positive changes in interpersonal skills and self-awareness. This was also the view of the fourteen Masters students in the Luke and Kiweewa's (2010) study. Ieva et al. (2009) found that PDG work enabled greater group cohesion amongst trainees and this was also identified by Anderson and Price (2001) and Luke and Kiweewa (2010). One of the added benefits of PDG's for the trainees was the opportunity they provided to learn about group dynamics and group processes (Kline et al.,1997; Anderson & Price,

2001). Trainees particularly valued the opportunity to observe how group leaders facilitated groups (Ieva et al., 2009; Luke & Kiweewa, 2010).

From the above findings it would seem that personal development groups fulfil their stated aim i.e. to facilitate the personal and professional development of trainees. There are however, some inconclusive and negative findings. Lennie (2007) set out to identify factors that contributed to the development of self-awareness in a sample of 88 British students. Just over half of the focus group sample was enrolled on practitioner training courses; the rest participated in personal development groups that were part of a part-time certificate programme. Mixed methods were used, four focus group interviews (*N*=66) were recorded and the transcripts were analysed. From this analysis topic areas were identified and these were used to construct a questionnaire. The questionnaire was distributed to all students in the same institution.

The findings reveal that trainees felt more comfortable in personal development groups at the start of training than at its end but that there was no clear relationship between discomfort and self-awareness (Lennie, 2007). However, the "extreme nature of the self-awareness ratings" (p.122) are problematic. Unfortunately, only the overall mean scores and no standard deviations are given and so it is not possible to evaluate the spread of the scores. Details of the scale used and the number of questions of which the questionnaire was comprised are not described, so the mean self-awareness scores that are included cannot be evaluated. The author acknowledges that the findings need to be considered in the light of the fact that the questionnaire may have no evident construct or concurrent validity. That is, the author cannot be sure that the instrument actually measured self-awareness as this was not tested. Lennie (2007) proposes that despite this, the findings are still relevant in terms of the "predictive" and "ecological validity"

(p.127) of the questionnaire. However, given the doubts raised regarding its construct and concurrent validity this seems unlikely. For this reason the quantitative findings will not be included in this review as they are unreliable. The findings of another, but well-designed British study, successfully addressed these problems. Knight et al. (2010) identified how personal development group work can result in negative and distressing experiences for trainees.

Knight et al. (2010) examined the impact of personal development groups on recently qualified UK clinical psychologists. One hundred and twenty-four psychologists, forty-two per cent of the maximum number of possible respondents, completed the Reflective Practice Group Questionnaire, which was devised for this study, following the completion of training. Forty-per cent felt they had learned more about reflective practice through other aspects of their training courses but given that they attended the group fortnightly during their first year, this is not surprising. Around fifty per cent of informants reported that they had experienced high levels of distress in PDG's. Half of these still found the group to be a valuable experience but a quarter of the sample reported that the they had found their personal development group to be both highly distressing and of a low value. Higher levels of distress were significantly related to group facilitators with "a more remote and unclear style of facilitation" (p. 435).

These findings need to be considered in the light of the fact that these trainees were attending groups on a fortnightly basis during their first year of full-time training which is recognised as a stressful time (Skovholt & Rønnestad, 2003). It may be that not meeting on a weekly basis made the experience less helpful and this could also account for higher levels of distress. Anderson and Price (2001) also found that a third (29%) of respondents experienced discomfort in Personal Development Groups. That over

seventy per cent of informants reported positive experiences of Personal Development Groups is important, but the needs of the minority who had totally negative experience in terms of personal distress and learning need to be recognised.

Wheeler's (2002) statement that trainees need to be able to use what is given in training is apposite here. It may be that trainees in Knight et al.'s (2010) study who found the experience entirely negative were unsuitable in some way, but no measures regarding trainee progress in other areas of their training were used. Therefore, issues regarding their suitability are not known. What is clear from this study is how group facilitator's style, when lacking in empathy and presence, may exacerbate trainee distress.

Personal therapy

Training therapy or analysis began with Freud who proposed that it was the best way to learn to be a therapist.

> "But where and how is the poor wretch to acquire the ideal qualification which he will need in this profession? The answer is in an analysis of himself, with which his preparation for his future activity begins"
> (Freud, 1964, p.246).

Holzman, Searight, and Hughes (1996) estimated that the prevalence of personal therapy amongst trainee psychologists in the US, during the 1990's to be around 38%. Norcross (2005) states the principal of personal therapy for the majority of trainees in the US is no more. In the UK mandatory personal therapy is a training requirement for all Counselling Psychology Students (BPS, 2010) and nearly all UKCP psychotherapy training courses (UKCP, 2011). This is not the case for BACP accredited courses

(BACP, 2011b) where the personal development of trainees is viewed more broadly and can include a variety of reflective activities (Atkinson, 2006).

Reviews of the research literature, which between them span forty years, conclude that investigations that have attempted to measure the impact of personal therapy on therapists have consistently failed to support the proposition that personal therapy makes people better practitioners (Macaskill & Macaskill, 1992; Macaskill, 1988; Norcross, 2005; Rennie, Brewster, & Toukmanian, 1985; Greenberg , 1981). The evidence in relation to the impact of personal therapy on the development of trainees is more positive. Trainees, like experienced therapists, generally report that personal therapy has positive benefits.

Macaskill and Macaskill (1992) found that that 87% of the twenty-five trainees in their study felt that personal therapy had a positive impact on their development. They report increases in: self-awareness, self-esteem and a reduction in personal problems. Grimmer and Tribe (2001) used a combination of 15 minute focus group interviews with the same group of seven trainee counselling psychologists during their training and at its end, alongside two longer focus group interviews with two different groups of trainees that numbered seven overall. The data were analysed using grounded theory. The trainees regarded mandatory personal therapy as positive. They felt it increased reflexivity, provided socialization into their professional role, validated personal experience and provided normative experiences. Therapy was also helpful in providing personal support during difficult times. Those informants, who had little experience of personal therapy prior to training, felt they had gained confidence in therapy as something that was effective.

Murphy (2005) interviewed five MA students who had experience of at least forty hours of personal therapy. The data were analysed using grounded theory. Personal therapy for these trainees was a positive experience and one that enhanced the process of becoming a professional counsellor. Murphy presents a model of the use of therapy and suggests that there are four key processes. These are:

1) Reflexivity: learning about the self, growth, and experiencing change.

2) Growth: the development of empathy

3) Authenticity: validation of self as a therapist and therapy as an effective treatment.

4) Prolongation: wanting to extend therapy and to continue learning about being a therapist.

Unfortunately, this study is a poor example of qualitative research. A single interview with only five trainees while convenient, makes obtaining meaningful data harder. These findings lack depth as a consequence and some of the categories indicate that informants may have been repeating received wisdom or were not encouraged during the interview to question and explore the meaning of personal therapy. The following category, which could have been taken from the course prospectus, illustrates this: "To be effective as a counsellor requires holding particular attitudes to the self and the other. These include unconditional positive self-regard and empathic understanding..." (p. 30). The author is a little presumptuous therefore, in presenting a model of the meaning of personal therapy given the chosen method and the small number of informants.

A very good example of a qualitative study that produced meaningful results was conducted by Moller, Timms, and Alilovic (2009). They used qualitative questionnaires

but in this case, had a large enough sample to collect sufficient data which was then systematically analysed using thematic analysis. The researchers investigated trainee experience of personal therapy during the first two months of their training. Thirty-seven trainees: 11 clinical psychologists, 13 counselling psychologists and 13 counsellors participated. Their findings were summarised in two central themes: 1) personal therapy helps me to be a better practitioner and 2) personal therapy costs me. The findings of this excellent study are worth presenting in detail because they bring to life the meaning of informant experiences in the way that all good qualitative research, as described by Elliott, Fischer, and Rennie (1999), should.

The findings reveal that personal therapy enabled trainees to learn about therapy experientially rather than theoretically. They gained a deeper understanding of the more difficult aspects of therapy for example, feeling vulnerable or afraid. They also valued the opportunity to learn about therapy through observing their therapists and experiencing how therapy works (Moller et al., 2009). Trainees reported increased levels of self-awareness and a greater understanding of their personal relationships as a consequence of their own therapy. Personal therapy provided a context for understanding the role of therapy in relation to mental health issues. In addition therapy was a source of personal support assisting them through the "psychologically arduous" (p.378) process of beginning training and minimising the impact of negative emotions on their performance on the course. Therapy was perceived as a providing a "safety net" (p.378) and "essential" (p.80) by the informants (Moller et al., 2009).

This investigation is unique in that it uses qualitative methods to examine the early experiences of trainees in relation to personal therapy. It communicates in a meaningful

way their experience and in doing so, sets out the benefits of personal therapy at the start of training.

The benefits of personal therapy for practice

The thirty six students interviewed by Ralph (1980) reported that their experience of therapy enabled them to use themselves and their feelings more immediately when working with clients. In Macaskill and Macaskill's (1992) research, 87% of the twenty-five trainee participants reported that personal therapy had a positive impact on their practice. It improved their ability to use self-knowledge to respond authentically to clients. Grimmer and Tribe (2001) conclude that personal therapy helps trainees to distinguish between their own issues and those of their clients.

Moller et al. (2009) reports that personal therapy helped trainees at the beginning of practice to develop their understanding of therapy from a client's perspective. It increased their empathy for their clients. Informants described higher levels of self-awareness and a deeper understanding of emotions and values and how these might impact on clients. Personal therapy was effective in aiding trainees to separate personal issues and feelings from those of their clients. In this way trainees felt that personal therapy protected clients from their unresolved issues and provided them with opportunities to develop their ability to practice reflexivity (Moller et al., 2009).

Following her review of the recent literature Rizq (2011) states that therapists cite personal therapy has having a very positive impact on their development. Rizq concludes that despite this, little interest has been shown by researchers in respect of the extent to which the personality of the therapist influences their use of personal therapy. The earlier findings of the Rizq & Target's (2010) mixed methods study suggest that

trainees who had secure attachment styles used personal therapy to manage feelings that were evoked with clients and to reflect on their practice. Insecurely-attached trainees were less able to explore complex aspects of their work during therapy but instead, used it for behavioural modelling i.e. how to behave as a therapist. Personal therapy during training may therefore provide important opportunities for professional development for trainees but may have less impact on the reflective capacity of insecurely attached trainees.

Summary: impact of personal development groups and therapy

Practitioner training is primarily concerned with the professional development of trainees therefore personal development needs to take place in this context rather than for its own sake. The most important selection criterion for trainees is that they have emotional maturity and good basic interpersonal skills that are expressed in their close personal relationships. Professional bodies require courses to produce graduates who are reflective practitioners and one way of achieving this is through the use of personal development groups and/or personal therapy

The findings of the majority of research in this area come from qualitative studies. This reflects the nature of the topic under investigation. Despite the small number of informants in most of these studies and the variety of methods used, their findings with regards to both personal development groups and personal therapy are consistent. Qualitative methods were used with varying success. Small samples e.g. Murphy (2005) and focus group interviews, some of which were very brief (Grimmer & Tribe, 2001) make it more difficult to gather meaningful data. Other studies such as Moller et al.'s (2009) thematic analysis provide an example of both methodological rigour and meaningful findings.

The quantitative studies used survey and questionnaire methods and yet their findings are similar to those of the qualitative studies. The only investigation that used mixed methods was conducted by Lennie (2007). Unfortunately it lacked methodical rigour and presented unreliable findings from the questionnaire data and so this aspect of the study was disregarded.

Personal development group work results in an improvement in self-awareness and interpersonal skills. The group setting engenders increased understanding of group dynamics and provides trainees with a rare opportunity to observe another therapist in action i.e. the group facilitator. The experience is an uncomfortable one for many but this is generally understood to be a necessary part of the process. A minority of trainees reported negative experiences that were distressing and produced no benefit This was associated with a group facilitator style which when emotionally distant, had harmful consequences for some trainees.

Both personal development groups and personal therapy are highly valued by trainees. Personal therapy is regarded as having many benefits by trainees. It provides an important and very personal introduction to the process of therapy and the role of the therapist. Like PDG's personal therapy provides a rare opportunity to observe a therapist at close hand but more importantly, a personal experience of how therapy works. It assists in the development of self-awareness and helps trainees to address relationship issues in their own lives and in their work with clients.

Personal therapy provides support during training which is generally acknowledged to be stressful. The main negative impact of personal therapy is that trainees suffer during this process and are fearful at the start of training that this may be destructive to themselves and their hopes of becoming a therapist. The financial cost of therapy,

particularly when it is a course requirement, may lead to resentment but despite this, personal therapy for those trainees who took part in these research studies cited above, regarded it as essential.

The impact of practitioner training on trainees

Skovholt and Rønnestad (1992) interviewed 100 therapists who were at different stages in their careers. From their findings they identified twenty themes in therapist development. Together, these themes provide a map of the therapist's journey over the course of a career. Therapist development is described in terms of movement towards individuation and maturity and growth away from professional uncertainty and narcissism. Twenty of the informants were novice therapists in their first year of practitioner training, and twenty were advanced trainees near its end. The development of these trainees is described in more detail in their follow-up study 'Struggles of a Novice Therapist' (Skovholt & Rønnestad, 2003). In this investigation the authors identify seven aspects of trainee experience at the start of their training. These are summarised below:

- Acute performance anxiety and fear
- Illuminated scrutiny by professional gatekeepers
- Porous or rigid emotional boundaries
- The fragile and incomplete practitioner-self
- Inadequate conceptual maps
- Glamorized expectations
- The acute need for positive mentors/tutors

Skovholt and Rønnestad (2003) describe the novice as someone whose lack of professional self-confidence means that they have little experience to draw upon when they encounter difficulties. Their anxiety is further compounded by increasing self-

consciousness, which fuels performance anxiety and impedes development particularly, in relation to work with clients.

The extent to which stress is such, that trainees require treatment is under researched. Not surprisingly, most research on stress in trainees has been conducted by trainees themselves through their research dissertations. One such study examined the impact of training on levels of trainee wellness (Roach, 2005). Wellness is defined as "An active process of becoming aware of and making choices toward a more successful existence" (National Wellness Institute, 2011, para.3). The study investigated changes in wellness levels in 204 North American counselling students who completed the Five Factor Wellness Inventory at the beginning, middle and end of training. No significant trends were identified and Roach (2005) concludes that training did not improve levels of wellness as predicted but neither did levels decline.

Hoffman (2006) describes fluctuating levels of stress in the 58 trainee counsellors he studied enrolled on a Master's programme in the US. The stress levels in these trainees increased over the course of training. However, these differences were not statistically significant. Maloney (2009) investigated coping mechanisms in sixty-five trainee counsellors enrolled on a Master's programme. The sample was divided into three groups: beginning, practicum, and graduating students. Maloney (2009) found that the graduating students had significantly higher rates of substance use than the other two groups. The extent to which these levels were harmful was not investigated. Gottesman (2008) investigated secondary trauma in 28 psychology trainees who were working with traumatised clients and found that greater exposure to such clients was related to higher levels of secondary stress symptoms. However, trainee resilience predicted their response. Those informants with higher resilience scores had lower levels of stress.

The overall mean score indicated that high levels of stress, that resulted from secondary trauma, was uncommon with only four (14%) of trainees reporting moderate to severe levels. Gottesman (2008) concludes that the majority of trainees are emotionally resilient and resourceful.

Miller et al. (2010) is unusual in that this research was not conducted by trainees but by professional researchers. Their pilot study measured stress hormones in 6 trainee therapists who were working with suicidal clients with borderline personality traits. The informants took samples of their saliva prior to seeing their clients and again at the end of the session. The number of informants was small but the samples were collected on the same client and therapist dyads for one year. Miller et al. (2010) found that levels of stress hormones were significantly higher in the trainee therapists before seeing their clients than those post-session. However, the higher levels of stress were within a normal range and so were consistent with those of a non-clinical population. The large post session reduction in levels not only indicates that trainees were able to manage short-term stress but given that they were studied for a year, these findings suggest long-term emotional resilience.

Feeling under emotional pressure and being stressed are different. Stress is not defined by anxiety alone but by feeling unable to meet external demands (NHS Direct, 2011). Harmful levels of stress are contingent on internal emotional resources rather than external pressures alone. Miller et al. (2010) suggest that similar levels of stress hormones have been identified in athletes prior to competing and that like the therapists in their study, their levels dropped significantly once the race was over.

Kumary and Baker (2008) investigated stress in British counselling psychology trainees. They devised a questionnaire to investigate trainee stress. The Counselling

Psychology Trainee Stress Survey (CPTSS) measure is comprised of four topic areas: academic demands; lack of support systems, placement stressors, and personal and professional development. This questionnaire, along with a General Health Questionnaire 12 (GHQ12), was used to identify which aspects of training were stressful and to measure levels of distress. The GHQ12 was also used to identify those informants who would meet the criteria for a psychiatric diagnosis i.e. caseness. These measures were distributed to 269 trainee counselling psychologists by post and 109 completed questionnaires were returned.

The female trainees, who accounted for 87% of the sample, reported higher levels of stress on the CPTSS than their male peers (p=0.003). The highest levels of stress were reported by the youngest trainees i.e. those below the age of 30 who accounted for 43% of the sample. Stress ratings on the CPTSS positively correlated with levels of distress on the GHQ12. Therefore, the younger trainees also had higher levels of caseness. Trainees at different stages of their training had similar levels of distress and the authors conclude that this finding indicates that stress levels remained constant throughout training.

The Kumary and Baker (2008) study produced findings that are similar to those of an earlier study of British clinical psychologists. Cushway and Tyler (1996) also identified sources of stress in a sample of British clinical psychology trainees and conclude, like Kumary and Baker (2008) that it is the cumulative effect of a combination of stressful factors that needs to be understood rather than the impact of individual stressors. Cushway and Tyler (1996) found that high levels of stress were associated with lack of experience, but that low job satisfaction, poor personal relationship and the use of

avoidant defences were important contributory factors. Being a younger, less experienced trainee was the typical profile of the most stressed students.

Fluctuating levels of therapeutic confidence in family therapists, particularly at the start of training, has been identified by Richard Bischoff and colleagues in three studies (Bischoff, 1997; Bischoff & Barton, 2002; Bischoff et al., 2002). The growth of the professional self requires intra-psychic adaption and this causes a degree of emotional instability and therefore some distress in trainees (Howard et al., 2006). Orlinsky and Rønnestad (2005) emphasise the vulnerability of trainee therapists and the risk of them experiencing "stressful involvement" (p.82) with clients because they lack cumulative professional development. De Stefano et al. (2007) conclude that when trainee supervisees encounter impasses with clients they experience it as a personal failure.

The findings of Truell's (2001) qualitative study also highlight the stressful experience of practitioner training. The most stressful, but also the most positive aspect of counselling training for the six participants was change in their personal relationships. At the end of training they had fewer friends but better relationships. They all reported that training had resulted in greater scrutiny of their relationships with their families. All but one trainee had experienced relationship difficulties with their partners during training but by its end, they felt that their relationships had improved. What this study demonstrates is that training places extra demands on trainees' personal relationship and this creates difficulties. These difficulties were resolved by the end of training and their relationships had improved as a result but, whilst in training, it was a source of on-going stress.

There are few examples of empirical studies that have investigated the influence of personal relationships on the professional development of trainees. Murray (2007)

conducted a qualitative analysis of the impact of practitioner training on the couple relationships of four students. Interviews took place at the beginning middle and end of training and data were analysed using grounded theory. Murray (2007) concludes that the trainees have a greater understanding of their relationships and these improve during training and that partners provide invaluable support during training.

Growth and learning for trainees is likely to be accompanied by a decline in "pervasive performance anxiety" (Skovholt & Rønnestad, 1992, p. 47). The informants in Bennetts's study describe the process by which professional growth emerges from the early stressful experience of training (Bennetts, 2002; Bennetts, 2003). Skovholt and Rønnestad (2003) point to the rewards of training and in particular, the satisfaction that comes from helping clients. The findings of two Swedish studies; Carlsson and Schubert (2009) and Carlsson, Norberg, Sandell, and Schubert (2011), differ from those of other investigations in that their findings indicate low levels of distress during practitioner training.

In the Carlsson and Schubert (2009) study forty-six trainee psychotherapists from three different student cohorts completed a questionnaire that was designed to gather data on factors that had influenced their professional development at different stages of training. Twenty one students completed the questionnaire on all occasions. They found that the biggest influences on development were similar to those identified by Orlinsky and Rønnestad (2005) except that clinical practice, rather than supervision, had the greatest impact on trainee development. As the trainees progressed through training theory and skills became more important and the impact of personal life and personality on their practice declined.

In the most recent study (Carlsson et al., 2011) qualitative, semi-structured interviews were used to investigate the experiences of eighteen trainee psychotherapists. The core category was: Searching for Recognition. The trainees described their desire for professional acknowledgement as therapists but also validation from their teachers. Once qualified, they felt they had the recognition they craved and the freedom to use their own judgement in their work.

These studies (Carlsson &Schubert, 2009; Carlsson et al., 2011) describe how the experiences of trainees change over the course of training. The findings differ from those of other investigations (Bischoff & Barton, 2002; Howard et al., 2006; Orlinsky& Rønnestad 2005, Skovholt & Rønnestad, 2003) in that the trainees were less anxious, although their need for external validation may indicate a lack of confidence, but there was not the same pervasive level of anxiety as described above. This may be because practitioner training in Sweden takes place in two parts with the final phase of training following several years of clinical practice. Consequently, practitioner training does not coincide with the demands of early practice and this is regarded as the most stressful phase in therapist development in other studies (Bischoff & Barton, 2002; Howard et.al 2006; Orlinsky & Rønnestad, 2005).

The impact of practitioner training on trainees is emotionally demanding and has the potential to be damaging and emotionally painful when things go wrong. They are vulnerable in a number of ways. Training is demanding and complex so it is not surprising that trainees struggle initially (Betan & Binder 2010; Eells et al., 2005; Howard et al., 2006; Kivlighan & Kivlighan, 2009; Orlinsky & Rønnestad 2005; Skovholt &Rønnestad 1992; Skovholt & Rønnestad, 2003; Orlinsky & Rønnestad 2005). The anxiety that is generated for most trainees goes beyond the demands of

academic learning as professional development also requires personal change (Howard et al., 2006; Moller et al., 2009; Skovholt &Rønnestad 1992; Skovholt & Rønnestad, 2003). Therefore, it may be the combination of demands that makes training difficult for trainee therapists. That said few studies have investigated levels of stress in trainees. That training is stressful does not mean that trainees experience harmful levels of stress. Most studies (Roach, 2005; Hoffman, 2006; Gottesman, 2008; Maloney, 2009, Miller et al., 2010) that have investigated stress levels of trainees and have found, even when working with difficult clients that trainees experience harmful levels of distress.

However, the degree to which stress and distress are the cause of non-completion of practitioner training has not been investigated. Neither have the difficulties trainees may have in reporting distress given the social and professional pressures they may be under. Similarly the impact of the stress experienced by individual students on their peers or course staff has not been studied.

The findings of the Kumary and Baker (2008) and the Cushway and Tyler (1996) studies are contrary to those cited above. Both investigations found high levels of distress in British trainee psychologists. However, based on the fact that their results are not typical, it is possible to conclude that the majority of trainees find training stressful but do not experience damaging levels of stress.

Literature review: summary of findings

Despite the number of studies relating to different aspects of therapist training few have described the process of trainee change i.e. how students become therapists and how this occurs.   Orlinsky and Rønnestad (2005) explain the paucity of research into therapist development as the result of a misconception of therapy as a treatment that is administered by technicians rather than a treatment that is reliant on the creation of a "professional-personal relationship" (p.6). The latter emphasises the importance of the personality of therapist whilst the former leads to research that excludes the personal aspects of the professional relationship. A few studies have investigated how trainees change but there is a need for further research and these are summarised below.

Few studies have been conducted on a UK population. British trainees may differ in a number of ways from their US and European counterparts who form the majority of students who have been previously studied. For example, full time training versus part-time, generic practitioner training rather than training in specific approaches e.g. school counselling. The majority of research subjects come from psychology courses in the US which operate a different system of training in many respects. The Carlsson and Schubert (2009) and Carlsson et al. (2011) findings illustrate that systems of therapist training differ from country to country and that it is likely that the impact of practitioner training also varies as a consequence. To date, investigations have tended to focus on specific aspects of training. Studies have been conducted with trainees during training (Ögren & Jonsson, 2003; De Stefano &, D'Iuso et al., 2007; Skovholt & Rønnestad 1992) and some have been retrospective (Anderson 2001; Knight, 2010;Truell, 2001). No investigations were found that examined changes in individual practitioners or training cohorts over the course of training. In addition, the learning environment and

the influence of nested aspects of the training are yet to be investigated. The research highlights that early practice is significant for trainees and yet few studies have examined the impact of training at its outset i.e.in the first few months. An exception to this is Moller et al., (2009) but they only examined the impact of personal therapy at this stage and not the impact of training as a whole.

There are few good examples of studies that have combined qualitative and quantitative methods. What is clear is that qualitative methods capture trainee experience but few studies have used individual face to face interviews and this limits the richness of those accounts. The use of reflective journals have produced valid and in some cases meaningful results (Bischoff,1997, Howard et al., 2006) but in the case of Howard et al., (2006) course staff had access to the journals while they were being written and this may have made it more difficult for trainees to disclose difficult or negative experiences. Similarly, focus group methods can lead to superficial results (e.g. Grimmer & Tribe 2001, Murphy, 2005).

Qualitative methods such as interviews that are conducted over time, by an independent researcher with the same individuals, would allow for a more in depth study of the impact of training on trainees. Such methods combined with quantitative findings would both capture trainee experience alongside a description of the overall pattern of change across groups of trainees. The review of the literature was not able to identify a study of this kind.

Most studies that have investigated stress levels in trainees have not found harmful levels of distress (Roach, 2005; Hoffman, 2006; Gottesman, 2008; Maloney, 2009, Miller et al., 2010). The evidence suggests that most trainees are resilient and resourceful but these studies have all been conducted on US populations. The

measurement of stress levels in British trainees has, to date, only been conducted only on trainee counselling (Kumary & Baker, 2008) and clinical psychologists (Cushway & Tyler, 1996). These studies differ from the findings of other investigation as they both identified high levels of distress, particularly in younger, less experienced trainees. The impact of training on distress levels and emotional resilience in one student cohort of trainee counsellors enrolled on a BACP accredited course has not been investigated.

Training courses are generally constructed on models of integrated learning and assume that knowledge and skills will be transferred across different elements. These elements are inter-dependent and inter-related. No studies have tracked trainee change, using a variety of methods, during training and none have investigated how trainees assimilate different kinds of knowledge.

Research Questions

Based on this review of the literature the following questions have been identified:

Main questions:

- How Do Trainee Counsellors Change?
- What helps trainee counsellors to change?

Subsidiary questions:

- Who undertakes counsellor training?

- How does professional training impact on early therapist development?

- How does professional training impact on overall therapist development? Specifically: a) therapeutic skill; b) work with clients c) mental well-being d) emotional fluidity and e) professional growth.

- Which aspects of training influence therapist development? Specifically: a) negative influences and b) positive influences.

- How do trainees assimilate different aspects of their training?

Chapter 3: Methodology and Overview of Methods

In this chapter the importance of researcher reflexivity and the influence of the researcher on the research design and methods will be examined. Then, the research methodology that underpins this investigation will be explained. This will be followed by a general description of the methods that were used to investigate how trainee counsellors change during training.

Researcher reflexivity

The development of researcher reflexivity is essential to the practice of social science research (Etherington, 2004). Bolton (2001) defines being reflective as a process of self-examination which aims to expose "practice to scrutiny" (p.7). Reflexive researchers take this a stage further in that they "acknowledge how their own experience and contexts, (which might be fluid and changing), inform the process and outcomes of inquiry" (Etherington, 2004, p.31-32).

Being involved with my own students, enrolled on a BACP accredited practitioner training course three days per week, throughout this study had a positive impact on my practice as a lecturer and tutor. The experience of interviewing trainees enrolled on similar training programmes but that was constructed around a different modality, helped me to observe my own teaching and the structure of my course differently. As Bolton (2001) describes, my own practice became more reflexive and 'strange' (p.10) to me. I actively used research findings and my growing knowledge of the process of trainee change in my teaching. In tutorials I shared my understanding of the normal pattern of trainee change with trainees to help to normalise their experience. This knew understanding made me more confident in my role.

The primary tool I used to support my reflexivity as a researcher throughout this time was a reflexive journal. Understanding my feelings through writing about them has been an important aspect of my adult life. As a trainee therapist I kept a journal to make sense of my personal and professional development. As a researcher the journal that I kept differed in one important respect in that I also aimed to provide a record of the research process. The frequency of entry writing tended to relate to specific tasks and stages of the research. For example, many entries were made following research interviews and during the data analysis and fewer were made during the writing of this thesis. I was fortunate in having supervisors who allowed space for reflexivity during our meetings but also in having fellow PhD students and colleagues to discuss the experience of conducting this research with. I also attended regular training events and research conferences which stimulated my thinking and supported my development as a reflexive researcher.

The aim of this study was to gain a deeper understanding of practitioner training. As described briefly in Chapter 1 above, before undertaking this research I was frustrated by the absence of an evidence base for the training that I was required to deliver. There were many assumptions, often stated as truths by colleagues, for example the conflation of age with maturity and personal suffering with therapeutic skill. The criteria for individual and course accreditation set by BACP, such as the number of client contact hours also seemed arbitrary. I understood that these conventions were to a certain extent historical. UK counsellor training began as part-time courses for mature students who were established professionals in social work, teaching, nursing etc. (Dryden, Mearns, & Thorne, 2000) therefore, trainees were likely to be older and more experienced that than the typical full-time undergraduate student. However, the notion that younger less experienced trainees should be excluded entirely on the grounds of

age, which was the case at the beginning of this research when a minimum age was often set by many courses, was clearly not based on empirical evidence.

Prior knowledge and experience

At the start of this research I felt that little had changed on the courses that I taught since I had qualified ten years earlier. The only guidance regarding the training of counsellors came from some excellent text books for example, (Dryden & Thorne, 1991; Jacobs, 1988; Mearns, 1997) but these were descriptions of existing practice and were based on personal experience rather than on the findings of empirical research. They were also written entirely from the perspective of course tutors.

My role as a tutor was primarily academic. The personal development group work that took place on the course which I taught, was facilitated by sessional-staff. My contact with the personal experience of students was through teaching, tutorials and group supervision. As a personal tutor I met with my tutees regularly and I had some insight into the emotional demands of practitioner training. However, my understanding of the process of becoming a therapist was largely informed by memories of my own training which had a positive impact on my personal and professional development and a good outcome.

The students who took up most of my time were those who were failing either academically or, more frequently, emotionally. As a tutor I had less insight into the experiences of the majority of trainees who completed training. The trainees who withdrew or failed often did so because it posed a considerable threat to their personal relationships, their emotional well-being and, on rare occasions, their sanity. Therefore, at the outset of this research, although I could be regarded as an experienced tutor my knowledge of how trainee counsellors changed was also limited by that role. I had a

theory of human development and of client change that was informed by psychodynamic theory but this alone did not provide an entirely satisfactory explanation regarding trainee change. This study provided me with the opportunity to engage more fully in a role and a process that, on reflection, I had only a tacit knowledge of at its start.

As the research study progressed I realised that despite having worked on practitioner training programmes for a number of years that I had a very limited understanding of trainee experience. The experience of training from the perspective of a tutor is necessarily very different from that of the trainee therapist. The most glaring difference for me was the fact that I was an example of a successful student who had become established in the career to which the students aspired. What became clear to me during the early stages of this study was that the dominant voice within the literature in terms of both research and academic texts were also the most powerful: that of course staff. Therefore, one of the most important decisions in relation to the research design was to not include course staff in the study and to concentrate entirely on trainee experience.

Expectations

At the beginning of this research, like most people who have successfully completed practitioner training, I expected most trainees to report that it had a positive influence on their personal and professional development. I expected the beginning of practice to be a time of anxiety and that the informants would find the training challenging. As stated above, as a tutor I had spent a disproportionate amount of my time with students who were struggling with the emotional demands of the training, most of whom ultimately withdrew. These experiences had led me to expect to find that a significant proportion of students would report serious emotional difficulties that might require a

psychological intervention or medical treatment. I also realised that those students who seemed to go through training without a hitch were the ones I knew the least about.

Influences on research design

The early stages of the study were dominated by the research literature. What became clear was the extent to which research evidence was largely derived from US trainee psychologists on full-time doctoral programmes. Therefore, the context in which training took place was very different from counselling training in the UK. Yet, it was difficult to judge the extent of these differences as most studies failed to provide even basic details of the informants let alone, information about the structure of training programmes or the influence of staff or peers on trainee development. The influence of the context in which the training took place was largely disregarded. In addition the failure of quantitative studies to describe trainee experience was evident and the argument for the necessity for qualitative studies made by Beutler et al. (2004) and others I found irresistible.

The methodological challenge these findings posed were both practical and personal. I did not hold qualitative methods in high regard having read a number of (what I now realise) were poor examples of this kind of research. I was also concerned that given my past and con-current experience of not only being a tutor but a course director of a BACP accredited programme by this stage, that I could justifiably be regarded as someone with a vested interest in producing positive findings. This was one of the reasons why the use of mixed methods was decided upon as it would provide a range of evidence and a number of perspectives on trainee experience. Alongside this, was the determination to find a qualitative method that was systematic and incorporated credibility checks, such as an auditing process.

My first experience of doing qualitative research were the three interviews with Margaret, a student enrolled on an undergraduate psychodynamic programme at the university where I taught. Although we had no prior relationship I felt that aspects of her experience were obscured by a degree of collusion in as much as we were both psychodynamic practitioners and had common knowledge of the course on which she was enrolled. Margaret knew that I was a member of staff and not just a PhD student and this influenced the interview process for example, during the first interview she assumed that I knew more about training than she did. These problems were also assets in as far as they helped to quickly build rapport but this experience also influenced my decision to study trainees at another institution.

I was very fortunate to have the opportunity to conduct all other qualitative interviews at another university that provided training in person-centred counselling and psychotherapy on both a full-time and part-time basis. This context was also culturally different from the midlands of England where I was living and working. The experience of being an outsider coming into an organisation to conduct research was liberating. I was free to be a student and a researcher rather than a lecturer and the research interviews provided me with a fresh perspective on the process of training.

My first experiences of being a client were with person centred therapists both of whom had a significant impact on me. I had read some of Carl Roger's writing at that time and during this study I returned to key texts. Although I am a psychodynamic therapist I regard orientation as primarily a matter of personality. I am passionate about my approach but completely disinterested in the notion that there is only one way of doing or thinking about therapy or that any one approach can claim superiority with regards to therapy outcome. I am more interested in common rather than specific therapy factors

such as orientation. Therefore, although being a psychodynamic practitioner had some influence on how the research was conducted and how I was perceived by my informants I felt that trainees related to me largely as a researcher and to a certain extent another student.

The final research design described below grew out of the recognition that there was a need to examine not only the context in which training took place but also other influences on the process of trainee change including peers and the training institution. The focus became the experience of trainees, an under researched area, and the aim was to understand how they changed over the course of training. I hoped that the use of mixed methods would not only reveal different levels of meaning and experience but that it would also provide different perspectives on the shared experience of trainees.

Research methodology

This research was conducted from a critical realist perspective. This relatively new ontology was first described by Roy Bhaskar (1978) in A Realist Theory of Science. This publication resulted in "a new realist philosophy of science" (Bhaskar & Lawson, 1998, p.3). Critical realism is founded on the notion of metaphysical realism that is, the way the world 'must be' for the findings or practices of science to be true. Collier (1994) states that although critical realism has its roots in the philosophy of Kant it differs in some important respects:

> "while Kant's arguments lead to a theory about the power of the mind to impose a structure on the world, Bhaskar's lead to conclusions not only about the mind but about ourselves, ... what the world must be like" (p.22).

Critical realists propose that all scientific discoveries begin with shared assumptions and beliefs about the world, and that these provide a necessary point of reference. Progress, in terms of contributing to the accumulation of human knowledge, is made through findings that inform our understanding of the world (Bhaskar, 1978). Critical realists assume that it is not possible to completely understand reality. From this perspective, empirical feedback shapes our current knowledge through understanding our perceptions of the world and the discourses that have a bearing upon it.

Bhaskar (1998a) states that the central paradox of any philosophy of science is that scientific knowledge is the product of social activity. He distinguishes this kind of knowledge from the knowledge of 'things', such as the speed of light, as these exist independently of human beings. Social Science research is primarily concerned with producing knowledge that is the result of social activity and therefore, from a critical realist perspective, research must be evaluated in the light of those factors that will have had an influence on it.

Abstraction and Causality in Social Science Research

Bhaskar (1978) proposes three different kinds of reality: empirical, actual and real. Empirical reality can be known directly and indirectly; actual reality is not necessarily experienced and real reality refers to those structures or mechanisms that create phenomena but which cannot be directly observed. The primary goal of research from this perspective is "to develop deeper levels of explanation and understanding" (McEvoy & Richards, 2006, p.67).

To illustrate the different kinds of reality and the process of abduction and theorising, recent attempts to introduce the statutory regulation of counsellors and psychotherapists will be used as an example.

Historical events, such as the attempt to introduce the statutory regulation of counsellors and psychotherapists in the UK, are examples of actual reality in that public records, from a variety of sources, exist. For the organisations and individuals who directly experienced these events, or were affected by this process, these historical events were part of their empirical reality.

The argument proposed in Section One of the literature review in Chapter 2 is that statutory regulation contributed to an on-going process of professionalization. Government aims, expressed through the HPC, became entangled with those of interested professional groups. This is why differences in practitioner training, particularly in relation to academic level, were used to elevate the status of psychotherapists. This argument is an example of abduction and theorising. It is an attempt to identify underlying mechanisms or structures that produce phenomenon. The argument is inferred from the existing evidence which includes theories of professionalization. This process produces a deeper understanding of those events. This analysis also reveals how the world, as it relates to therapist training, 'must be'. That is a world where professional interests take precedence over other factors.

Critical realism facilitates a scientific process that leads to abstraction and theorising. Pierce (1965) defined this process of abductive reasoning as guessing. Abductive guessing is the production of a plausible explanation of a phenomenon. Critical realism provides a theory of causality which can be investigated at a three levels of reality and across two different knowledge domains. It is concerned with understanding particular phenomena in relation to the world in which they exist and vice versa. The aim of research from a critical realist perspective is to reveal the deeper meaning of mechanisms or structures that cause phenomena.

Researcher perspective

Given that the researcher is inevitably part of how research is conducted and the findings that are produced, it is important to evaluate this influence. What follows is a description of the researcher's perspective using the central ontological constructs of critical realism.

That an actual reality exists which is observable and where, shared meanings can be held, is a fundamental assumption of this researcher. This position rejects philosophical or methodology assumptions that are absolute e.g. that everything is socially constructed or that everything is relative or open to interpretation. Actual reality includes the fact that the researcher is a white, middle aged professional woman from a working-class background and that each of these factors had an influence on all aspects of this investigation. In the context of therapist training, it is assumed that there is an actual reality that can be observed.

This is influenced by empirical reality which in this case, includes the researcher's personal beliefs that are founded on principals of social justice and personal experiences of practitioner training. Empirical reality refers to direct or indirect experience of a phenomenon. There exists an actual body of knowledge, which has been examined in the literature review that provides a reference point for investigating trainee change. What can be observed, by both the researcher and the informants, is coloured by personal and professional experiences and these influences need to be considered when evaluating this research.

The researcher's personal experience of training, (as described above), despite attempts to minimise its influence, influenced the research design, data collection and the

research findings. What was clear at the outset of this investigation was that the researcher's knowledge of this topic area was inevitably incomplete.

With regards to the real reality, through her actual and empirical experience the researcher had a theory, prior to undertaking this research, regarding how trainee counsellors change. This theory can be summarised thus. That, although different from personal therapy, training creates an environment in which trainees can change and that this process of change is likely to be similar to that experienced by clients. Like clients, trainees are more likely to change in the presence of empathic, boundaried relationships. This theory, as with each aspect of reality, was recognised as incomplete and untested. The desire to understand mechanisms of change and the deeper meaning of practitioner training was therefore, the impetus for this research.

Overview of Methods

Training courses are generally constructed on models of integrated learning and assume that knowledge and skills will be transferred across different elements. These elements are inter-dependent and inter-related. Only one study conducted by Ladany,Walker, Pate-Carolan, and Evans (2008) has tracked change in individual trainees over time but this study focussed on supervision and work with clients. No investigations of how different elements of practitioner training i.e. self-knowledge, theory and skills are integrated and assimilated by students were identified in the literature review. This section will present a critical realist perspective on the use of mixed method methods and describe how these were incorporated into the design of this investigation.

Why mixed methods?

Therapist training is a complex process and therefore, the research methods chosen to investigate it, need to be capable of capturing this. The research questions stated at the end of the Chapter 2 included quantitative and qualitative questions. Quantitative questions seek information and/or aim to identify patterns or relationships between variables. Quantitative methods assume that phenomena can be measured or observed and aim to produce findings that can be generalised to a wider population (Sirkin, 1999). Qualitative questions require methods that seek to: "map and explore the meaning of an area of human experience" (McLeod, 2001, p.viii). The use of mixed methods to answer such questions is a controversial topic amongst some social scientists.

Tashakkori and Teddlie (1998) identify two methodological positions: the purists and the pragmatists. The use of mixed methods is regarded by methodological purists as untenable because their ontological differences are deemed to be irreconcilable (Ford-Gilboe, Campbell, & Berman, 1995; Guba & Lincoln, 1989; Leninger, 1994). Whilst, methodological pragmatists such as Onwuegbuzie, Johnson, and Collins (2010) or Teddlie, Tashakkori and Johnson (2008) regard the use of mixed methods as necessary despite the difficulties this poses when it comes to interpreting findings (Onwuegbuzie, & Johnson, 2006). In addition to the purists and the pragmatists are the anti-conflationists. They stipulate that methods should only be combined when it is possible to identify common methodological principles (Bryman, 2004; Bryman & Bell, 2003; Hammersley,1992).

Research from a critical realist perspective is not contingent upon the use of specific methods. It proposes that the most appropriate methods be used (Danermark, Ekstrom,

Jakobsen & Karlsson, 2002). Consequently, there are no methodological restrictions regarding either the use of one method or the combination of many. Critical realists generally value the use of mixed methods as they produce a more detailed picture of the problem or phenomenon being studied. The findings of such investigations are more likely to provide a sounder basis for the process of abduction and theorising. The combination of methods from a critical realist perspective therefore, does not create obstacles to understanding but rather facilitate the development of theories that begin to explain casual mechanisms and underlying structures (Cook & Campbell, 1979; McEvoy & Richards, 2006;).

Triangulation

McEvoy and Richards (2006) describe two approaches to methodological triangulation: confirmation and completeness. The first, aims to corroborate facts identified across results with the aim of strengthening the validity and/or reliability of findings. Completeness on the other hand, aims to provide a detailed picture of phenomena and so does not seek to confirm findings but rather, to describe what is being investigated. In this study, where the aim is to describe the complexity of practitioner training and how trainee counsellors change, the findings produced by quantitative and qualitative methods will be presented with the aim of completeness rather than confirmation.

Methods for Training Research

The suggestion that new methods be utilised to investigate practitioner training (Beutler et al., 2004; Rønnestad & Ladany, 2006) are in part recognition of the limitations of quantitative or single method studies. Goldfield (2005) proposes that methods used to investigate client change, such as those common in Change Process Research, be used

to research change in trainees. This suggestion is significant in that it implies that trainee change processes may be similar to those of clients. Change Process Research (CPR) is a major area of therapy research that has developed over the past twenty years. It is comprised of a variety of both quantitative and qualitative methods. Such research aims to identify causal relationships between therapy and client outcome and the process by which change occurs. CPR researchers are largely concerned with "the nature of relationships" (Goldfield, 2005, para.1).

The use of mixed methods to study naturalistic i.e. routine practice rather than therapy in controlled environments is a common feature of CPR research. Naturalistic studies have the additional advantage of producing "context-based practical knowledge" (Elliott, 2010, p. 427). That is, knowledge that is more applicable to routine practice, or in the case of this research, routine practitioner training. The use of mixed methods to produce applicable knowledge is exemplified by systematic case study research which is "well placed to capture, describe and analyse evidence of complex processes" (Dattilio, Edwards, & Fishman, 2010, para. 1). In naturalistic studies there is less room for certainty, with regard to causal inference, than experiments in a laboratory (Cook & Campbell, 1979) and findings need to be considered in the light of other factors that may be responsible for the changes observed or that may have had an influence on the results.

A mixed method study of how trainee counsellors change

This research study was designed to study change processes in both individual trainees and across student cohorts and used quantitative and qualitative methods. A hierarchical nested design (Kenny & la Voie, 1985; Winer 1971) was chosen for the following reasons.

The advantage of a nested study is that it enables related levels of analysis within groups as well as across a whole sample. This approach is more likely to produce a more complete picture of how trainee counsellors change than a one dimensional design (Kenny & la Voie, 1985; Winer 1971).

The Qualitative Study of Early Practice: Margaret (MCS) was the pilot study for this investigation and took place one year before the data collection began for all other studies and so does not form part of the nested study sample. Following the pilot study three levels of analysis on the same sample of trainee counsellors (n=63) took place. These six studies were part of two investigations: The Early Effects of Practitioner Training and, A Longitudinal Examination of Trainee Change. Each study incorporated discrete, but inter-related quantitative and qualitative investigations. The measures and instruments, with the exception of the Assimilation of Problematic Experience Sequence (APES) are described in full in Chapter 4. Details of the APES scales can be found in the method section of the Assimilation Model Analysis: The Case of Mandy (AMA) in Chapter 5. The overall study design is described in detail in Table 4 below.

Table 4 *Overall Study Design*

The Early Effects of Practitioner Training Study Design (N=64)

Study	Sample	Method	Measure/Instrument/ Apparatus	Time of data collection
A Cross-Sectional Investigation of Trainee Counsellor Characteristics (CSI)	All training Cohorts *(n=63)*	Quantitative	Development of Psychotherapists Common Core Questionnaire Trainee Background Form (DPCCQ-TBF)	Beginning of training Weeks 1 to 3 of first term
			Clinical Outcomes in Routine Evaluation – Outcome Measure (34 items) (CORE-OM 34)	Beginning of training Weeks 6 to 9 of first term
			Strathclyde Inventory (SI)	
			Development of Psychotherapists Common Core Questionnaire (Trainee Process Form) (DPCCQ-TPF)	
Beginning of Training Qualitative Study (BTS)	Full-time course, *n=7*.	Qualitative individual interviews 2 x 50min	Change Interview Schedule- Trainee Version (CI-TV)	Wks: 6-9 *(n=7)*
A Qualitative Study of Early Practice: Margaret (MCS)	*n=1* Part-time DIPHE Psychodynamic Student	Qualitative 3 x 50min interviews	Change Interview schedule (Trainee Version) (CI-TV)	Week 3 Week 6 Week 11

A Longitudinal Examination of Trainee Change (n = 24)				
Study	Sample	Method	Measure/Instrument(s)/ Apparatus	Time of data collection Teaching weeks/months/year
The Longitudinal, Quantitative Investigation (LQI)	*n=20* (paired)	'Postal' questionnaires	DPCCQ- TBF, SI; CORE-OM (34). DPCCQ- TPF	Wks: 1-3, September-Year One Wk. 8 – Year One
End of Training Qualitative Study (ETS)	Full-time course, *n=4*.	Qualitative individual interviews 2 x 50min	CI-TV	Wk. 58 End of Course *(n=4)*
Assimilation Model Analysis: The Case of Mandy (AMA)	Full-time course, *n=1 case study*	Qualitative interviews 5 x 50 min	DPCCQ- TBF CI-TV. Assimilation of Problematic Experience Sequence/Scale (APES)	December February March May June

The methods for each study are described in detail in Chapters 4 and 5 but before presenting the methods and findings for each of these investigations it is first necessary to provide an overview of the sample and specify procedures and safeguards that related to all studies namely; confidentiality, ethics and consent.

Confidentiality, ethics and consent procedures

The ways in which informant information would be analysed, stored and used was considered carefully at the design stage of this project. To begin with, it was decided that the analysis of the quantitative data would be delayed until the end of the taught component of the psychodynamic training course i.e. for eighteen months, for the following reasons.

The psychodynamic trainees were enrolled on a course where the researcher was a tutor and the course director. Although informants were not asked to give their names on any of the questionnaires, they were required to provide information such as age, ethnicity and gender. The small size of the teaching group meant that these characteristics were likely to reveal the identities of participants to the researcher. It was hoped that trainees would feel less inhibited about completing measures if they knew that their answers would not be examined until after they had completed their training. It was made clear to all informants that confidential information would be accessed by the researcher, research supervisors and a research assistant. These additional precautions were put in place to protect existing relationships and to strengthen the integrity of the research project.

Consent

All informants involved in the quantitative investigations completed a consent form at the beginning and end of their training and these were returned in the same envelope as the questionnaires. Trainees who took part in qualitative interviews signed a consent form at the start of the study and these were reviewed at the beginning of each interview. Consent was considered to be on-going until the completion of the data collection period and informants understood that they could withdraw from the study at any time and, if requested, their data destroyed. How the data would be used, who would have access to it, and where it would be stored, was made clear to all interviewees both on the consent form and during the recruitment process. Informants understood that the use of verbatim quotes for conference presentations and publications would require additional permission. It was made clear to all participants that any raw data from informants who had a current relationship with one of the research supervisors, who was also their tutor, would not be shared during the data collection phase of the investigation.

As part of the consent process informants were made aware of the complaints procedure. They understood that course tutors knew about the study and that if additional support was needed they should be contacted by the trainee. Each informant had a clinical supervisor in place at the time of the interviews but none were engaged in personal therapy. In the event of a trainee being deemed by the researcher to be at risk of doing harm to themselves or others and if they were unwilling or unable to seek help, the informants understood that course staff would be contacted directly by the researcher and that in an emergency, appropriate action would be taken.

Additional consent

Additional consent was sought two years after the completion of the qualitative interviews. All informants, except for one person who withdrew from the study, gave permission for specific quotations to be included in this thesis, conference presentations and in future journal publications. Those informants who requested copies of interview transcripts and the first conference presentations were provided with these.

Data Storage

All completed questionnaires were stored in a filing cabinet at the researcher's home. Recordings were stored on an external hard drive of a personal desk top computer. The raw data was only seen by one of the researcher's supervisors for the purpose of audit. Members of the teaching staff at either the University of Strathclyde or the University of Leicester had no access to the transcripts of interviews.

Specific study methods

What follows in the next two chapters is a detailed description of the Early Effects of Practitioner Training and A Longitudinal Examination of Trainee Change investigations. Each chapter will contain the results of each investigation and will conclude with a discussion of the findings.

Chapter 4: The Early Effects of Practitioner Training

The methods used in this investigation are described. This is followed by the findings for all three studies and a discussion of these results.

As shown in Chapter 2 there is a consensus that practitioner training is likely to be stressful, particularly at the start of practice. It is generally agreed that beginning work with clients marks a personal and professional watershed for trainees. Yet, only a few studies have investigated how trainee therapists prepare for practice or have explored early experiences of client work. Most findings are derived from retrospective accounts or personal learning journals and reflect the experience of North American trainees enrolled on full-time psychology courses.

The Early Effects of Practitioner Training study investigated three aspects of training and employed quantitative and qualitative methods. It aimed to:

- Identify the characteristics of a sample of British trainee counsellors at the start of training.
- To examine how two counsellor training programmes prepare trainee counsellors for work with clients.
- To explore one trainees experience of beginning practice.

The Early Effects of Practitioner Training study is comprised of three investigations: The Cross-Sectional Analysis of Trainee Counsellor Characteristics, The Beginning of Training Qualitative Study of Trainee Change (BTS), and A Qualitative Study of Early Practice: Margaret (MCS). The methods and findings of each study are described below.

A Cross-Sectional Investigation of Trainee Counsellor Characteristics (CSI)

Research Questions

This study and set out to answer the two main questions i.e. how do trainee counsellors change? What helps trainee counsellors to change? And the following subsidiary questions:

- Who undertakes counsellor training?
- How does professional training impact on early therapist development?
- Which aspects of training influence therapist development? Specifically: a) negative influences and b) positive influences.

Sample

The basic demographic characteristics of the study sample are summarised in Table 5.

Table 5 *Whole Sample Characteristics at Beginning of Training*

Student Cohorts Total trainee population *N* =94	Sample *N*=63	% of Whole Sample	Gender	Mean Age	Minority Status
Psychodynamic Part time	19	30.16%	17 F 2M	43	7
Person Centred Full-time.	20	31.75%	16 F 4M	36	5
Person Centred Part-time.	25	39.68%	22 F 2M	42	4

Sixty three trainee counsellors participated. The student cohorts were similar in that the majority were female, middle aged and white. The full-time cohort had the lowest mean

age and the psychodynamic group had the highest proportion of trainees who identified as members of a racial ethnic minority.

The training courses

Two courses were part-time and one was a full-time counsellor training programme. They all awarded a Postgraduate Diploma (PGDip) in either psychodynamic or person centred counselling to successful students. Students could opt to complete an additional MA year but this part of all programmes was not BACP accredited and therefore was not part of the core training.

The full-time programme is not typical of the majority of counsellor training programmes in the UK. Of the current 87 BACP accredited courses (BACP, 2011) full-time programmes represent around 9%. Full-time courses meet the same criteria as part-time programmes but trainees need to satisfy course requirements over a shorter period of time.

Selection procedures

Trainees across all programmes submitted written applications to their chosen university. These were used by course staff to select applicants for interview. The entry criteria were similar across all programmes. These were: academic qualifications, relevant work experience; an interest in the particular approach of counselling and candidates must have completed some counselling skills training. Those trainees who were selected needed to have demonstrated that they were: motivated to train, and were practically able to do the course. They needed to have an appropriate personality for a counsellor such as the ability to sustain personal relationships, and have an awareness of issues of difference and diversity. They were required to have the ability to reflect on

personal experience and could show that this was the right time to train. They needed to demonstrate that they a personality that was compatible with the model taught.

Structure of the courses

Students on the part-time programmes attended the taught part of the course for one day per week for two academic years, although it was not unusual for some trainees to be completing outstanding requirements such as client contact hours for a further year or more following the end of the taught part of the training. Students on the full-time, one year course attended the university for five days per week for the first six weeks of the first term. From the seventh week, trainees attended the university for three days per week during term time and this pattern continued for the remainder of the course.

Work with clients

Work with clients took place in a variety of statutory and voluntary agencies. Trainees enrolled on the person centred part-time programme began practice during terms two and three in their first year. Students on the psychodynamic course began work with clients at the start of their second year. Trainees on the full-time programme began working with clients at the start of the second term and generally had two placements.

Supervision

On each of the person centred courses students participated in case discussion groups. These were facilitated by a tutor who was also an experienced person centred therapist. Students paid for individual supervision with an external supervisor. Supervisors were recommended by the course and were trained in the person centred approach. Supervision on the psychodynamic programmes took place in weekly groups which met for an hour and a half during the course day throughout the second year. All supervisors

were psychodynamically trained and employed by the university. All supervisees were formally assessed by their supervisor through an end of year assessment and report and could be awarded the following grades: fail re-submission, pass, merit and distinction.

Personal therapy

No course in this study required trainees to undertake personal therapy during training but all trainees attended personal development groups on a weekly basis on the part-time programmes. On the full-time course personal development groups met more often and sometimes for longer.

Course aims, content and assessment

The central aim of each course in this study was to produce graduates who were reflective practitioners. That is, effective therapists who are able to use their self-awareness to function at a sophisticated level with clients (University of Strathclyde, 2008).

On all courses students worked in small and large groups to: develop their counselling skills, their understanding of theory and professional issues, and to participate in case discussion. Topic areas were taught in workshop or seminar sessions and all courses aimed to integrate course topics which were explored in a variety of different ways in different contexts e.g. supervision, personal development, placements etc.

Student progress was examined through written assignments such as theory essays, case studies and the submission of recordings of therapy sessions. Progress was also assessed through self-appraisal procedures and written reflective statements.

Funding

The majority of students paid their own fees. Part-time students usually had other employment to enable them to undertake training whereas the full-time trainees did not. Total course fees for the PGDip at the time of the study were on average around £5,000 per trainee.

The professional standard of the training programmes.

All courses were accredited by the British Association for Counselling and Psychotherapy (BACP). This meant that they were each required to provide 450 hours of direct teaching/contact with students and that core staff were professionally accredited practitioner members of the BACP or an equivalent accrediting body. This also meant that standards relating to the selection of students, assessment, clinical placements, supervision, and course administration had also been met. All students and staff on accredited courses were required to abide by the BACP ethical framework.

Method

Procedures

Informant selection

The main selection criteria for this study were: that training programmes were BACP accredited British courses; that trainees were at the beginning of training when the study commenced and that they were engaged in routine practitioner training.

The sampling strategy was driven by convenience. The researcher was given ethical approval from the University of Leicester, where she worked as a Lecturer, to recruit students enrolled on the psychodynamic course for this study. Ethical approval was also granted by the University of Strathclyde, where one of the researcher's supervisors was a lecturer.

Measures

The investigation used a number of quantitative measures and qualitative instruments. The qualitative instrument the Change Interview Schedule –Trainee Version (CI-TV) is described later in this chapter in the Beginning of Training Study. The Assimilation of Problematic Experience Sequence (APES) is described in detail in Chapter 5 in the Assimilation Model Analysis: The Case of Mandy. The intention was to collect a variety of data that together, would provide a rich and detailed picture of trainee characteristics at the start of training. The following four measures were used in the Cross-Sectional Investigation of Trainee Counsellor Characteristics.

Development of Psychotherapists Common Core (Trainee Version) (DPCCQ-TV)

The DPCCQ-TV was adapted by members of the Society for Psychotherapy Research, Collaborative Research Network in 2006 from a well-established instrument that has been used to investigate the development of psychotherapists for the past 20 years. Details of the development of the original measure are given in chapter two of "How Psychotherapists Develop" (Orlinsky & Rønnestad, 2005).

The trainee version of the DPCCQ differs from the original in a number of ways. Firstly, the questionnaire is divided into two parts which can be used independently or together, (both forms can be found below in Appendix A). In this study both questionnaires were used but at two different points in time. The first part is The Development of Psychotherapists Common Core Questionnaire – Trainee Background Form (DPCCQ – TBF).

The Development of Psychotherapists Common Core Questionnaire – Trainee Background Form (DPCCQ-TBF)

The DPCCQ-TBF collects data on trainee demographic characteristics and details of their training. The topic areas and scales are the same as the original Development of Psychotherapists Common Core Questionnaire (DPCCQ) but the wording of questions were changed to make them more appropriate for trainee therapists and some subsidiary questions were added. For example, informants are asked about training methods such as role play or time spent each week in supervision etc. These questions are not included in the original DPCCQ. The background form has forty-six questions and these are equally divided between two sections. Some questions also have one or more subsidiary questions e.g.

2-8.   Were your parents divorced or separated? _ 1. No. _____ 2. Yes
          [b. If Yes, how old were you?_____]

The DPCCQ-TBF includes the following topic areas: current training, qualifications, theoretical orientation, personal therapy, practice experience, relationship status, family background, religious belief and current levels of life stress and satisfaction. Informants answer the questions in three ways:

1) By rating their response to a given question or statement on a six point scale that ranges from 0 = not at all to 5 = greatly, or on a 0 to 10 scale, 0 = not at all important in my life and 10 = the most important thing in my life.

2) By providing a written description e.g. 2-1 (b) In which country were you born?

3) By checking one or more boxes to denote Yes or No.

The second part of the questionnaire is the Development of Psychotherapists Common Core Questionnaire – Trainee Process Form (DPCCQ-TPF).

The Development of Psychotherapists Common Core Questionnaire – Trainee Process Form (DPCCQ-TPF)

The DPCCQ- TPF is comprised of 132 main questions that are distributed over 10 topic areas which are:

- demographic information
- client experience
- change and improvement as a therapist,
- theoretical orientation
- therapist style
- current work with clients
- difficulties in practice
- coping strategies
- influences on current practice or training
- current well-being

The DPCCQ- TPF uses the same six point scale as the background form but has fewer

questions that require a written answer or with subsidiary questions. It contains one

scale that is not used in the background form. This is given below.

How much <u>influence</u> is each of the following having on your <u>current</u>
development as a therapist? [You may circle both a <u>positive</u> and a <u>negative</u>
response.]

4-12.   Experience in therapy with patients

-3 very negative	**-2** moderately negative	**-1** somewhat Negative	0 Neutral	**+1** somewhat Positive	**+1** moderately Positive	**+3** very positive

The DPCCQ is a comprehensive and reliable measure. It was first used in 1991 and its

construct validity and internal and external validity has been consistently demonstrated

over the past twenty years (Orlinsky & Rønnestad, 2005). A factor analysis of each

dimensional scale (Orlinsky et al., 1999) found that levels of Cronbach's alpha ranged

from 0.67 to 20 and on this basis its internal consistency has been judged as ranging

from good to satisfactory. This investigation was one of the first to use this version of

the DPCCQ. However, the items and component scales used for this study were

identical to those of the original DPCCQ e.g. Healing Involvement. Therefore, it was

not necessary to perform a factor analysis or other tests regarding the construct

reliability of this version of the measure for the purpose of this study.

The DPCCQ (Trainee Version) was not designed to provide detailed information about

the psychological health of informants. For this reason it was decided that a measure of

psychological distress was needed in addition to the DPCCQ trainee questionnaires in

order to accurately assess trainee therapist well-being.

Clinical Outcomes in Routine Evaluation- Outcome Measure (34 items)

The Clinical Outcomes in Routine Evaluation- Outcome Measure (34 items) i.e. the CORE-OM (34) is a therapy outcome measure of client distress. It is a free measure and this is one of the reasons why it is one of the most commonly used questionnaires in clinical settings in the UK. It has been used to develop a national data base of 50,000 clients and 600 therapists. The validity and reliability of the CORE-OM (34) measure has been clearly demonstrated (CORE-IMS, 2010).

The CORE-OM (34) has been designed for use with clinical populations. Clinical cut off scores provide guidance, not only in respect of who is in need of treatment but these are also used to evaluate reliable and clinically significant change (Evans et al., 2002; Jacobson & Truax, 1991). There are a number of versions of the CORE-OM but the one used in this study is comprised of 34 questions and uses a five point scale. Scores can be calculated to produce an overall measure of client distress but measurements can also be made in relation to four sub-scales: risk, well-being, problems, and function (CORE-IMS, 2006).

Clients are asked to "Please read each statement and think how often you felt that way last week. Then tick the box which is closest to this". They record their answers to a given statement by ranking their response. For example:

Question 2   I have felt tense, anxious or nervous.

0 = not at all 1 = only occasionally 2 = sometimes 3 = often and 4 = most or all of the time.

The total score is the mean of the sum for either all questions or each sub-scale. The maximum mean score is 4 for all items and for each dimension. Higher scores indicate

higher levels of distress. The clinical cut off for men is 1.19 and 1.29 for women (CORE-IMS, 2006). In this study it was used to identify trainees who may be in need of help or treatment and those who had scores that were consistent with a non-clinical population. The mean total distress scores for a non-clinical population are 0.69 for men and 0.81 for women (CORE-IMS, 2006).

As described above, CORE-OM (34) measures levels of distress and is primarily concerned with symptom identification and diagnosis. Therefore, another instrument was needed that would measure emotional functioning as it was anticipated that this would be particularly relevant to understanding the changes experienced by trainees. This was also important given that the majority of informants were not expected to present with levels of distress above the clinical cut-off. For this reason the Strathclyde Inventory was added to the existing battery of measures.

The Strathclyde Inventory (SI)

The Strathclyde Inventory (SI) is a new measure that was developed by Freire, Cooper, and Elliott (2007) at the University of Strathclyde and a copy of this questionnaire can be found in Appendix A. Like the CORE-OM (34) the SI is a clinical outcome measure. Informants are asked to: 'Please read each statement below and think how often you sense it has been true for you during the last month. Then mark the box that is closest to this. There are no right or wrong answers – it is only important what is true for you individually.' It contains 31 questions and uses a five point scale: 0 = never 1 = only occasionally 2 = sometimes 3 = often and 4 = most or all of the time'.

The SI is based on Rogers's (1963) notion of the fully functioning person and aims to measure experiential fluidity and rigidity. Mean scores across all items indicate overall

levels of emotional functioning but scores for two sub-scales can also be calculated. These specifically measure congruence i.e. experiential processing, fluidity, and self-acceptance, and incongruence i.e. sense of fear, interpersonal/experiential constriction. Higher scores on all scales indicate greater emotional functioning.

Construct reliability, convergent and discriminant validity

This study was one of the first investigations to use this questionnaire and the SI data collected, i.e. trainees were assumed to constitute a non-clinical population, has contributed to the further development of its cut off scores. During its development it has been subjected to advanced psychometric analyses (Freire et al., 2007). A Cronbach's Alpha of 0.94 indicates that is has excellent item-reliability and it has good convergent validity with Rosenberg's Self-Esteem Scale. Its overall convergent validity in relation to the CORE-OM (34) questionnaire is good (-0.66, p<0.01). However, the degree of overlap between the two measures was greater than anticipated and there were some concerns about its discriminant validity. The overlap between the SI and the CORE-OM (34), like most self-report support measures, indicates that the questionnaire is able to measure levels of distress but be less accurate in capturing conceptual distinctions of the experience of that distress (Freire et al., 2007). The authors propose that the fully functioning person, as measured on the SI, provides a mirror image of those clients with high levels of clinical distress (Freire et al., 2007). Although there is some overlap between these two measures with regards to distress the advantage for this study of using both measures was that they use different constructs to measure distress. In addition, it was hoped that the SI would reveal something that the CORE-OM (34) could not i.e. "conceptual distinctions of the experience of distress" (Freire et al., 2007, slide 28).

Clinical cut-off

The clinical cut-off level at the time of writing is still in the process of being established. Therefore, the clinical cut off of <2.4 is provisional and may need to be adjusted in the light of future research.

Data Collection

The Cross Sectional Study of Trainee Counsellor Characteristics began in the first three weeks of an academic year. A total of 376 questionnaires i.e. 4 per information pack which also included an information sheet, a stamped addressed envelope and a consent form were distributed to 94 trainee counsellors enrolled on counselling courses at the universities of Leicester and Strathclyde. Trainees were asked to return completed questionnaires and a signed consent form in a sealed, stamped addressed envelope, to either their course tutor, from whom they would be collected by the researcher, or to post them directly to the researcher.

The aim was to collect data on trainees at an early point in training when they were beginning to understand the difference between basic counselling skills training and practitioner training but had not yet begun to work with clients. Given the influence that clients are likely to have on trainee development (Orlinsky & Rønnestad , 2005) it was important to measure their development before they began practice in order to establish a pre-training level to which any end of training scores could be compared. This also provided the opportunity to measure the early impact of the training programmes.

Trainees were instructed to use role play experiences to answer questions that related to practice. This was particularly appropriate for the majority of trainees who as part of

their person-centred training were expected to work with personal issues in role-plays with peers. The psychodynamic trainees did not use personal material but would have experience of working with real emotions with fellow students role-playing client scenarios. This decision was influenced by published studies where trainees work with volunteer clients who are also students, in preparation for beginning practice (Hill & Lent, 2006; Kivlighan, 2010). These authors suggest that work with role play or 'practice' clients is similar to work with real clients.

Questionnaires returned

The population sample for this study was ninety-four trainees. The return rate for those questionnaires distributed at the beginning of the first term was high i.e. 67% of this sample. The total number of returned questionnaires had dropped to forty-two by the end of the first term. However, this still represented an acceptable return rate of 44.68%. The reasons for this drop were not investigated but nonetheless, there were some problems with the data collection that may have had an impact on the number of returns.

 To begin with, it was anticipated that some difficulties may occur because of the challenges of collecting data at a distance i.e. where the researcher was not present to either distribute questionnaires or to encourage staff to collect the data. Questionnaires, for the *Early Effects* study were distributed by tutors to students and returned to the researcher. The return rates for the Strathclyde cohorts may have reflected the enthusiasm of course tutors and or the students as only 8 trainees on the full-time programme, around 27% of that student cohort returned questionnaires compared to 21 (70%) on the part-time course at the end of the first term. Just over half (10) of the

psychodynamic trainees returned forms and it is not clear why this occurred although most of those students who opted to return questionnaires by post failed to do so.

The other possible reason was that the time it took to complete the questionnaires was off putting i.e. 243 questions. Students may have been feeling more time pressure towards end of their first term than at the beginning and felt unable to complete the questionnaires as a consequence.

Data analysis

The data were analysed using SPSS version 16.0 to calculate distribution, mean scores, standard deviations and percentages. Trainee demographic data were collected via the DPCCQ-TBF. Means for scales such as helpful and unhelpful influences, trainee characteristics, professional growth etc. were computed using data from the DPCCQ-TPF. Means levels of emotional distress was calculated for both the SI and the CORE-OM (34). These results are presented next.

Results

The results of the first study provide an overview of the characteristics of British trainee counsellors enrolled on three BACP accredited programmes at the start of training and a description of the early impact of that training on the informants.

Informant characteristics

The characteristics of trainees at the start of training are summarised below in Table 6.

Table 6 *Demographic Characteristics of Sample*

	Total & % of sample	Mean	Range	SD
Whole sample	63(100%)	-		-
Gender		-	-	-
F=female	F = 55 (87.03%)			
M=male	M = 8 (12.70%)			
Age at start of study	-	41 yrs.	23-64 yrs.	-
Year of birth	-	1966	1943-1984	9.97
Members of ethnic or racial minority	8 (12.70%)	-	-	-
Married or living with a partner	35 (55.55%)	-	-	-
Single	13 (20.63%)	-	-	-
Divorced	3 (04.76%)	-	-	-
Engaged	3 (04.76%)	-	-	-
Widowed	1 (01.68%)			
Separated	2 (03.17%)			
Other (not specified)	1 (01.68%)	-	-	-
Missing data	5 (07.94%)			

Of the sixty three trainee counsellors who participated in the study 87% (55) were female. They ranged in age from 23 to 64 years. The median birth year of birth was 1966 and so at the start of the study the average age of trainees was 41. These data were normally distributed with the majority i.e. 44 (69.4%) born in the 1960's and 1970's.

Eight trainees belonged to a racial or ethnic minority. The majority of trainees were in committed personal relationships although a minority were divorced or separated and over 20% were single. These and other findings are summarised in Table 6 above.

Although all informants were enrolled on post-graduate programmes, not all trainees held a first degree. The highest qualification of just fewer than forty-per cent of the sample (38.9%, 24) held a first degree and degree topics were evenly split between science and humanities. Twelve informants (19.05%) had a post graduate qualification. The highest qualification for fourteen (22%) of the sample was either Certificate or HE Diploma. Two trainees stated that their professional qualification was their highest

qualification. However the high rate of missing data (33%) needs to be considered when evaluating these percentages. It was not possible to determine the reason for this.

Pre-clinical training

All informants had completed some pre-clinical or counselling skills training with the majority, over 65% (65.08%, 41) of the sample, having completed a counselling skills qualification. Nearly thirty per cent (28.57%, 18) had completed in-house skills training as part of an existing professional or voluntary role. Four informants did not complete this question (6.35%).

Previous experience of working as a counsellor

As described above informants were asked to complete the DPCCQ-TBF questions that related to clinical practice based on their work with role-play clients. They were asked to provide details of previous experience but this question may have been answered in relation to previous experience of working with role-play clients. The findings from this section of the questionnaire were therefore unclear and it was not possible to determine the number of students who had previous experience of working with real clients.

Only 5% (3) of students described their professional identity as "counsellor", four (2.4%) as "psychologist" and 0.6% (1) as "psychotherapist". Just under ten per cent (9.6%) (16) of informants stated that they were in regular supervision. Although the extent of previous clinical experience is not clear from these findings they do provide some evidence to support the view that the majority of the informants had no previous experience of working with clients as therapists.

Theoretical allegiance

Trainees commenced training with a strong allegiance to their chosen core theoretical model. Around (40) 90% of the person-centred trainees were greatly influenced by the person-centred approach, rating it highly i.e. 4 or above compared to 16.66% (3) of the psychodynamic trainees who's highest rating was 4. Similarly, the students on the psychodynamic courses had a strong allegiance to the psychodynamic model above all other approaches but a smaller percentage of this cohort, compared to the person-centred trainees (66.66%), rated it as highly influential. The influence of the person-centred approach was greater on the psychodynamic trainees than the psychodynamic/analytic approach was on the person centred students. Nearly 17% (3) of the psychodynamic cohort rated its influence highly compared to 6.66% (3) of person-centred trainees.

Value and incidence of personal therapy in trainees

A minority of the trainees (15.87%, 10) were engaged in personal therapy at the start of training, but more than half (57%, 36) of the sample had some experience of it. All of those who had experience of personal therapy i.e. 57% of the sample valued it greatly (Median 4.53, SD: 0.845)

Family backgrounds of informants

Table 7   *Family Backgrounds of Informants*

	Total number & % of sample	Mean	Median	SD
Whole sample	63 (100.00%)	-	-	-
Grew up in families with siblings	51 (80.95%)	-	-	-
Middle children	23 (36.51%)	-	-	
Youngest children	16 (25.40%)	-	-	-
Oldest children	2 (03.17%)	-	-	-
Only children	7 (11.11%)	-	-	-
Had parents who did not divorce	41 (65.08%)	-	-	-
Felt well cared for and supported in childhood (0=not at all to 5 = very much)	58 (92.06%)	3.62	4.00	1.48
Family functioned well emotionally & psychologically? (0=not at all to 5 = very much)	-	2.33	2.00	1.47
Experienced childhood trauma and/or abuse (0=not at all to 5 = very much)	-	2.71	3.00	1.83
Missing data	5 (07.94%)	-	-	-

The majority of informants describe relatively stable upbringings in as much as having parents who did not divorce can be interpreted as such. They felt very much cared for and supported by their families in childhood. However, their families did not function well psychologically.

Childhood Trauma or Abuse

The scores for the questions 'Did you experience any emotional or significant trauma or abuse?' were quite widely distributed (SD 1.826) therefore the median score of 3.00 was used and this indicated the experience of some abuse for the majority of informants. The frequency and distribution of childhood abuse or trauma in the sample are described in detail in Table 8 below.

Table 8 *Frequency of Childhood Trauma or Abuse*

The frequency of significant trauma or abuse was high given that 12 trainees (19.05%) had no experience of childhood trauma or abuse. Forty-six informants had some experience of significant

Experience of abuse or trauma		Frequency
	0 Not at all	12
	1	6
	2	5
	3	10
	4	14
	5 Very much	11
	Total	58
Missing		5
	Total	63

trauma or abuse in childhood, 11 low, 10 moderate and 25 (40%) high i.e. much or very much.

Experience of loss and bereavement

Forty-five (71%) of the sample had lost one parent, and twenty-six (58%) of these had lost both. Twenty-six trainees (41%) were orphans with 22 (85%) coming from the Strathclyde courses. Fifty-nine per cent (10) of trainees in the Leicester cohort had experienced the loss of one or more parents compared to 78% (36) of trainees enrolled on the Strathclyde courses. It is not possible to determine when bereavements occurred as nearly half of all informants did not answer to this question. However, given that the

mean age for the sample was 41 years it is likely that for some trainees their parent or parents died prematurely.

Mental health and well being

Table 9   *Pattern of Distress at the Start of Training*

Measure/ question	Cut off/scale	Sample (*N*=63)	Mean Score	Range	SD	Number Above/below cut off	Range of Clinical Scores
CORE-OM(34)	>1.29	59	0.41	0 – 1.54	0.331	2 above 57 below	1.49 – 1.54
SI	< 2.4	57	2.89	1.77-2.90	0.476	11 below 46 above	1.77 – 2.39
Life Stress (DPCCQ – TBF)	0 = not at all - 5 = very much	58	2.98	0-5	1.221	-	-
Life Satisfaction (DPCCQ-TBF)	0 = not at all – 5 = very much	58	3.86	2 - 5	0.868	-	-

As shown in Table 9 above, on the DPCCQ-TBF informants reported moderate levels of life stress and so felt stressed fairly often. On the CORE-OM (34) two trainees had scores in the clinical range. On the SI eleven informants were above the clinical cut-off i.e. 19% of respondents. The SI scores were normally distributed whereas those for the CORE-OM were positively skewed. The mean life satisfaction score on the DPCCQ-TBF of 3.86 indicates that most trainees experienced much life satisfaction. Trainees had low levels of distress, incongruence, moderate levels of stress and high levels of experiential fluidity and life satisfaction. A minority of trainees reported levels of

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distress and experiential rigidity that were consistent with those in a clinical population on the two outcome measures. The highest mean CORE-OM score of 1.54 would place a female client in a mild to moderate range of difficulty. Similarly, although more informants had scores in the clinical range on the SI these indicate moderate to mild levels of emotional rigidity/constriction with a mean score for those in clinical range of 1.99 i.e. 0.41 below the cut off. Since the analysis, the clinical cut off for CORE-OM (34) has been revised and is now set at 1.00. If this were used then the number of informants above the clinical cut off would double from 2 to 4 but the incidence of trainees above the clinical cut-off would still be low.

Personal Life of Trainees

The following provides an overview of the private lives of informants at the beginning of training as described through their answers to questions on the DPCCQ-TPF. The median (Mn) scores are used due to fact that all results exceed one standard deviation.

Trainees reported that they (*Mn*=4.00, *SD*= 1.12) felt able to express private thoughts and experienced being genuinely cared for (*Mn*=4.00, *SD*= 1.18) quite often, in their private life. They experienced moments of enjoyment (*Mn*=3.00, *SD*= 1.22), satisfying intimacy (*Mn*=3.00, *SD*=1.46) and a sense of belonging (*Mn*=3.00, *SD*=1.39) fairly often. They also managed to find opportunities to relax (*Mn*=3.00, *SD*=1.15) on a fairly regular basis. The trainee counsellors felt hassled by pressures (*Mn*=3.00, *SD*= 1. 21) and a heavy burden (*Mn*=3.00, *SD*= 1.35) fairly often. They experienced significant personal conflict (*Mn*=2.00, *SD*= 1. 48) and worries about money (*Mn*=2.00, *SD*= 1.35) only occasionally.

The early effects of training

The findings for this study come from data that were collected using the Development of Psychotherapists Common Core Questionnaire – Trainee Process Form (DPCCQ-TPF). This was distributed to informants between week 6 and week 8 of the ten week term. The response for this questionnaire was lower than that for the beginning of training questionnaires and this is reflected in the increased levels of missing data for all items. These results are summarised in Table 10 below.

Table 10 *Early Impact of Training on Professional Development*

N= 63	Change as a therapist	Progress	Decline	Overcoming past limitations	Becoming more skilful	Deepening understanding	Becoming disillusioned	Loosing capacity to respond	Performance becoming routine
N	40	40	40	39	40	40	40	40	40
Missing	23	23	23	24	23	23	23	23	23
Mean	3.15	3.85	.35	3.03	3.20	3.68	.48	.33	.48
Median	3.50	4.00	.00	3.00	3.00	4.00	.00	.00	.00
Mode	4.00	4.00	.00	3.00	3.00	4.00	.00	.00	.00
Std. Deviation	1.27	1.12	.80	1.27	1.24	1.21	.99	.66	1.04

Despite the fact that the informants had only been in training for a couple of months they felt that they changed much and were making significant progress as therapists. At this stage, trainees were not required to be engaged in work with clients but they were asked to comment on their development in relation to role play experiences. The highest median score was for 'deepening understanding of therapy' (4.00). The trainees reported moderate change as therapists (3.00) and in their level of skill (3.00) at the end of their first term.

The mean scores for feeling disillusioned about therapy, decline or impairment, losing

the capacity to respond or that therapist performance had become routine, were all

below 0.48 for each. This indicates that generally there was very little decline in

therapist development at this time.

Positive and negative influences on trainee development

The question: How much <u>influence</u> is each of the following having on your <u>current</u>

development as a therapist? Informants are asked to rank the influence of different

aspects of training as: somewhat (+1), moderately (+2) or very positive (+3) and very (-

3), moderately (-2), or somewhat (-1) negative. Informants could also have selected a

neutral score (0). The results are summarised in Table 11 below.

Table 11 *Positive and Negative Influences on Early Therapist Development*

N=63	Observing therapists (Negative)	Observing. Therapists (Positive)	Getting & giving feedback (Negative)	Getting & giving feedback (Positive)	Practising role play (Negative)	Practising role play (Positive)	Getting personal therapy (Positive)	Experience in personal life / adult (Negative)	Experience in personal life / adult (Positive)
n	24.00	24.00	24.00	24.00	23.00	23.00	24.00	24.00	24.00
Missing	39.00	39.00	39.00	39.00	39.00	39.00	39.00	39.00	39.00
Mean	.13	1.17	.13	1.79	.43	.13	.08	.38	1.33
Median	.00	1.00	.00	2.00	.00	.00	.00	.00	1.00
Mode	0.00	2.00	0.00	2.00	0.00	0.00	0.00	0.00	2.00
SD	.45	.92	.45	1.02	.84	.34	.41	.77	1.01

	Informal case discussion (Negative)	Informal case discussion (Positive)	Reading books or journals (Negative)	Reading books or journals (Positive)	Attending courses or seminars (Negative)	Attending courses or seminars (Positive)
n	25.00	25.00	25.00	25.00	24.00	24.00
Missing	38.00	38.00	38.00	38.00	39.00	39.00
Mean	.12	1.56	.12	1.20	.13	1.79
Median	.00	2.00	.00	1.00	.00	2.00
Mode	0.00	3.00	0.00	1.00	.00	1.00
S.D.	.60	1.23	.60	.91	.45	.93
N	25.00	25.00	25.00	25.00	24.00	24.00

Based on the mean scores the most positive influences on early trainee development were attending seminars and classes, getting personal therapy and getting and giving feedback. Reading books and journals which had a moderately positive influence on the trainees, as did informal case discussion. The most surprising finding was the influence of role play which had a neutral impact on early trainee development.

Summary of the Cross Sectional Study Findings: Trainee Characteristics and the Early Effects of Training.

The average trainee in this study was middle-aged, white, female and a graduate. The majority grew up in families in which they felt cared for but a significant proportion had experienced childhood trauma and abuse. Most had some experience of personal therapy but were not in therapy at the start of training. All but a few were emotionally resourceful. They had satisfying personal lives but were experiencing some stress in relation to the training but low levels of distress.

These findings show that over the course of a few weeks that training had a largely positive impact on the informants with most aspects having a moderate impact on their development. They felt they were making much progress and had a much deeper understanding of therapy than they had at the start of their training. They reported feeling more skilful and that they were overcoming their limitations. There was little decline or disillusionment. The two most positive influences on development at this stage of training were reading books and journals and giving and receiving feedback. No negative influences on development were identified but the mean score for role play indicates that it had little or no impact on trainees at this time.

The Beginning Training
Qualitative Study of Trainee Change (BTS)

Research Questions

This study set out to answer the main study questions which are: How do trainee counsellors change? What helps trainee counsellors to change? And the following subsidiary questions:

- Who undertakes counsellor training?

- How does professional training impact on early therapist development?

- Which aspects of training influence therapist development? Specifically: a) negative influences and b) positive influences.

Design

The aim of this study was to capture the experience of a group of trainee counsellors at the end of their first term of training. This study, as with the Cross-Sectional Investigation presented above, explored the influence of training on trainees prior to beginning work with clients. Qualitative methods were used to investigate changes in seven individual members of one student cohort. The informants were all enrolled on the same person-centred, full-time programme and were invited to take part in individual interviews towards the end of the first term. The group were part of the larger sample described in the Cross Sectional Investigation.

Method

Informants

Three of the seven informants were white men. Two identified as ethnic minority women and two were white women. This group was not intended to be representative of the wider sample but it is worth noting that it was not typical. The Beginning of Training Qualitative study was comprised of 29% ethnic minority students whilst men represented 43% of the group and white women, who predominated in the whole sample, were in a minority. Three of the 7 participants had moved from another country, England, the Caribbean and Africa, to undertake training. Only one informant lived locally. The mean age for the group was 37 years with an age range of 24 to 51 years. The mean age was therefore, a little below that of the whole sample. None of the informants were in therapy at the time of the interviews, but three had experience of short term therapy.

Instruments

The trainees in this study completed the DPCCQ-TBF form at the beginning of training. The Change Interview -Trainee Version (CI-TV) was used to facilitate semi-structured interviews. The Change Interview Schedule (Elliott et al., 2001) was designed to be used with clients at either the end of therapy or every 8 - 10 sessions during therapy. It is used to identify helpful and unhelpful aspects of therapy and factors that are responsible for change, including extra-therapy factors. The schedule was adapted for the purpose of investigating trainee change during the first study to be conducted which was the case study of Margaret. To begin with, specific therapy questions were deleted for example, question 1a. that asked for details of current medication. Minor changes

were made to the wording of questions for example, Question 1c. What has therapy been like for you so far? How has it felt to be in therapy? Became question 1.b.What has training been like for you so far? How has it felt to be in training?

The most substantial amendments were made following the first interview with Margaret. At this point all but one question regarding change attribution (including the Change List), were removed. This decision was made because the process of ranking each change was felt to detract from the primary purpose of the interview i.e. a qualitative enquiry with the aim of capturing the experience of a trainee rather than change attribution. In addition, the self-description section was deleted as the informant offered this information without prompting in the first interview and with two more interviews planned over a period of 8 weeks it was decided that this question would not need to be asked again. In this way, the Change Interview – Trainee Version (CI-TV) was shortened. It was reduced from 10 topic areas to 6 and from 27 to 14 questions. The CI-TV is given in full in Table 12 below for two reasons. First, to describe this version of the schedule and second, to show the origin of the topic domains that were later incorporated into the generic qualitative analysis of the interview data.

Table 12 *CI-TV & Origin of Topic Domains*

1a.Review of consent form

1b.What has training been like for you so far? How has it felt to be on the course?

1c.How are you in general?

Change

> Origin of Change domain, questions 1b, 1c, 2a, 2b

2a.What changes, if any, have you noticed in yourself since the course began/the last interview?

2b.Has anything changed for the worse for you since training began/last interview?

2c.Is there anything that you wanted to change that hasn't since the course started?

2d.What changes, if any, have you noticed in your work with your client (s) since training started?

Change Attribution

3. In general, what do you think has caused these various changes?

Helpful Aspects

> Origin of Helpful Processes domain, questions 3, 4 & 5b.

4. Can you sum up what has been helpful about your training so far?
Problematic Aspects

5a.What kinds of things about your experience of training have been hindering, unhelpful, negative or disappointing for you?

5b. Were there things that have happened on the course (since we last met) which were difficult or painful but still OK or perhaps helpful? What were they?

> Origin of Unhelpful Processes domain, questions 5a, 5b & 5c.

5c.Has anything been missing from your experience of the course?

6a.Do you have any suggestions for me, regarding the research or the course?

6b.Do you have anything else that you want to tell me?

Procedures

Selection

Trainees enrolled on the full-time training programme were sent an information pack four weeks into the first term of their training. The pack contained an information sheet which described the Beginning of Training Qualitative Study (BTS) study and the consent process. Interested students were asked to return an appointment form to the researcher using a stamped addressed envelope or to contact her by email. Informants were required to: be about to begin work with clients, be enrolled on the full-time programme, and have no prior relationship with the researcher. Appointments were arranged by the researcher and all interviews took place on university premises in a private room.

Nine volunteers contacted the researcher and all were invited to take part in individual interviews six to eight weeks into the first term and seven trainees attended.

Interviews

The aim of the interviews was to provide participants with a reflective, supportive space that would not only facilitate the collection of data but would also be of some benefit to those participating. It was anticipated that the research would contribute to the development of their reflective capacity. The chosen research method was in sympathy with the aims of professional training i.e. the development of reflective practitioners who have an understanding of practice based research. Each interview began with a detailed description of the investigation and the completion of a consent form. Interviews lasted for between 45 and 60 minutes. All were audio recorded and transcribed.

Qualitative Data analysis

Methodical Hermeneutics proposes that the majority of qualitative methods share a common philosophical root and that they are more similar than they are different. Methodical Hermeneutics is not defined by method but by commonly held philosophical and scientific assumptions (Rennie, 2000; Rennie, 2007a; Rennie, 2007b). The unification of qualitative research through the recognition that it is largely one method rooted in a shared philosophy, artificially divided by brand names is also proposed by Elliott and Timulak (2005). If one accepts that qualitative research is defined by its philosophy then there are few advantages for the researcher in confining oneself to one method.

Most new qualitative methods are largely a combination of other methods and influences. For example Consensual Qualitative Research (CQR), which was developed in the first half of the 1990's, has some unique features but it is essentially a hybrid of other approaches , "CQR incorporates elements from phenomenology, grounded theory and comprehensive process analysis" (Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005, pp.196-197).

Qualitative researchers, even those associated throughout their careers with a particular brand, have often adapted that approach over time to fit their personal philosophy and their area of research. For example, David Rennie's later grounded theory analysis is more explicitly phenomenological (Rennie, 1996; Rennie & Fergus, 2006) than his earlier studies, but it is still recognizably grounded theory.

 A generic qualitative method provides an alternative to either attempting to develop a new approach or adapt an existing brand. It provides the researcher with the freedom to

be a bricoleur (McLeod, 2001). The 'bricoleur' is defined by Denzin and Lincoln (2008, p.5) as a "maker of quilts" that is, someone who stitches together different methods or materials to make a whole approach. In this way, the qualitative method emerges in response to the research rather than making the research fit the method (McLeod, 2001).

This pragmatic approach is also consistent with critical realism which has been described in detail above. The disadvantage of using different aspects of a number of qualitative methods is that it may be difficult for other researchers to replicate unless it is clearly described. The generic qualitative method used in both the BTS and the case study of Margaret study combined aspects of grounded theory (GT), as exemplified in David Rennie's work (Rennie, 1994; Rennie & Fergus, 2006), Consensual Qualitative Research (CQR) (Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005), and Interpretative Phenomenological Analysis (IPA) (Smith, 2003).

The procedures and concepts used to analyse the qualitative data are described in Figure 1 below. References are cited that relate to those publications that had the most influence on the development of this approach. Given the degree of overlap between different methods of qualitative research the aim is not to describe the origin of each process or task but simply to identify the influence of specific research on the development of the methods used.

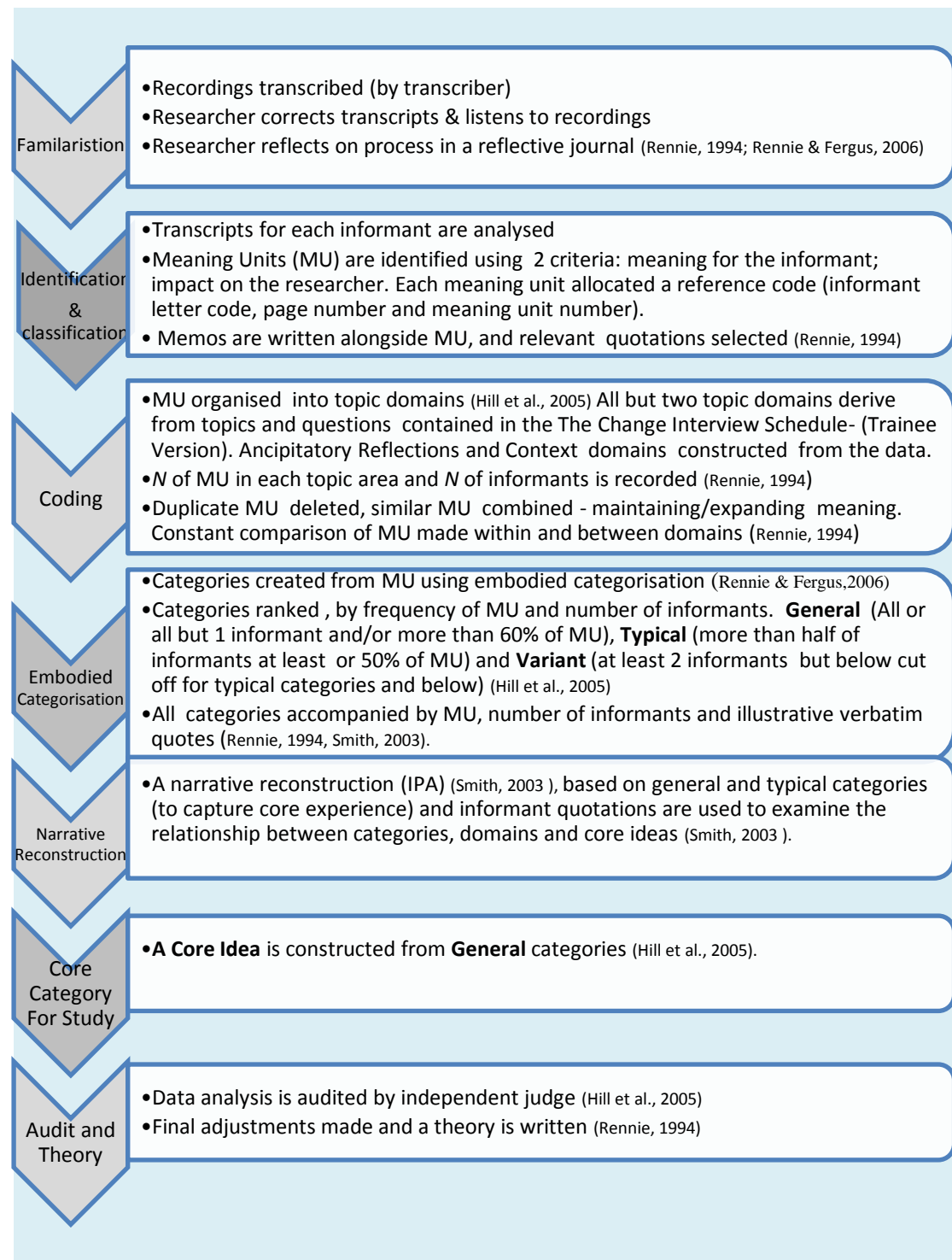| Familiarisation	• Recordings transcribed (by transcriber) • Researcher corrects transcripts & listens to recordings • Researcher reflects on process in a reflective journal (Rennie, 1994; Rennie & Fergus, 2006)
Identification & classification	• Transcripts for each informant are analysed • Meaning Units (MU) are identified using 2 criteria: meaning for the informant; impact on the researcher. Each meaning unit allocated a reference code (informant letter code, page number and meaning unit number). • Memos are written alongside MU, and relevant quotations selected (Rennie, 1994)
Coding	• MU organised into topic domains (Hill et al., 2005) All but two topic domains derive from topics and questions contained in the The Change Interview Schedule- (Trainee Version). Ancipicatory Reflections and Context domains constructed from the data. • N of MU in each topic area and N of informants is recorded (Rennie, 1994) • Duplicate MU deleted, similar MU combined - maintaining/expanding meaning. Constant comparison of MU made within and between domains (Rennie, 1994)
Embodied Categorisation	• Categories created from MU using embodied categorisation (Rennie & Fergus, 2006) • Categories ranked, by frequency of MU and number of informants. **General** (All or all but 1 informant and/or more than 60% of MU), **Typical** (more than half of informants at least or 50% of MU) and **Variant** (at least 2 informants but below cut off for typical categories and below) (Hill et al., 2005) • All categories accompanied by MU, number of informants and illustrative verbatim quotes (Rennie, 1994, Smith, 2003).
Narrative Reconstruction	• A narrative reconstruction (IPA) (Smith, 2003), based on general and typical categories (to capture core experience) and informant quotations are used to examine the relationship between categories, domains and core ideas (Smith, 2003).
Core Category For Study	• **A Core Idea** is constructed from **General** categories (Hill et al., 2005).
Audit and Theory	• Data analysis is audited by independent judge (Hill et al., 2005) • Final adjustments made and a theory is written (Rennie, 1994)

Figure 1 A Generic Qualitative Method: of Data Analysis procedure.

The Auditing Process

Each stage of the analysis was audited by one of the researcher's research supervisors who is an experienced qualitative researcher. The auditing process consisted on compiling a file of all data and documents. These included transcripts of interviews, memo's, and detailed accounts of each stage of the analysis. These were sent to my research supervisor in advance of a planned meeting. At this meeting the process of the analysis was discussed and categories and core categories were examined and refined.

The Topic Domains

The topic domains identified for the BTS study were:

- Change

- Helpful Processes

- Unhelpful Processes

- Anticipatory Reflections

- Context

Results

The categories are presented by topic domain. As shown in Figure2 below, the analysis generated 282 meaning units and these resulted in: 7 general categories where six or more informants had contributed data, 3 typical categories where between four and five informants had contributed data and 3 variant categories where two or three informants had contributed data. At the start of training the majority of the meaning units and categories concerned change. This domain contained 100 meaning units and from these, three general categories were produced. In the Helpful Processes domain there were

two general categories and one typical category and a total of 69 meaning units. No

questions in the Change Interview schedule (Trainee Version) relate specifically to

Context so this topic domain emerged from the data. The Context domain reflected the

need for students to explain their current experience of training as it related to their

lives and past experiences. Forty eight meaning units were organised under this topic

and from these, one general and one variant category were identified. Unhelpful

Processes yielded only two typical categories and these were comprised of 34 meaning

units.

The Anticipatory Reflections domain had been identified in the qualitative analysis of

the interviews with Margaret that is described in the next section. This domain was used

on a trial basis at the start of the analysis and was retained because the trainees in the

BTS study also looked ahead to what the training would lead to. This topic domain

produced one general category and this was comprised of 31 meaning units. The

distribution of meaning units (MU) and categories are shown in Figure 2 below.

Figure 2 The Distribution of MU, Informants, Categories & Topic Domains
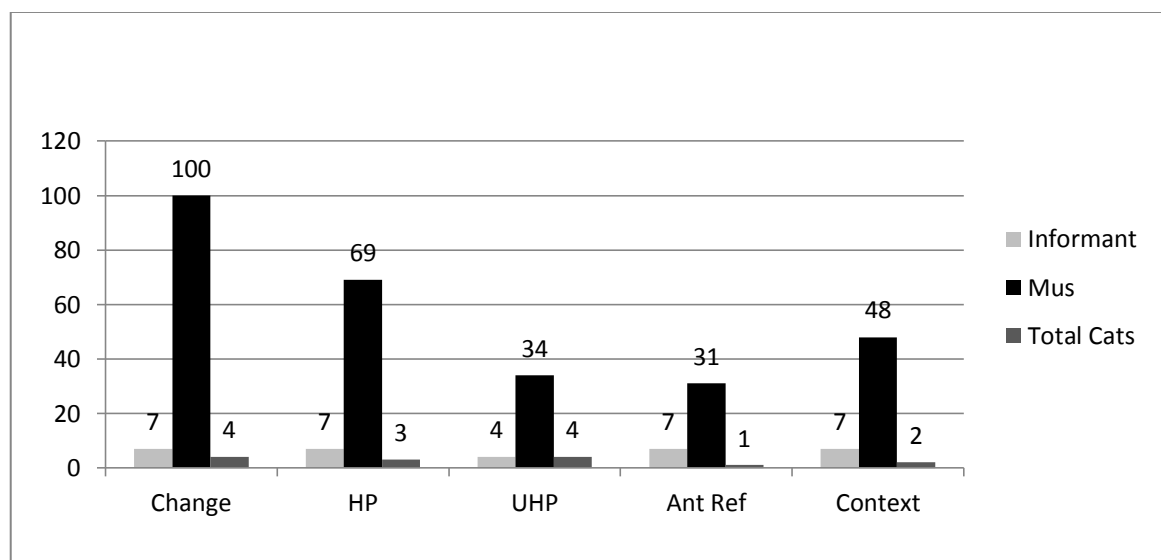
A summary of the findings for this study are given below in Table 13.

Table 13 *Beginning of Training Findings*

TOPIC DOMAIN	ALL CATEGORIES FOR EACH DOMAIN	*N*=INFORMANTS *NO*: MU PER CATEGORY
CHANGE *(N=7 MU=100)*	**General categories:** • Self -discovery: the hope of a 'better' self**.** • Radical reflexivity: capturing the self to prepare for clients • The rise and fall of Self-confidence **Typical categories: 0** **Variant categories: 0**	(N=7, MU=33) (N=7, MU=31) (N=6 , MU=36)
HELPFUL PROCESSES *(N=7, MU =69)*	**General categories:** • Group work: confronting emotional reality: groundwork for future clients. • Skills work: 'walking the walk'. **Typical category:** • Private study: space to make connections **Variant categories:0**	(N=7, MU=37) (N=6, MU=25) (N=4, MU=7)
CONTEXT *(N= 6, MU=48)*	**General categories:** • Precipitating stressful events: being primed for change. **Typical category: 0** **Variant category:** • Relocating to do the course – putting all Your eggs in one basket	(N=7, MU=33) (N=3, MU=15)
UNHELPFUL PROCESSES *(N=4,MU=34)*	**General categories: 0** **Typical Categories:** • Negative Group Work Experiences • Course inequalities: not meeting diverse needs. **Variant categories: 0**	(N=4, MU=20) (N=4, MU=14)
ANTICIPATORY REFLECTIONS *(N=7, MU=31)*	**General category:** • Anticipating practice and finding a way to live a life **Typical categories**: 0 **Variant categories**: 0	(N=7, MU=31)
Core Idea	*Altruistic Reflexivity: self-awareness for the sake of future clients*.	(N=7, MU= 193)

A Narrative Reconstruction

What follows is a narrative reconstruction of the informants experience at the beginning of training by topic domain. To ensure that the experience of the majority of informants is explored this will be based on General and Typical categories i.e. where data was contributed by between 7 and 4 of the informants for each domain. All category names, along with the topic domain, the number of informants who contributed data to that category, and the number of meaning units, is presented in bold type in the text. Quotes from informants will be included with each category. Each quotation is referenced with a meaning unit number and the name of the informant. The informants were given the following pseudonyms: John, Clare, Mandy, Paula, Brian, Derek and Jane. These names were chosen to provide greater anonymity to those informants where the use of a pseudonym that accurately reflected ethnic or racial origin would be likely to reveal their identities given the size of the training cohort.

No verbatim quotes from the interview with Derek are included as this informant withdrew from the study and did not give additional consent for his words to be used in this thesis.

Context, Change and Anticipatory Reflections

The trainees came to training with a mind-set that change was essential if they were to become counsellors and in this sense they were ***primed for change (Context: N=7, MU: 33).*** This is not surprising given that they were hoping to enter a profession that is primarily concerned with change. Therefore, they wanted to learn how to take their existing understanding to another level. They arrived with knowledge of person-centred theory and with the intention of becoming the core philosophy, rather than to just to

learn about it. They started the course therefore, with a pre-existing faith in the course and the model.

> "I think before I was actually thinking person centred but I didn't know what I was doing .. this is how I am" (Paula:5.5).

Therefore, trainees arrived in a state of change having had a recent experience of stressful events that triggered the application process. They were *primed for change* by previous life experiences and prior training.

> "I had a crisis where I got a new boss who was....it was never going to work between us and for the first time in my life I think...yeah for the first time in my life my confidence went" (John: 8.1).

They arrived with skills and experiences that they expected to build upon. Undertaking counsellor training also represented a breaking away from an old way of life e.g. feeling unhappy or confined by professional roles or self and family expectations. Trainees were *anticipating practice but also finding a way to live a life (Anticipatory Reflections: N=7, MU:31).*

> "When I started the course I became impassioned. It was the first time in my life I could think clearly I knew what I wanted to say and I was able to articulate my words and describe things the way I wanted to do it" (Mandy: 4.1a-4.4).

The most significant changes experienced during their first term were to self-awareness and this process was characterised by introspection and the growth of reflexivity. New aspects of the self were constantly evaluated in relation to: other course members; person-centred theory; and future work with clients. What ensued was a painful but

exciting process of *Radical reflexivity*: *capturing the self in relationship (Change: N=7, MU:31).* This self-discovery was driven by the belief that in order to be a counsellor, trainees needed to become better people *Self-discovery: the hope of a 'better' self (Change N=7, MU: 31).*

Group work (Helpful Processes: N=7, MU: 37), became the focus of this process. Attempts to capture an understanding of oneself had a sense of purpose. At this stage of preparation, clients and being a therapist were imagined and the trainees were concerned with becoming what they needed to be for their clients.

> "I think this is a big difference with the emotional kind of factors of it and getting more in touch with my own emotional side so that I can be more empathetic and congruent towards other clients when I'm actually in the therapy session"(Brian:1.2).
>
> "I love the fact that like the more I start to look at different aspects of my personality and the more I interact with other people in the group who are of similar mind and [with] the literature. The more other parts of me start to open up and I get more in touch with myself and....it makes me just become more alive" (Mandy: 4.6).

The informant's hope was accompanied by some uncertainty and self-doubt. *The rise and fall of self-confidence (Change: N=6 MU =36):*

> "It's like 'Jenga' [the game] with the wooden pieces it's like somebody has just pulled the bottom one - [I'm thinking] hold on a minute I thought all these [concepts] were pretty solid" (Jane: 9.2).

Helpful Aspects of Training

The most helpful aspect of the course at the beginning of their training for these informants was: *Group work (Helpful Processes: N=7, MU:37),* which took place in small and large groups. The groups were helpful in that they instigated and facilitated real encounters with the self and with others. What made these groups 'real' was the intellectual and emotional struggle of informants who shared a desire to discover what it meant to be a 'real' person centred counsellor. The groups provided support and encouragement but also demanded change. The course was therefore, experienced as a 'testing' environment i.e. it set standards by which progress was gauged. The central anxiety at this stage was 'Am I good enough?'

> I'm actually asking myself quite a lot of questions because I want to capture it....that's the difference, I think I've got a purpose that I want to capture it, not solely just for my own benefit (John:1.3)

During the first few weeks of the term each trainee was asked to present an account of their personal history in their Personal and Professional Development Groups (PPD). This exercise was helpful in that it began the process of building emotional bonds between trainees but it also provided opportunities for them to practise their counselling skills. These experiences resonated throughout the course. Personal suffering and the struggle to understand its meaning was seen as worthwhile. The personal histories provided living proof of people's ability to change as well as their hope of becoming a therapist. This exercise inspired individual growth and provided a real experience of work with distress and strong emotions that was regarded by informants as good preparation for practice.

> "To say 'how do you want to use this time' to me that's real. It can be frustrating but it's actually real" (John:10.1).

[Its exposing] "certain behaviours that I did when I was a child and I'm sitting thinking 'I've just thrown a tantrum' or 'I just became such a child there' and be able to see it and go 'right well the next time something like that happens I'm going to try a different approach" (Mandy: 5.1) .

"I was shy, they see me battling with it. They know that it's been difficult for me to speak: they appreciate that and they've noticed" (Clare: 4.3).

As important at this stage of training was skills work which took the trainees practise to another level: ***Skills work: 'walking the walk' (Helpful Processes: N = 6, MU:25).*** Through this aspect of the course trainees began to awake to what it meant to be a therapist. Role-play 'clients' were peers who presented them with real difficulties and emotions. Another helpful aspect of this part of the course was the feedback from tutors and peers on the informant's skills and way of being with clients. Through being observed by peers and tutors and at times video recorded, the informants learned more about how to be a therapist. Meaningful feedback i.e. feedback that was accurate and honest both built and undermined therapeutic confidence. At this stage in the training the informant's confidence was fragile. Hard won self-assurance could be lost with one negative comment but could also be restored with praise. The need to do well was fuelled by the fear of failing as a therapist. Skills work therefore brought trainees closer to both the experience of working with real clients but also a step closer to the discovering that they may not succeed.

"I finished the session thinking 'that was terrible', although the tutor was saying some positive things all I heard was the negative watching the video made me feel better I could see it as if it was someone else and not me. I could see what I had done wrong and what I had done right"(Clare: 8.7).

Another helpful aspect of training identified by informants was the sharing of real client experiences by staff and the way tutors modelled the person-centred approach through their interactions with each other and the students. Having staff and students who *'walk the walk'* (John: 9.6) rather than just 'talk the talk' (John: 9.6) created meaningful learning opportunities. Tutor openness encouraged trainee openness. They helped trainees by giving practical guidance regarding placements and practice and built their confidence through making them feel valued and understood. The encouragement and guidance given by tutors was more significant because they were also practitioners.

> "The staff here, are very committed to this as a way of being, and it isn't something that they're teaching [So there] are real life examples of [the approach] in action" (John: 4.6 -5.2).

Outside of the course private study provided the space for some trainees to make connections between themselves and the core theoretical model: ***Private study (Helpful Processes: N=4, MU:7)***. Finding a degree of fit between themselves and the model brought with it some reassurance that they were on the right course. Private study created a space in which learning could be integrated and understood at a personal level.

> I am quite reassured when you read…a lot of stuff… if you read Rogers stuff he didn't work with any rules (Brian:1.7)

Unhelpful Processes

Unhelpful aspects of training were identified by the some of the informants. These were negative group work experiences, in particular feeling overlooked and unsupported by

group members: ***Negative Group Work Experiences (Unhelpful Processes: N=4, MU:20)***, that resulted in emotional retreats from the self and from others.

> "And then there are times when people say something and people just go with their emotions without listening… that was the one of the hardest things" (Paula: 5.1).

Trainees experienced frustration in relation to diversity within the student cohort. The experience of peers, particularly those who did not understand the 'basics' of person centred counsellor training: ***Course inequalities (N=4, MU: 14)*** was a source of frustration for some. There was the expectation that the majority of trainees would enter the course with the same level of understanding. This lack of shared understanding was seen by some informants as holding up group processes and learning. Implicit in this were doubts about tutor judgement – how did these people get selected?

> "[I expected] that there would have been [more of a] level playing field with regards to experience" (John: 1.8).

Only two black people took part in the study and these students were the only informants to raise issues of cultural and racial difference. They felt that the course was not proactive in assisting black trainees in the process of integrating the course philosophy with non-Christian and non-white cultures. One trainee had not spoken of this on the course as they were unsure if this was 'allowed'. The other had attempted to discuss issues of race in the large personal development group but felt verbally attacked by another trainee and unsupported by a staff member. This trainee concluded that such issues were too difficult for her peers to think about.

> "Everybody has an issue you know [having prejudices/ being racist], we just don't bring it up…. it was a good topic to bring up, so I brought it up and I was attacked" (Paula: 6.1).

[My culture is] "slightly alien, sometimes it doesn't seem to fit and I do get the looks of 'what are you talking about, we're all trying to be person centred' … because [my experience] is different ... A lot of person centred counsellors are classed a Buddhists... yet I don't hear anything about that" (Jane;7.1- 8.1).

Three informants who took part in the study had relocated to do the course. All three felt disadvantaged when it came to finding a placement.

"What I'm finding is that this is like a one year course and I'm in an area where I actually don't have a clue about the set-up of agencies, structures...I feel as if I'm kind of like peddling really fast at the moment to catch up on that side where maybe people who have been living here don't" (John: 9.2-9.3).

Anticipatory Reflections

For the informants at the beginning of training placements were regarded as the testing ground for their new role and for developing a professional identity. They were a little fearful that they would not be able to help clients but alongside this, was the desire to be very good at being therapists. They were not expecting it to be easy: ***Anticipating practice and finding a way to live a life (Anticipatory Reflections: N=7, MU:31).***

"I think that would be quite difficult if somebody says your rubbish or you're no use to me or if someone says I've been coming here for ages and I feel no different "(Brian: 8.2).

There was also the hope that growth in self-awareness would continue in particular, there was the belief that greater self-awareness would facilitate clearer communication with clients. There was also the expectation that practice would deepen their understanding of person-centred theory and help them to develop better ways of relating. They wanted to be more congruent with clients and in their personal

relationships. There was the hope that becoming a counsellor would provide them with a better way to live their lives.

> "I want to use what I'm learning to live my life"(Jane: 8.3)

The Core Idea for the beginning of training

The final analysis of the General and Typical categories across all domains produced a core category for the beginning of training study. This was Altruistic Reflexivity. These trainees not only demonstrated Radical Reflexivity, a term coined by Rennie (2006), i.e. the ability to observe their own self-awareness, but they took this a step further in being concerned with self-awareness for the sake of others i.e. future clients. It was characterised by intense self-scrutiny and the informants had the conscious aim of constructing a therapist-self worthy of future clients. Trainees aspired to embody their chosen core philosophy not only to guide their professional practice but as a way for living their lives.

Theoretical Conclusion

The BTS findings indicate that these trainees experienced the beginning of training as a time of intense self-scrutiny. The informants arrived in a state of change and their decision to train had been instigated by stressful events. The trainees in this study experienced introspective change, with a view to becoming a better person and altruistic change: aspiring to embody the course philosophy in order to become worthy to help future clients. These trainees were primarily concerned with change and evaluated their

training on the basis of how far it assisted or hindered change. There were three main drivers for change:

- Trainee motivation: they arrived in a state of change and with the desire for more.
- The prospect of real clients.
- The course as a gateway to practice: a testing environment in which change was evaluated, facilitated and accelerated.

By the end of the first term of training these trainee therapists were optimistic but they also expressed some anxiety about beginning practice. They were keen to get started in order to test themselves, but they also felt ready to help clients. The first few months of training had prepared them for work with clients. The most helpful aspects of the course were: personal development work, and training in counselling skills and the therapeutic process. The developmental groups were helpful in that they instigated personal change and facilitated 'real' emotional encounters between participants. These meetings provided opportunities to increase self-knowledge but also to practice therapeutic skills and observe change processes in others. They found observed role play experiences to be uncomfortable but role play was valued when meaningful feedback was given by tutors who were also experienced therapists. Feed-back and skills practice helped the informants to begin to learn how to be therapists. Some trainees found private study helpful in that it provided the space for them to make connections between themselves and the theory. This in turn supported the process of personal and professional growth.

The most unhelpful aspect of the course identified by the some informants was negative group work experiences, in particular feeling overlooked and unsupported by other group members. Negative experiences also included times when group process was held

back by a lack of shared understanding of the person-centred approach. Some informants who perceived themselves as different or having different needs i.e. ethnic minority or non-local trainees, felt that their needs were not acknowledged or adequately addressed by the course.

However, at the beginning of training these informants were idealistic. They regarded practitioner training as more than a change of career but as the start of a better way of life. They were looking forward to beginning work with clients and recognised this as the point at which they would become therapists.

A Qualitative Investigation into Early Practice: the Case of Margaret[1]

This investigation forms the third part of the Early Effects of Practitioner Training

study. It had two aims: first, to depict the experience of beginning practice from the

perspective of one trainee counsellor and second, to pilot and develop a trainee version

the qualitative instrument: the Change Interview Schedule (Elliott, Slatick, & Urman,

2001).   It set out to answer the following questions:

How do trainee counsellors change? What helps trainee counsellors to change? And the

following subsidiary questions:

- How does professional training impact on early therapist development?

- Which aspects of training influence therapist development? Specifically: a)

  negative influences and b) positive influences.

Design

As shown in the review of the literature in Chapter 2, early practice marks a watershed

in therapists' professional development but few studies have attempted to investigate

the experience of therapists at this important time. This study was the first of the six

studies to be undertaken. The single subject Case study method was chosen not only

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[1] First published in: FOLKES-SKINNER, J., ELLIOTT, R., WHEELER, S., (2010). "*A baptism of fire*: A qualitative investigation of a trainee counsellor's experience at the start of training". *Counselling & Psychotherapy Research,* 10 (2), pp. 83-92.

because it would capture trainee experience but also to provide a context for later studies. As Flyvberg (2006) explains:

> " the case study produces the type of context dependent knowledge that research on learning shows to be necessary to allow people to develop from rule-based beginners to virtuoso experts" (p.221).

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Therefore, it was hoped that it would not only provide an in depth account of one trainee's experience but that it would also provide a way into understanding training from that perspective rather than from that of a tutor. In addition to providing an in-depth account of one student's experience it was also anticipated that through the development of a trainee version of the Change Interview Schedule, it would provide a basis for the two other qualitative studies. At this early stage the overall design of the study had not been decided and so other than basic demographic data Margaret did not complete any of the quantitative measures described at the start of this Chapter.

The aim was to create a collaborative relationship with the informant to enable feedback on the research process. It was also decided that the informant would have a role in commenting on the accuracy of the findings and editorial rights in this respect with regard to any future publications. The study consisted of three, one hour, semi-structured interviews with the researcher during one trainee's first three months of seeing clients.

Informant

Margaret, (not her real name), was a 50 year old woman with a professional business background of fifteen years. She had completed a two year, part-time pre-clinical counselling skills certificate five months earlier and had recently enrolled on a part-time

Diploma in Psychodynamic Counselling at the same university. Margaret's decision to undertake practitioner training had grown out of her experience of personal loss. Margaret's decision to undertake training was prompted by personal experience of bereavement in her late 40's when her parents and her in-laws all died within a short space of time. This had prompted her to undertake voluntary work on a telephone help-line and then to undertake counselling skills training course and then the practitioner training. Margaret was enrolled on a part-time psychodynamic counselling course.

At the time of the study Margaret worked four days per week. She had been in her current work role for over ten years. She had a network of friends and family and had been in a stable and supportive relationship for over twenty years. Margaret had some experience of personal therapy but was not engaged in therapy at the time of the study. Margaret was funding the course herself.

Margaret's supervision took place with two fellow students. The group met weekly during the normal teaching day and was supervised by an experienced psychodynamic therapist who had more than 5 years' experience of supervising trainee counsellors.

Specific Aspects of Informant Consent

Margaret understood that she had the right to withdraw from the study at any time and was encouraged to contact the researcher by email between interviews with any queries or concerns. During the investigation, most email contact involved practical arrangements for interviews. Only one email was received relating to the content of an interview in which Margaret requested that five lines of the transcript be deleted and this was done immediately. Both Margaret's supervisor and her personal tutor were aware of her involvement in the study, (they had no knowledge of the process of the

research or access to the interview data). They were informed to provide additional support to Margaret should it be needed.

Method

Procedures

Informant Selection

The course leaders of a professional counselling course were consulted regarding the study and agreed to help with the recruitment of participants. (The course was offered by the same university department in which the researcher was employed but had no involvement with). All student members (*N*=17) of the cohort were given an information sheet which briefly described the study, during a course business meeting. Any students interested in taking part, and met the given criteria, were asked to add their names and contact details to a list that was circulated. The sampling strategy was primarily driven by convenience as the timescale was short with only two week's between the start of the course and the first interview. Eleven trainees (65%) put their names forward for the study.

The selection criteria were that the informant was: about to begin work with their first client, had no prior experience of working as a counsellor, and had no existing relationship with the researcher. The first person contacted on a list of 11 trainees became the subject of this study. However, although by chance, as shown in the findings of the Cross-Sectional study Margaret could be regarded as a typical trainee given her age, ethnicity and that she was enrolled on a part-time training programme.

Interviews

In order to investigate trainee experience of early practice three, fifty minute qualitative semi-structured interviews were conducted with one trainee therapist at the start of her training, using an adapted version of the Change Interview schedule. Each interview took place during the informants first term, a period of twelve weeks, at three points:

- The beginning– prior to beginning clinical practice (week 3), to explore issues such as preparation for practice and expectations regarding beginning work with clients.

- The middle – early practice experience (week 6), to explore early experiences of working with clients and of formal training and supervision.

- The end - end of first term (week 11), to explore current experience and reflect on the first term of training and identify helpful and unhelpful aspects. All interviews were audio recorded and transcribed.

Prior to the first interview Margaret was emailed an information pack which gave details of the study and the consent process. An interview date and time was agreed for the following week. Margaret was asked to bring a completed participant form with her to the first interview. The form asked for the following information: basic demographic information, details of her previous counselling training and education, past and current work experience, and past or current personal therapy. The first interview took place the day before meeting her first client.

The other two interviews were arranged at times that were mutually convenient. They took place in a teaching room at the University that is situated away from the rooms used by Margaret's course. The consent form and research procedures were discussed and reviewed at each interview.

Data Analysis

The generic qualitative approach described above in the Beginning of Training Study (BTS) was used to analyse the interview transcripts. It differed in one respect. As a single case it was not possible to rank categories by the number of informants so the percentage of meaning units for each domain was used for this purpose. General categories were those with 50-60% of meaning units within a topic domain, Typical categories were those with between 40-49% of the meaning units, and Variant categories had below 40%. However, where the total number of meaning units was below 5 for a domain all categories were treated as variant regardless of the percentage of meaning units they represented within that domain. Core Ideas were not assigned to topic domains as this was a single case consisting of only 3 interviews and there was insufficient data to warrant an additional level of analysis. It should be noted that the frequency of meaning units does not necessarily reflect significance. There were a number of quality checks e.g. auditing and feedback from Margaret on the final categories to ensure that the general categories and core ideas accurately captured her experience. In this case, frequency of meaning units did reflect significance.

As a single case the rank given to each category was determined by the percentage of meaning units. The process of the analysis, final categories and core ideas were audited by my research supervisor in the same way as described in the BTS section above. As described above, from each interview transcript meaning units were extracted, coded and organised under topic domains. The topic domains were entitled:

- Change
- Helpful Processes
- Unhelpful Processes

- Anticipatory Reflections

- Research process

For this study four of the topic domains: Change, Helpful Processes, Research Process and Unhelpful Processes, came from the Change Interview schedule (Trainee Version) and their origin is described in Table 12 above. One domain, Anticipatory Reflections was constructed from the interview data. Meaning Units, codes and categories were developed using the process of embodied categorisation described by Rennie and Fergus (2006). For example in the first interview Margaret described the importance of the support of her tutors and their management of the course. This became coded as 'the holding environment' to capture the emotional meaning of this support which was conveyed in the way that Margaret spoke but also through the empathic engagement of the researcher with the recording of the interview and the text.

Meaning Units and then categories were organised by topic domain. In the third interview, where most of the changes experienced by Margaret could be regarded as negative and unhelpful, the domains under which these codes should be placed was less clear. Initially some Meaning Units and codes were placed in Unhelpful Processes but this was not satisfactory as Margaret had not identified these experiences as unhelpful. The other option would have been to create a new topic domain and organise these meaning units under a 'painful but OK' which related to a question on the Change Interview Schedule but this was also rejected. The transcript and the recording of the third interview were re-examined and these Meaning Units and categories were moved to the Change domain because Margaret had identified these experiences as primarily change related. Thus, just over half of the meaning units and codes for this interview were assigned to the Change domain guided by Margaret's responses to the Change

Interview questions and what was understood by the researcher to be Margaret's experience.

Results

A summary of the findings for this case study are given below in Tables 14, 15 and 16.

Table 14 *Summary of the Findings: Margaret's start of training interview*

Total MU	ALL CATEGORIES FOR EACH DOMAIN	Number & % of MU

Beginning
 	
(MU=53)
	CHANGE (20 MU)
	General:
	   • Loss of certainty
	Typical
	   • Real clients looming – a therapist in waiting
	
	Variant:
	   • **Being put back on track through theory**
	
	HELPFUL PROCESSES (24 MU)
	General:
	   • The prospect of real clients: making it real.
	Typical
	   • Tutor guidance & emotional holding: modelling a way to be.
	Variant
	   • Group discussion bringing insight into practice
	
	UNHELFPUL PROCESSES (6 MU)
	General: 0
	Typical: 0
	Variant
	   • General: Conflicting demands
	   • Split teaching groups
	   • Limited amenities
	   • Didactic teaching
	
	ANTIC. REFL. (2)
	Variant:
	   • Hope that course will meet personal therapy needs
	   • Fear of being undervalued **as a counsellor**
	
	RESEARCH PROCESS (1)
	
	Variant
	• Acknowledgement of personal history
		(10 MU, 50 %)
		
		(8 MU, 40%)
		
		(2 MU, 10% MU)
		
		(12MU, 50%)
		
		(10 MU, 42 %)
		
		(2 MU, 8 %)
		
		(3 MU, 50 %)
		(1MU, 16%)
		(1MU, 16%)
		(1MU, 16%)
		
		(1MU, 50%)
		
		(1MU, 50%)
		
		(1 MU, 100%)

Core Idea	**Becoming something new – finding a way to be with future clients.**	**(40 MU, 75%)**

Table 15 *Summary of the Findings: Margaret's middle interview*

| Total MU	ALL CATEGORIES FOR EACH DOMAIN	Number & % of MU
Middle (MU =41)	**CHANGE (14 MU)** **General** • Growth in potency • A new self-awareness **Typical**: 0 **Variant**: 0	(7MU, 50%) (7MU, 50%)
	HELPFUL PROCESSES (19 MU) **General:** • Experiential learning – (role play) supporting work with clients. **Typical** • Group supervision – validating practice **Variant**: 0	(11 MU, 58%) (8 MU, 42%)
	UNHELFPUL PROCESSES (0 MU) **General**: 0 **Typical**: 0 **Variant**: 0	
	ANTIC. REFL. (8) **General:** • Hoping to be better able to help clients **Variant**: • Will training be worth it? **RESEARCH PROCESS (0)**	(6 MU, 75%) (2 MU, 25%)
Core Idea	Growth in therapeutic confidence through: practice and experiential learning	(33 MU, 80%)

Table 16 *Summary of the Findings: Margaret's final interview*

Total MU	ALL CATEGORIES FOR EACH DOMAIN	Number & % of MU
Middle (MU =41)	**CHANGE (23 MU)** **General** • A 'baptism of fire': emotional pain, self-doubt & disillusionment. **Typical**: 0 **Variant**: 0	(23 MU, 100%)
	HELPFUL PROCESSES (13 MU) **General** • Supportive supervision. **Typical**: 0 **Variant**: 0	(13 MU, 100%)
	UNHELFPUL PROCESSES (1 MU) **Variant** • Too many voices in personal development group **General**: 0 **Typical**: 0	(8 MU, 42%)
	ANTIC. REFL. (4) **Variant**: Fear of failing & wanting to succeed. **General: 0 Typical**: 0	(4 MU, 100%)
Core Idea	**Surviving stressful involvement: supervision puts her pain into perspective.**	**(36 MU, 88%)**

Distribution of meaning units

The first stage of the analysis generated 135 meaning units and these were organised

under five topic domains: Change, Helpful Processes, Unhelpful Processes,

Anticipatory Reflections and The Research Process. Forty-two per cent (57) of the

meaning units concerned Change and 41% (56) related to Helpful Processes. The

remaining 26 meaning units related to: Anticipatory Reflections 10% (14), Unhelpful

Processes 5% (7), and the Research Process 0.7% (1). As a single subject case the

categories could not be organised by number of informants therefore the percentage of

meaning units was used to identify General, Typical and Variant categories. As shown

in Figure 3 below, the majority of the total number of meaning units related to either the

Change or Helpful Processes domains.

Figure 3   The Case of Margaret: the Distribution of Meaning Units
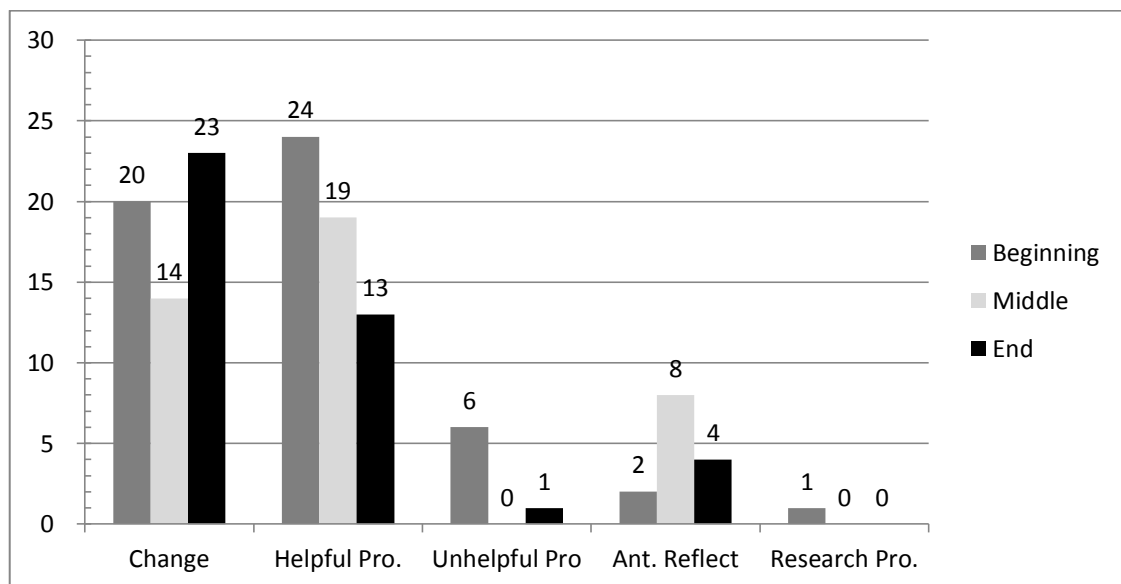
The final stage of generic qualitative method, as described above in the BTS, was to

reconstruct a narrative based on the general and/or typical categories. In the narrative

that follows all category names, along with the topic domain and the number of

meaning units will be referenced in bold type in the text. Each category will be

expanded to form the narrative. Quotes from the informant will be included alongside each category, and every quotation is referenced with the meaning unit number from the original interview transcript. A summary of the categories for each topic domain will be presented at the end of the narrative as described above in the BTS.

Narrative Reconstruction

Interview one: the beginning of training- week 3

"I started the course thinking oh right I've lost the plot here.." (1.4).

For Margaret the early weeks of training were characterized by the loss of certainty in what she had learned during her pre-clinical training, and some anxiety about her ability to do the work of a therapist effectively: *Loss of certainty (Change: MU: 10, 50% of domain),* "I wonder whether I'm actually going to be able to help the clients at the end of the day." (12.1). Despite this, an embryonic therapist-self emerged in response to the prospect of real clients: *Real clients looming (Change: MU: 08, 40% of domain)*.

Margaret found some comfort in her sense of belonging to a particular therapy tradition. This was most clearly demonstrated through the theoretical focus of the course but most importantly, through her supportive relationships with her tutors. They gave Margaret the opportunity to observe the therapeutic approach as it was modeled by them. Margaret found her anxiety and loss of confidence manageable at this stage because she felt supported by the tutors and emotionally contained by the course: *Tutor guidance and emotional holding: modelling a way to be, (Helpful Processes: 10 MU, 40 % of domain).*

 The course was experienced in a holistic, positive way and Margaret began at this time to make connections between her-self and psychodynamic theory through experiential

learning.   "The whole course is being developed in a way to allow us space this term, to prepare for clients." (3.2). Every aspect of the course was experienced by Margaret during these the early weeks of training more intensively because of the prospect of meeting real clients: *The prospect of real clients: making it real*, *(Helpful Processes: 12 MU, 50% of domain)*.

Core Idea for interview one

The core idea for the first interview was identified through further analysis of the general categories for all domains. The core idea for the beginning of training was: Becoming something new – finding a way to be with future clients.

Middle of Term Experience: Interview two - week 6.

At this time Margaret reported a period of rapid growth in potency as a therapist and a new awareness of herself and the therapy process: *Growth in potency (Change: 7 MU, 50% of domain*), "I'm not necessarily doing it but I know what I'm meant to be doing. It feels good to know that I can help," (25.2). There was excitement and relief in beginning work with her first client and this became the focus of her learning on the course. Margaret identified *Experiential learning (role play)* as *supporting* her *work with clients, (Helpful Processes: 11 MU, 58% of domain).* Her growth in therapeutic confidence and her stronger sense of professional identity was influenced by role play exercises. Through these she discovered new ways of experiencing herself, *A new self-awareness (Change: 7 MU, 50% of domain),* and they also provided valuable opportunities for her to reflect on her practice.

"[A role-play client] asked me simply 'what qualifications have you got?' which I suppose is my worst nightmare… I ignored it which was the worst thing for me to do... it gave me the chance to realise that it is something that I've actually got to think about and practise some sort of answer for (3.1-3.3)."

Supervision became more distinct from other aspects of the course at this time. It was helpful in that it provided another arena for experiential learning, validated clinical decisions and provided reassurance to Margaret that she was 'on track' in the early weeks of practice."Supervision is helping me very directly with the client work... for reassurance probably to check out I'd done the right thing. [It] widens my experience, I can learn from other group members." (9.3)

The core idea for the second interview was identified through further analysis of the general categories for all domains. The core idea was: **Growth in therapeutic confidence through: practice, and experiential learning.**

End of term experience: interview three – week 11.

"The client work has been quite painful, that I wasn't expecting, the way the clients impact on you … I'm very able to go on a guilt trip, let's put it that way, so I thought it was me, … I really was quite upset when I got home from work, it's just the sudden realisation that this is what it means to work with a client … what I really do question now is, is that something I'm going to have to cope with always? Or is it something I'm going to get a handle on? I really don't know the answer to that." (1.3)

Margaret's work with a troubled client became extremely stressful towards the end of her first term of practitioner training. Her sense of potency disappeared and was replaced with anxiety, disillusionment and self-blame: *A 'baptism of fire': emotional pain, self-doubt and disillusionment, (Change: 23 MU, 100% of domain).* Margaret was overwhelmed by stressful involvement (Orlinsky & Rønnestad, 2005). This

negatively impacted on her life and left room for little else, including other aspects of the course.

The only helpful aspect of training at this stage of her training was supervision, (*Supportive supervision Helpful Processes: MU 13,100% of domain).* By the end of the first term, the course had become supervision for Margaret, and not only the group supervision that was usually provided, but additional emergency supervision that was offered by her supervisor on an individual basis. Margaret was able to ask for extra help and to tell her supervisor what she was feeling. This was indicative of the trust she had in her and the supportive nature of their relationship. The supervisor helped Margaret to explore her feelings and to understand the impact the client was having on her.

> "I didn't think it was to do with the client, but my supervisor helped me to see that it's probably a mixture of both … she helps to keep me focussed, she put it into perspective for me, which was brilliant." (1.8)

The core idea for the third and final interview was identified through further analysis of the general categories for all domains. The core category was identified as: **Surviving stressful involvement through supervision that puts her pain into perspective.**

Theoretical Conclusion

Core ideas for this study were:

- Becoming something new – finding for a way to be for future clients.
- Growth in therapeutic confidence through: practice and experiential learning
- Surviving stressful involvement: supervision putting her pain into perspective

Each interview revealed different kinds of change. At each stage, different aspects of the training programme were helpful. At the beginning the tutors helped Margaret to prepare for practice through deepening her understanding of the approach. Experiential learning was the most helpful aspect of training during the early weeks of her practice, which was a time of significant professional growth. At the end of the term supervision had the most influence on Margaret as this was helping her to survive the negative impact of stressful involvement with a client. Margaret's work with her first real client was the main driver for change throughout this period.

Piloting a Trainee Version of the Change Interview Schedule

The aim of this study was twofold: to investigate change processes in one trainee, Margaret, at the beginning of her practice and to pilot a trainee version of the Change Interview Schedule. The details of the changes made have been described above in Beginning of Training Qualitative study. The version piloted with Margaret became the version used in all qualitative interviews in this study of how trainee counsellors change.

Margaret's experience?

Margaret was sent copies of the categories for each interview and the narrative re-construction six months after the last interview and asked to comment on the extent to which the analysis fitted her experience. Margaret was asked to highlight any inaccuracies or aspects of the findings which she felt unhappy with, she responded with a short email in which she stated that she had nothing to add or change as she felt the results reflected "my experience." This research was published in 2010 (see Appendix B) and Margaret was sent a number of drafts over the preceding twelve month period

for comment and was happy to go ahead with its publication. It is possible to conclude therefore, that the above findings accurately depict Margaret's experience of both early practice and of Stressful Involvement. It could be said that Margaret would have found it hard to disagree with the findings of this research. However, her agreement did not waiver and over the three years from the interviews to the final publication this did not change when there were many opportunities for her to do so.

Epilogue

At the time of writing i.e. 2011, it is five years since Margaret took part in this study and in this time she has continued to develop as a practitioner and has now accrued over 500 hours of client hours and is still working as a counsellor.

The Early Effects of Practitioner Training:
Summary of findings

A summary of the findings of the three Early Effects studies are presented below. The findings are organised in response to the research questions.

Who undertakes counsellor training?

Majority were female, middle-aged, and white graduates. For a significant proportion (22%) a certificate or an HE diploma was their highest qualification. All trainees had successfully completed preparatory counselling skills training. These trainees began training strongly allied to the core theoretical model of their chosen course. More than half of the trainees had experience of personal therapy but few began training in therapy.

The majority of informants felt well cared for and supported in childhood but they were less positive about aspects of their emotional and psychological care. Most (81%) reported some experience of significant childhood trauma or abuse in childhood. The majority of trainees in the sample and in the single case study, had experience of bereavement, having lost a mother or father or both. At the start of training, trainees reported moderate levels of stress and high levels of life satisfaction. The majority had healthy levels of distress and emotional fluidity.

How does professional training impact on early therapist development?

Trainees experienced change from the outset, felt they were making progress and deepening their understanding of therapy. They reported moderate increases in

therapeutic skill. The BTS findings indicate that these trainees experienced the beginning of training as a time of intense self-scrutiny. The informants' decision to train had been instigated by stressful events. They began training in a state of change. The trainees in this study experienced two types of change at the beginning of training. Introspective, with a view to becoming a better person and altruistic: aspiring to embody the course philosophy in order to become worthy to help future clients. Altruistic Reflexivity was the primary focus i.e. personal development was driven by the desire for professional development.

How do they change?

The findings of the BTS indicate that early training was a time of rapid personal growth and there was no evidence of decline in the informants in this study. However, despite a brief period of personal and professional growth in the first two months of training Margaret's experience of Stressful Involvement with her first client resulted in a significant degree of self-doubt and disillusionment. As a consequence, at the end of her first term of training Margaret was not sure she wanted to be a therapist. These findings indicate that gains made at this early stage are superficial and that trainees are likely to experience fluctuating levels of confidence.

What helps them to change?

The most positive, but moderately positive, influences on early trainee development were: reading books and journals, getting and giving feedback, attending courses, seminars and personal therapy. The most positive influence on early development in the BTS findings was personal development work that took place in groups. These provided opportunities for personal growth and professional development. Skills work

that included detailed feedback to trainees was also helpful at this time. Private study had a positive role in early development. This was not solely an academic activity but through reading about person centred theory trainees found a means of understanding and integrating the learning they had experienced on the course. The prospect of real clients was also key motivating factor for the BTS informants. Margaret found support and guidance from tutors and her supervisor had a very positive influence. Margaret also reported that role play and experiential learning had a positive influence on her development. The opportunity to observe another therapist 'doing it' was also valued. In addition, as with the BTS findings, both the prospect of working with clients and the beginning of her practice were positive influences on her early development.

No negative influences were identified in the Cross-Sectional study. However, in the neutral score for role play, indicates that it had little or no influence on trainee development which differs from the findings presented above for the BTS and Margaret studies. The findings of the BTS identified two negative aspects of early training; negative personal development group work experiences where they felt their needs or experiences were not responded to by other group members and course inequalities. The needs of ethnic minority students in particular were experienced as not being adequately responded to and this resulted in issues such as race becoming a no go area for the students affected. Margaret identified some negative influences but these were more minor and largely practical e.g. teaching room size and didactic aspects of the teaching.

Discussion

The primary aim of this study was to examine how trainee counsellors change at the start of training. These informants were enrolled on courses that reflect a specific sector of practitioner training. These trainees had not only decided to train to be therapists but they had also elected to train at a university and to undertake a BACP accredited course that awarded a postgraduate qualification. In this respect they were enrolled on programmes of study that are not typical of the majority of counsellor training courses in the UK (Aldridge & Pollard, 2005). It is proposed, therefore, that these findings are not only derived from a particular training sector but that this sector reflects legitimate counsellor training in the UK.

Professional organisations, specifically BACP and UKCP, are likely to have a bearing on the future employment of therapists in the NHS and beyond (National Institute for Mental Health in England (NIMHE), 2010). BACP accredited courses represent legitimate, that is the accepted, standard of training for counsellors because trainees are expected to meet both academic and professional standards. In broad terms, legitimate practitioner training is comprised of an academic qualification which leads to professional accreditation as is the case for the only legally regulated counsellors in the UK at present, counselling psychologists (British Psychological Society, 2011). In this respect although the informants in this study were enrolled on courses that may not be typical, they were engaged in training that is consistent with the standards of similar professions. This is why graduates of these courses are likely to take their place alongside regulated psychological professionals in the future ((National Institute for Mental Health in England (NIMHE), 2010).

The characteristics of trainees who participated in the Cross-sectional Investigation (CSI), Beginning Training Qualitative Study (BTS) and the Qualitative Study of Early Practice: Margaret (MCS) are similar to those of the Coldridge and Mickelborough (2003) study. This is the only published study to date that set out to describe the characteristics of trainee counsellors engaged in BACP accredited practitioner training. The authors conclude that, based on their demographic profile of seventy-five trainee counsellors enrolled on four BACP part-time person centred programmes, significant differences exist between trainees who undertake training courses in Higher and Further Education. They found that the two Higher Education (HE) courses were largely comprised of white, professional middle class women whereas the two Further Education (FE) programmes were ethnically more diverse, had a higher proportion of men and more students of a lower social class. The average age of trainees also differed with FE students being younger than those on the HE courses. They state that these differences can largely be explained by the fact that FE courses are cheaper than those offered by universities and are therefore easier to access by people on lower incomes. That a higher proportion of male trainees were enrolled on the FE courses, that is 33% compared to 9% in HE, was not examined. The findings of the CSI, BTS and the case study of Margaret, a white middle-aged female, suggest that these informants are typical of those undertaking BACP accredited practitioner training in HE institutions.

Gender

That nearly ninety per cent of the trainees in this study were white and female was not surprising as the high proportion of female trainees is consistent with that of a number of other British investigations (Coldridge & Mickelborough, 2003; Dexter, 1996;

Watson, 2004; Truell, 2001;Bennetts, 2003; Kumary & Baker, 2008; Moller, Alilovic, & Mundra, 2008).

In Dexter's (1996) investigation, 85% of the 34 informants were women and Moller et al. (2008) describe 83% of their sample as female. Coldridge and Mickelborough (2003) also found the proportion of female trainees to be high with women constituting 90% of the 42 students enrolled on the HE courses they studied. Eighty-seven per cent of the 109 British counselling psychology trainees in Kumary and Baker's (2008) study were female. Only Watson's (2004) qualitative sample had a higher percentage of male informants but they still only accounted for a quarter of the 44 counsellors who participated in the interviews. It should be noted that Watson's study relied on retrospective accounts of training and that a significant proportion of the informants were recruited at conferences and professional meetings where a higher number of male therapists may have been present than is typical of training cohorts. The other studies cited above all concerned trainees who were engaged in training.

It would be possible to conclude that the small proportion of male respondents could be due to their reluctance to participate in research were it not for the fact that counselling and psychotherapy in the UK are female dominated professions. Dalziel (2009) writing on a BACP student webpage describes his experience of being one of the 16% of male members of the organisation and of being one of the few men on his training course. Dalziel, a middle aged, white, (and presumably) heterosexual male, describes how being a trainee counsellor is his first experience of being in a minority. He presents a largely positive picture of his experience of training and is concerned more with the novelty of his situation rather than pre-occupied by disadvantage. His choice of title: Rooster in a Hen House suggests that being a white male in a predominantly female

cohort may offer some advantages. Therefore, being in a minority of white males may provide such trainees with a position of power and influence within both the training cohorts and the profession. However, the experience of minority groups within training cohorts, or for that matter, occupational groups, has rarely been investigated.

> "The lives of men nurses, as men who do "women's work," provide insight into the complexity of gender and the structure of the gender regime in nursing and the broader society" (Evans & Frank, 2003, p.277).

Evans and Frank (2003) propose that female dominated professions, such as nursing, create a number of obstacles to both the recruitment of men to training programmes and to their retention once qualified. In their qualitative study of Canadian male nurses they found that male nurses felt that they were not only regarded as not real men by family and colleagues but that they were perceived as less competent as carers by their patients. Evans and Frank (2003) suggest that men working in female dominated professions may be doubly disadvantaged in that they feel they are regarded as neither 'proper' men, nor as competent as their female colleagues. Khele, Symons, and Wheeler (2008) in their audit of BACP complaints found male members were disproportionately complained against. The authors did not investigate the reasons for this but it may be that, like the male nurses in the Evans and Frank study (2003) male counsellors may be perceived as less able than their female colleagues.

The three white male informants in the BTS did not describe feeling disadvantaged because of their gender. Two of them had re-located to undertake the training and reported feeling discriminated against but this was on the basis of being non-locals rather than because they were men. This may be because were not yet in practice and had not encountered the prejudicial attitudes described by Evans and Frank (2003). The

male nurses who participated in their study were experienced practitioners and so had greater exposure to the prevailing culture in their day to day practice.

However, the two black women in the BTS study, who were at the same stage of their training as the male trainees, were able to identify and describe ways in which race and issues of difference were having a negative impact on their training. Therefore, this may reflect the fact that many white males have little experience of oppression and so may find it hard to recognise it when it occurs or that like Dalziel (2009) they found being in a minority on the basis on their gender was advantageous.

Regardless of the advantages or disadvantages of being a male trainee in a female dominated profession the underrepresentation of men is an area of professional concern. In 2003 the BACP's journal, Counselling and Psychotherapy Research, dedicated an entire issue to this topic. It began with an editorial entitled "Men and therapy are they compatible?" (Wheeler 2003). Wheeler identifies the need for therapists and therapy agencies to question the image they project of the therapy they offer and the ways they currently work with male clients. The implication being that little has been done to address the gender imbalance that exists within counselling and psychotherapy in the UK. The barriers that a largely female profession may pose to male trainees may also create obstacles for male clients. Although professional bodies in the UK require their accredited courses to address issues of difference and diversity systematic training in either cultural or gender competence is not required. One of the reasons for this may be a pervasive culture of gender blindness, particularly in relation to therapy itself.

Owen, Wong, and Rodolfa (2009) challenge the notion that therapy is gender neutral i.e. that gender has little impact on its effectiveness. They found that training in gender competence had a positive impact on therapy outcome and that the gender of the client

was the most influential factor. These findings were based on the therapy outcomes of 93 male and 229 clients seen by 31 psychotherapists. However, these results are at odds with those of other studies e.g. (Lambert, 2007; Okiishi, Lambert, Nielson, & Ogles, 2003) that have found no relationship between gender and outcome.

The challenge for practitioner courses is not only to increase the proportion of male trainees but to develop systematic training in gender competence to meet the needs of a more diverse client population.

Ethnicity and Race

The findings of research into therapist training are mostly derived from the experiences of white women. The psychodynamic course took place in Leicester and this cohort had the highest proportion of ethnic/racial minority students (41%) which was more than double that of the person centred courses that were based in Glasgow. There is agreement that practitioner training programmes need to provide training in working with difference and diversity, including race and ethnicity (Pattison, 2003; Tuckwell, 2002; Watson, 2004; Wheeler, 2006) but, like gender competence, there is little evidence of systematic training on the courses of which the Early Effects Study sample was comprised.

The beginning of training interviews with trainees in the BTS identified some negative experiences of trainees from racial and ethnic minority groups. The two trainees, Paula and Jane felt they lacked professional role models both on their course and in the person-centred literature. They reported difficulties in raising issues that related to race and racism. Paula in particular, felt unsupported and misunderstood when she tried to discuss a racial issue during a large group meeting. This experience resulted in Paula

not participating in group work and, she disclosed in the End of Training Study, that her early withdrawal from these meetings became permanent. Being silenced by silence had an impact on both Paula and Jane i.e. when the topics of race or culture were not openly discussed by white students or staff. This prevented these trainees from raising such issues themselves.

Watson's (2004) qualitative study investigated the training experiences of over forty UK black counsellors of training and concludes that issues of race are largely ignored by course staff and training providers. As with the findings of the BTS study, Watson identified that feeling silenced was a common experience amongst the informants and that retreat from what was perceived as a hostile learning environment was a common strategy. It should be noted that both Jane and Paula regarded this as an aspect of the course that could be improved and it should therefore, be considered in the context of a largely positive experience of training. However, the fact that the researcher is a white female and a lecturer on another professional programme may have prevented these informants from fully exploring this topic. Conversely, that they felt able to break the silence and to talk about this subject to such a person could also be regarded as helpful in as much as the interview provided an opportunity for each of them to be finally heard by a white person rather than feel silenced by one. Watson's (2004) assessment of practitioner training is more critical of the way black trainees are treated.

> "...this research indicates that the presence and ethnicity of black counsellor trainees was ignored, or seen as problematic, in the training environment. Research results show the direct experience of racism at a personal and institutional level is a common component of black counsellors' experience" (Watson, 2004, p.13).

That the researcher, Watson, was a black female therapist may have enabled informants to be more open about their experience. Watson acknowledges that shared assumptions between herself and the informants may have resulted in "high levels of disclosure" (p.118). The white researcher is, according to Watson, inevitably an outsider to black people and therefore unlikely to be trusted with descriptions of racism when they are perceived as not only different but complicit in such abuse. That Paula and Jane felt able to talk about negative experiences at all to a white woman, and that their experience was similar in some respects to Watson's findings suggests that the relationship between race and levels of disclosure may not be so clear cut.

The experience of ethnic and racial minorities within training cohorts and within a predominantly white profession is an area where further research is not just needed but essential. That any trainees from ethnic or racial minorities feel silenced, particularly in an environment which requires openness, not only limits their experience of training but robs those student cohorts of valuable opportunities to develop a deeper understanding of such issues. As Tuckwell (2002) states, white counsellors also need to understand their racial identity. The need for a more diverse range of role models within training and the profession is clear as is the development of research and counselling theory that reflects contemporary British society.

Entry qualifications

As would be expected on a post-graduate programme the majority of students had a first degree or a post graduate qualification. However, the highest qualification of almost a quarter of the informants was below that of a first degree. All trainees had completed some pre-clinical training and most had successfully completed a counselling skills course. Training cohorts, even at HE level, are likely to be comprised of students with a

range of academic abilities. All trainees in this study began training with some proficiency in the use of basic counselling skills and a strong allegiance to a theoretical model but for some this was their highest academic qualification. The certificate and practitioner training courses provide access to higher education for a significant proportion of trainees who have no previous experience of studying at either an undergraduate or postgraduate level. For those students who began training with no more than a certificate in counselling, the work that would be required to meet the required standard is not to be underestimated.

Universities have made a commitment over the past decade to widening access to higher education through continuing education (Osborne, Sandberg, & Tuomi, 2004). This has led to an increase in the proportion of non-traditional students for example, mature students who meet entry requirements through an accreditation of prior learning route (APL). Some of the informants in this investigation fit this trend but most can be said to be traditional students in that they have at least a first degree. Practitioner training at this level largely attracts traditional students with regards to academic achievement but also a significant proportion of non-traditional students who are likely to need considerable support to meet the demands of academic study.

One of the general categories regarding unhelpful aspects of the training in the BTS was that the course was as not able to meet diverse needs, this included the belief that the pace of learning was slowed down by those students who had less understanding of theory or group process than other more knowledgeable trainees. The experience of non-traditional trainees and their impact on group learning processes or staff has not previously been investigated. These findings, which are based on the experience of only small number of trainees, therefore provide a starting point for further research.

Emotional resilience

The findings of the CSI reveal that the majority of the trainees grew up in families where they felt well cared for and supported. Early relationships are likely to be key to the therapist's ability to create warm responsive relationships with clients and build their emotional resourcefulness (Orlinsky, Norcross, Rønnestad , Wiseman, & Botermans, 2005; Orlinsky & Rønnestad , 2005). Bohart (2007) describes the fully functioning person as a product of the individual's creativity, emotional openness and receptivity. These qualities are characteristic of a secure attachment style.

Attachment theory was developed by Mary Ainsworth and John Bowlby during the 1950's and 1960's (Bretherton, 1994). Secure attachment describes a positive relationship between child and care giver which leads to emotional resourcefulness and confidence in adults. Securely attached therapists are likely to create warm supportive relationships with their clients and a secure emotional base to which they can return and ultimately, leave. Fearful attachment styles in therapists are more likely to re-enforce fearful relating in clients and pose problems for therapists with regards to negative counter-transference reactions and separation anxieties.

Diener and Monroe (2011) conducted a meta-analyses of seventeen studies (*N=886)* that had investigated the relationship between therapist attachment style and its impact on the therapeutic alliance. They found that secure attachment styles were associated with stronger therapeutic alliances. Insecure attachment styles were negatively associated with poorer alliances and this was found to be significant (*p=0.001)* and have a medium effect (*r* =0.17).

As discussed in Chapter 2 findings suggest that securely attached trainees are more reflective and able to process complex aspects of their personal therapy than those with an insecure attachment style (Rizq & Target, 2010; Rizq, 2011). Mohr, Gelso, and Hill (2005) also examined the attachment style of trainees and found that a fearful or dismissing style of attachment was positively associated with negative counter-transference reactions to their clients. Skovholt (2005) describes the Cycle of Caring that is central to the work of the therapist. He concludes that therapists need to not only be able to form attachments but that they also need be skilled in separating from them. "The ability to do this over and over again" (p.82), he proposes, defines mastery.

The majority of the informants in the CSI study reported feeling well cared for and supported during childhood. This may mean that they were more likely to have secure attachment styles however, without a specific measure of attachment it is not possible to be sure. For example, anxiously attached children may receive more care and support in terms of time and energy on the part of parents than those who with secure or dismissing attachment styles. Equally, attachment style may change over time. Therefore, childhood attachment behaviour may not be the same in the adult. Vice (2005) concludes, following a meta-analysis of 21 longitudinal studies, that anxious attachment styles in adult clients can become secure. The fact that the majority of the CSI informants reported positive and moderately satisfactory personal relations while influential are also not sufficient evidence of secure attachments. Regardless of what may occur later, the experience of anxious attachment or emotional neglect in childhood will have an impact on the adult therapist.

Wounded healers?

There is some evidence that therapists develop therapeutic skills as children to compensate for deficiencies within their families. Becoming a skilled negotiator and emotional support for adult carers or siblings whilst still a child may be the origin of therapeutic talent, but it is also a source of emotional deprivation and vulnerability in the adult therapist (Guy, 1987; Miller, 1981). Cushway and Tyler (1996) propose that the desire to become a counsellor stems the need to resolve early developmental difficulties. The wounded healer, an archetype to which therapists are often compared, is a product of painful childhood experiences (Jung, 1951). Stone (2008) describes the circle of compassion in helping relationships and proposes that healing is a consequence of the use of such wounds not only for clients but also for helpers. The growth of compassion in response to early trauma is, however, only one of a number of possible outcomes. Trauma does not necessarily result in compassion for others as it can also lead to their abuse (Guy, 1987; Mander, 2004). Therefore, to have suffered is not, on its own, a sufficient indicator of therapist suitability.

Eighty-on per cent of the sample reported that they had experienced some significant trauma or abuse in childhood. Pope and Feldman-Summers (1992) conducted a national survey of 500 US counselling and clinical psychologists and 58% returned completed questionnaires. They found that 69.93% of the female psychologists and 32.85% of the men had experienced physical or sexual abuse. Little and Hamby's (2001) survey of 501 therapists found that 32% had experienced childhood sexual abuse (CSA) but other forms of abuse were not investigated and this may account for the prevalence rate being less than half of that reported by Pope and Feldman-Summers (1992). Beach (2008) studied CSA in US psychologists, and suggests that the rate of CSA in the profession is significantly higher than the average rate of abuse in the general population.

The findings of this small number of studies suggest that the high proportion of trainees who reported significant childhood trauma or abuse in the CSI study is likely to be a reliable figure. However, the only study that investigated both sexual and physical abuse in therapists, Pope and Feldman-Summers (1992) reported a slightly lower incidence rate. The CSI findings are broader as they include significant trauma, abuse or emotional and psychological neglect. This may account for the difference in these results i.e. the question on the DPCCQ-TBF can be more widely interpreted on the part of informants and so responses are likely to include experiences that could not be described in terms of sexual or physical abuse. The severity of the trauma is also not clear as this question focuses on frequency and this is not necessarily the same as severity.

The National Society for the Prevention of Cruelty to Children (NSPCC, 2011) reports that one in four young British adults experience severe childhood abuse. Severe abuse is associated with the development of personality problems and disorders that would make satisfactory relationships harder to achieve in adult life (National Institute for Health and Clinical Excellence, 2011).   Trainees who experience severe levels of abuse in childhood are therefore likely to represent a minority of CSI sample. What may be relevant for the majority of trainees is the significance of the trauma rather than its severity. Trauma may be significant because of the positive events that followed very negative, painful experiences. For example serious illness is traumatic but what can make it significant is the experience of recovery.

The family backgrounds of British trainees have not previously been investigated. The findings of the CSI reveal positive early relationships but also high levels of significant trauma and abuse. The proportion of trainees who reported abuse exceeds those of other

studies of therapists in the US. These findings indicate that therapists experience a range of influential traumatic experiences in childhood. However, the severity of such abuse or the nature of events or experiences was not investigated.

Bereavement

The majority of trainees in the sample had experience of bereavement, having lost a mother or father or both. Margaret's decision to undertake training was prompted by personal experience of bereavement in her late 40's when her parents and her in-laws all died within a short space of time. Seventy-one per cent of the CSI sample had lost at least one parent and fifty-eight per cent had lost both. It is not possible to determine when these bereavements occurred as nearly half of informants who had lost a parent did not provide an answer to this question on the questionnaire. However, given that the mean age for the Cross Sectional Study sample was 41 years it is likely that for some trainees their parent or parents died prematurely.

The decline in research into therapist characteristics over the past thirty years, as identified by Beutler et al. (2004) has meant that little is known about factors influencing their career choice. Only one study has been identified that investigated the impact of early loss on their professional development. Siegel (1998) interviewed eleven US psychologists who had lost a parent in childhood or adolescence. The thematic analysis identified six themes that related to career choice and the impact of bereavement on practice and professional development. The informants each felt that their loss had influenced their decision to become therapists and that their bereavements had helped them to develop the ability to tolerate strong emotions with clients. These findings support the connection between the experience of childhood bereavement and the decision to become therapists but no comparison was made with the experiences of

other professionals who had lost a parent during childhood so it is not clear if this pattern is peculiar to therapists. Why people choose to train to be therapists is a topic area where there are many theories but little empirical research evidence.

Stress and Distress

With regard to mental well-being, the results of the CSI suggest that most trainees had low levels of distress and incongruence, moderate levels of stress and high levels of experiential fluidity and life satisfaction. Two trainees reported levels of distress (3%) above the clinical cut off on the CORE-OM (34) whilst 11 had scores (19%) that placed them in the clinical range on the SI.

That almost three times the number of trainees were in the clinical range on the SI compared to the CORE-OM (34) may reveal "conceptual distinctions of the experience of distress" (Freire et al., 2007, slide 28). That the SI uses concepts and ideas familiar to many of the trainees may mean that it more accurately captured their emotional experience than the CORE-OM (34). If this is the case then these findings indicate that although levels of distress for 97% of sample would not require treatment based on their CORE-OM (34) scores, the SI findings reveal that some twenty-per cent of these trainees had levels of emotional functioning that was unsatisfactory and distressing at the start of training.

The concept of the fully-functioning person (Rogers, 1963), on which the SI is based, is not predicated on the notion of psychological treatment, unlike the CORE-OM (34), but on personal growth. These findings suggest that the SI was able to provide a different perspective on trainee emotional distress in that not all distress indicates the need for

treatment. However, that 80% of informants had low levels of distress and high levels of emotional functioning is further supported by the personal life of the informants.

Trainees also reported that they felt able to express private thoughts and experienced being genuinely cared for quite often, in their private lives. These findings provide an important indicator that informants could make and sustain personal relationships that were satisfying. The informants had low levels of distress and the satisfactory personal relationships and these findings suggest emotional resilience and resourcefulness. On this basis most trainees were likely to have the necessary resources to complete training and to support their development as practitioners.

The early impact of training

Although some research has been conducted on the early stages of training, no studies have attempted to identify its impact on preparing trainees for practice. The few studies that have been conducted have been concerned with early experience of working with clients rather than with preparation for practice (Howard, Inman, & Altman, 2006; Ladany, Walker, Pate-Carolan, & Evans, 2008; Skovholt & Rønnestad, 1992; Skovholt & Rønnestad, 2003). Orlinsky and Rønnestad (2005) suggest that preparation for practice, once trainees have enrolled on practitioner programmes, should be reasonably short and that the development of theoretical and practical knowledge should be developed to provide a foundation for practice. This guidance has largely been extrapolated from their own research which relies upon retrospective accounts of training from experienced practitioners.

Although Orlinsky and Rønnestad have investigated therapist career development this research was never intended to identify mechanisms of change. Change Process

Research has developed a number of methods to both describe the process of change that takes place in psychological therapy and produced models of change that attempt to explain process and outcome (Elliott, 2010). The aim of the BTS study was to investigate change processes at the start of practitioner training.

The theory derived from the findings of the BTS study proposes that these trainees were highly motivated from the outset and began training in a state of change. They experienced the beginning of training as a time of intense self-scrutiny but this was primarily altruistic in that they were motivated to understand themselves in order to able to help clients. The informants were primarily concerned with change and evaluated their training on the basis of how far it assisted or hindered personal change and professional growth. The pace of change was rapid as the informants reported significant gains in respect to their development over a short period of time. Given, that trainees described a period of rapid change these findings will be discussed in relation to the concept of sudden gains and the findings of relevant studies.

Sudden gains that is "large, enduring reductions in symptom intensity from one session to the next" (Stiles et al., 2003, p.14) , was first identified by Tang and DeRubeis (1999a, 1999b) in a series of clinical trials. They propose that sudden gains were most likely to occur early in treatment. Trainee therapists differ from clients in two important respects. First, in undertaking training they are not ostensibly seeking treatment and second, they are unlikely to be experiencing overwhelming levels of distress. However, not all clients that undertake therapy are in a clinical range and some are not necessarily seeking treatment.

Naturalistic studies, such as that recently conducted by Greenfield, Gunthert, and Haaga (2011) often reveal a significant proportion of clients attending for psychotherapy who

are outside of the clinical range. Sudden gains research has largely focussed on clinical populations but this pattern of change may not depend on clients being in therapy. Kelly, Roberts, and Bottonari (2007) observed sixty college students who had been diagnosed with depression over a five week period and found that 60% of them experienced sudden gains. The authors conclude that sudden gains occur outside of therapy and may be preceded by changes in client's self-evaluation processes. This provides some support for Bohart and Tallman's argument that client factors may have a greater impact on therapy outcome than other aspects of treatment (Bohart & Tallman, 1999; Bohart & Tallman, 2010).

The findings of sudden gains research suggest that the pattern of change in clients may occur in fits and starts and be characterised by periods of instability and improvement. This pattern is similar to that of the trainees in the BTS study whose confidence levels fluctuated in response to the development of new understanding and/or self-doubt. This pattern has also been identified as typical of the development of clinical self-confidence (Bischoff & Barton, 2002; Howard et al., 2006) in trainees.

The findings of the case study of Margaret (MCS) also reveal early sudden gains in the first few weeks of training and of practice. Feeling prepared for practice through experiential learning, tutor modelling and support was followed by a period of growth and self-confidence during the middle of her first term. These gains quickly evaporated however, in response to her work with a disturbed client. This case study is the only qualitative investigation of stressful involvement. Margaret described this experience as a "Baptism of Fire" and although, at the time of the study she did not seek personal therapy or other treatment this was a period of significant personal and professional deterioration. The early sudden gains made by Margaret at the beginning of training

may have provided her with some resources but what is more likely is that the experience of early gains made their loss more painful. In her last interview Margaret felt foolish for having believed that she could be a therapist and had doubts about this choice of career.

Negative influences on early development

The CSI study failed to identify any negative influences on early trainee development. However, the neutral scores for role-play were surprising. The questionnaires were completed following an intensive period of counselling skills training. The informants in this study would have much experience of role-playing client-therapist scenarios. Role-play is a key feature of counsellor training at both an introductory level and forms an important part of practitioner training (Hill & Lent, 2006; Palmieri et al., 2007, Ladany, 2007)

The positive and negative aspects of role-play are clearly described in the BTS. Role-play helps to build confidence but it can also undermine it. As these finding show, role play can be very uncomfortable and negative feedback can undermine confidence. Margaret describes the usefulness of role play in confronting her anxieties about practice. The CSI findings are at odds with those of the BTS and the case study of Margaret. The influence of role play, particularly at this stage of the training, where it formed a significant part of the syllabus across all courses, would be expected to be greater. The reasons for this finding are not clear but research evidence regarding the usefulness of role-play in preparing students for practice is needed. In addition research is needed into the extent to which what is learned through role-play is transferred to work with clients.

Conclusion

That the trainees in the BTS and MCS experienced sudden gains or rapid change is further supported by the findings of the CSI study where the informants reported at the end of their first term that they had already experienced much change and no decline. This process of change is one that is likely to occur not only in clinical populations but also in trainees. The extent to which sudden or early sudden gains in trainees are maintained at the end of training or if non-change is a cause of trainee non-completion was not investigated. These findings are significant in that they investigate change processes in trainees prior to beginning practice whereas most investigations have focussed on changes that occur in relation to work with clients.

Contribution to existing knowledge

The findings discussed above contribute to the existing research literature in the following ways. They provide a unique description of the personal characteristics of British trainees enrolled on BACP accredited courses at the start of training. They also show that at the beginning of training, despite or perhaps because of childhood trauma and bereavement as younger adults, the majority of trainees have high levels of emotional resourcefulness and resilience. These results concur with those of a small number of other studies but make an original contribution in that this is one of only two studies have been conducted on a UK trainee population.

Most research studies have been concerned with trainees work with clients. How trainees prepare for practice and which aspects of practitioner training courses are supportive or obstructive has not previously been investigated. These findings therefore, provide a unique insight into change processes and trainee experience at the start of

practitioner training. They suggest that trainees are largely motivated to engage in personal change by their desire to help clients. The early stages of training may be characterised by Altruistic Reflexivity and this has not been previously suggested or explored. This notion is important in that it provides a focus for the design of course modules that intend to prepare trainees for practice but also describe ways to facilitate trainee change.

These results provide a valuable contribution to the literature in that they provide an example of the value of the use of methods and concepts, previously used to investigate change in clients. These studies demonstrate that such methods may be helpful in identifying the process of change in trainees. These findings further support the proposal that early sudden gains occur in non-clinical populations and may be indicative of periods of personal and professional development. But evidence for the value of role-play is more mixed and further research is needed.

The case study of Margaret is the only contemporary account of stressful involvement by a trainee. This study makes a significant contribution to the existing literature in that Margaret's experience not only supports this theory but also re-enforces the importance of trainee therapists both beginning practice with suitable clients and the value of supportive supervision in ameliorating the harmful effects of stressful involvement.

Limitations

The Early Effects studies are based on a UK sample of informants who were engaged in training in a specific sector i.e. HE and BACP accredited courses. The courses studied may not be representative of other UK courses but this sample had many characteristics similar to those of other investigations.

In addition, the attachment styles in trainees were not measured and this would have been helpful in evaluating the impact of childhood and later life experiences on their response to the training. The sample size of the CSI study was not sufficient to test differences between the psychodynamic and person-centred courses and this would have provided a valuable opportunity to identify the extent to which common factors exist across different modalities and course structures.

The qualitative investigation was small, even for a study of this type, but despite this a high degree of saturation was reached. The single subject, qualitative case study is the first of its kind and so it was not possible to compare Margaret's experience with those of similar studies. However, these findings do concur with both the theory and the quantitative findings of Orlinsky and Rønnestad (2005) and so provide some corroboration.

Areas for further research/recommendations

These findings challenge UK practitioner courses to develop systematic training in gender and racial competence to help trainees and trainers to meet the needs of a more diverse client and student populations. There is a need for further research that identifies the barriers that may exist to men undertaking practitioner training and to ethnic minority students fully participating in it.

In addition, there is a need for further research on the extent to which sudden or early sudden gains in trainees are maintained at the end of training and how non-change is a cause of trainee non-completion. Research into the experiences of trainees who fail to complete training is also needed as this has not been investigated. The influence of attachment styles on trainee development and the extent to which these may change

during training is an area for further research. Finally, there is a need to investigate the incidence of early sudden gains in training. If these gains are maintained and how they impact trainees work with clients is also an area for further research.

Chapter 5: The Longitudinal Examination of Trainee Change

The specific methods used in this investigation are described. This is followed by the findings for all three studies and a discussion of these results.

The aim of this study was focus on those aspects of practitioner training that have been neglected in the research literature.   As shown above in Chapter 2 researchers have tended to focus on specific aspects of training but few have examined the personal and professional changes in individual trainees and none have studied changes in training cohorts over the course of training. The Longitudinal Examination of Trainee Change (LETC) set out to address previously neglected areas of practitioner training research.

The term longitudinal refers to the length of time over which the study was conducted i.e. one and two years. However, it is recognised that many longitudinal studies span longer periods of time e.g. life spans and involve many measurements. This study was concerned with the life-span of the training programmes and for the purpose of this study only two measurements were necessary.

The LETC is comprised of three inter-related studies:

- The Longitudinal Quantitative Investigation of Trainee Change (LQT)
- The End of Training Qualitative Study of Trainee change (ETS)
- An assimilation model analysis: the case of Mandy (AMA)

The research questions, methods and results for each study are given below. This will be followed by a discussion of the results at the end of this chapter.

Longitudinal Quantitative Investigation of Trainee Change

Research questions

This study and set out to answer the two main questions i.e. How do trainee counsellors change? What helps trainee counsellors to change? And the following subsidiary questions:

> How does professional training impact on overall therapist development? Specifically: a) therapeutic skill; b) work with clients c) mental well-being d) emotional fluidity and e) professional growth.
>
> Which aspects of training influence therapist development? Specifically: a) negative influences and b) positive influences.

From these questions the following hypotheses were constructed.

Main hypothesis

> If formal training has a positive impact on trainees then by its end they will report higher levels of healing involvement, therapeutic skill, emotional fluidity, professional growth and lower levels of in-session anxiety and distress.

Sub-hypotheses:

i) Levels of congruence are likely to increase during training. Therefore, higher levels of congruence/ fluidity and lower levels of incongruence/rigidity are likely to be characteristic of trainees who complete professional training.

ii)   Trainee counsellors will report lower levels of distress at the end of their training.

iii)   Trainee therapists will have higher levels of healing involvement by the end of training.

iv)   Trainee therapists are likely to report less stress and anxiety in relation to their practice at the end of their training.

v)   Trainees will report an increase in professional growth rather than depletion at the end of their training.

Study design

This study was designed to investigate trainee change through measurements taken at the beginning and end of training. This study is therefore, an example of a "Simple Interrupted Time Series" design (Cook & Campbell, 1979, p.209). One of the problems anticipated at the design stage of the study was the small size of the sample i.e. *n=20*.

Type II error, i.e. false negative or a 'no difference conclusion' (Cook & Campbell, 1979, p.42) is more likely in studies with small samples. Repeated testing on a small sample will also increase the incidence of Type I error i.e. false positive results. The challenge of using quantitative methods to investigate change in one cohort of trainee counsellors was to do so in a way that reliable findings could be obtained.

Training groups tend to be small, as illustrated in the Cross Sectional Study described above, where the student cohorts at the start of training ranged from 16 to 30 students. One solution was to set the alpha level higher than the usual $p = 0.05$ or to abandon statistical tests in favour of Effect Size(ES) calculations which do not depend on sample

size as they measure the magnitude of relationships rather than statistical significance (Cohen,1988).

Effects Sizes are also commonly used in the evaluation of treatments i.e. pre-post designs (Timulak, 2008) and so would be suitable for this study. Cohen (1988) hesitantly defined effect sizes as "small, $d = .2$," "medium, $d = .5$," and "large, $d = .8$", stating that "There is a certain risk inherent in offering conventional operational definitions for those terms for use in power analysis in as diverse a field of inquiry as behavioural science" (p. 25). These are the ES estimates used in this study.

Controlling for Type I and Type II Error

The problem of multiple comparisons is well established and a number of solutions have been developed (Cooke & Campbell, 1979; Drydan 1959; Tukey, 1949). It was anticipated that the increased power of the sample size through the use of paired-samples *t* tests would control for Type II errors therefore steps were taken to control for Type I.

To begin with, the number of tests was limited to those that related to a specific hypothesis. Next, hypotheses were grouped into families i.e. where they shared a topic area (Hochberg & Tamhane, 1987; Tukey, 1949). The alpha level was then adjusted using a Bonferroni correction (Pallant, 2007) i.e. the given alpha level of $p < 0.05$ was divided by the number of pair-wise comparisons for each hypothesis or family of hypotheses.

Method

The Informants

The informants were twenty trainee counsellors who were enrolled on a part-time PGDip person-centred training course. Eighteen were female and two were male. Their average age was 42 and ages ranged from 31 to 55 years. Four trainees (21%) identified themselves as members of an ethnic, cultural or religious minority. Sixty-five per cent (13) were living with a partner and seven (35%) were married.

Procedures

Selection

This student cohort was selected on the basis that they were the only cohort of the three described in the Cross-sectional Investigation (CSI) that returned a sufficient number of completed questionnaires at both the beginning and end of training. The total number of completed forms returned at the end of training was twenty-six and of these 21 were from the part-time person-centred students. This reduced the return rate from 67% at the beginning of training to 28% at its end. This drop was a result of a series of problems relating to the data collection.

It is possible that some questionnaires had been lost in transit i.e. between their completions and being collected by the researcher as only one set of completed questionnaires i.e. from one informant, was returned from the full-time course at the end of training. As for the Leicester course, the researcher was unable to distribute the questionnaires as planned at the end of the final term due to taking compassionate

leave. As a consequence this meant that questionnaires were sent by post, rather than distributed in person, one month after the end of the final term and as a consequence only four informants returned completed forms.

Data Collection

The informants in this study completed questionnaires at the beginning of training, as described in the CSI in Chapter 3 above. They then completed the same questionnaires 20 months later, four weeks before the end of their training programme. The questionnaires were distributed and collected using the same procedures as described in the CSI study.

Instruments

The data for this sample was collected using the same battery of measures described in detail above in the CSI (see Chapter 4). The only exception being that the DPCCQ-TBF was not distributed again as its purpose was primarily to collect demographic data on the informants and this would not have changed.

Data analysis

The nature of the data i.e. interval level scaling, met one of the assumptions for parametric tests. A preliminary analysis revealed that all scores, with the exception of the CORE-OM (34) scores and some of the SI end of training scores, were normally distributed. This meant that a paired samples t test could be computed for the beginning and end of training scores for those data that fulfilled these assumptions.

The total mean CORE-OM scores were positively skewed at both the beginning (Time 1) and end (Time 2) of training i.e. low levels of distress. The SI scores were negatively skewed i.e. high levels of function at the end of training. However, the mean scores for the two subscales for the SI scores were normally distributed at both Time 1 and Time 2. It had always been intended to test these sub-scales rather than the overall mean scores for the SI and so no adjustment was made to the skewed data. This was not an option for the CORE-OM (34) total scores. Two solutions to this problem were considered.

First, the use a logarithmic transformation using SPSS Version 16 to modify the existing CORE-OM (34) scores in the hope of producing a more normal distribution. Second, to use a non-parametric test, in this case the Wilcoxon Signed Rank test, as normally distributed data is not required. The first option was tried but this was unsuccessful as the data were still skewed. Therefore, the Wilcoxon Signed Rank test was used to calculate the differences between the means of the beginning and end of training scores produced from the CORE-OM (34) data.

Effect Size Calculations

Effect size (ES) calculations were computed using an on-line calculator (http://www.cognitiveflexibility.org/effectsize/effectsizecalculator.php) for each paired samples *t* test. Rosenthal and Rosnow (1991) recommend that when calculating the ES in paired *t* -tests that the paired t-test value be used. Dunlop, Cortina, Vaslow, and Burke (1996) disagree. Following their investigation of meta-analytical studies that used matched or repeated study designs they conclude that the most reliable method for matched or repeated measure designs is to calculate the ES using standard deviations. To correct for the dependence that exists between the means in paired or within subject

designs another approach is to use the Morris and De Shon's (2002) equation 8. This calculation includes Time 1 and Time 2 means, the standard deviations and the correlation between the two means. This was the method employed in this study for all ES calculations.

The ES calculation for the Wilcoxon Signed Rank Tests was calculated by dividing the z value by the square root of N i.e. the number of observations. The ES values used were those for *r*. Cohen's (1988) criteria of 0.1 = small effect, 0 .3 = medium effect, 0.5 = large effect were used to evaluate these results.

Results

Demographic Characteristics

The group were typical of those trainees described in the CSI sample. Half had a first degree and one person had a post graduate qualification. The highest qualification held by five of the trainees was a Certificate of Higher Education in Counselling. The remainder had professional qualifications. All informants had completed preparatory counselling skills training prior to undertaking the professional course. Their median scores regarding their family backgrounds were identical to those of the wider sample and these are in the Cross-Sectional study in Chapter 4 above.

Experience of bereavement

Six (30%) of the group had lost both parents. The average age of these students was 41 years (age range 31 to 48). Four (20%) had lost a mother only and two (10%) lost a father, most before they were fifty (age range from 31 to 53). Therefore, 12 (60%) had personal experience of the loss of a close relative.

Personal therapy

Three (15%) of the sample were in therapy at start of training. The DPCCQ-TPF has questions about the influence of personal therapy but does not collect information about frequency. At end of training six informants rated 'getting personal therapy' as highly influential therefore, this may suggest that the number of informants engaged in personal therapy had increased to around 30% (6) of informants in this study by the end of training but this is conjecture.

Life Satisfaction

Table 17 *Changes in Life Satisfaction*

		Enjoyment	Express feelings	Genuinely cared for	Satisfying intimacy	Opportunities to relax	Sense of belonging	Life satisfaction.
N	Valid	18	18	18	18	18	18	18
	Missing	2	2	2	2	2	2	2
Median (BT*)		3.00	4.00	3.50	3.50	3.00	4.00	4.00
Std. Deviation (ET)		1.06	0.94	1.23	1.41	1.18	1.29	0.96
Median (ET**)		4.00	4.00	4.00	4.00	3.00	4.00	4.00
Std. Deviation (ET)		1.05	1.12	1.18	1.07	.97	1.05	.96

BT*=Beginning of training scores   ET** = End of training scores

The only aspect of life satisfaction that changed over the course of the training was the ability of trainees to freely express feelings. Overall life satisfaction was unchanged

with trainees reporting that they felt much satisfaction with their lives. The informants were people they could turn to for emotional support and reported moderate levels of satisfying intimacy. They also had moments of pleasure and these occurred fairly often. They had some opportunities for relaxation and overall, were satisfied with their personal lives quite often.

Life Stress

Table 18 *Changes in Life Stress*

		Hassled by pressures	Feel significant personal conflict	Feel a heavy burden	Worry about money	How stressful is your life
N	Valid	18	18	18	18	18
	Missing	2	2	2	2	2
Median (BT*)		2.50	2.00	2.00	2.00	3.00
Std. Deviation		1.06	1.06	1.29	1.18	1.00
Median (ET*)		2.00	2.00	2.00	2.00	3.00
Std. Deviation		1.37	1.34	1.75	1.54	1.29

BT*=Beginning of training scores   ET** = End of training scores

There was no difference between the median scores for life stress at the beginning and end of training. These findings indicate that occasional levels of stress were typical of trainees at both the beginning and end of training of training. However, the overall scores of life stress were the same at both Time 1 and Time 2.

Distress and emotional functioning

On the two clinical measures, when the mean scores for individual students were investigated, two trainees were in the clinical range on the CORE-OM (34) (1.49 & 1.54) indicating low to moderate levels of distress at the beginning of training. At the end of training no informants were in the clinical range, the highest score was 1.12 and lowest 0.00. The results of the other outcome measure, the SI, identified eleven trainees with scores in the clinical range at the start of training. These ranged from 1.77 – 2.39 indicating moderate levels of emotional rigidity. At the end of training no trainees were in the clinical range on the SI, the highest score was 3.97 and the lowest 2.55.

Practice Patterns

At the end of training twelve (60%) of the trainees had been seeing clients for one year, five (25%) for two years and one person (5%) for three, (two informants did not complete this question). The total number of clients seen by members of this student cohort was 285. On average trainees saw 17 clients during the course of their training. Between them they spent 64 hours per week seeing clients, an average of 4 hours per week.

At its end the trainees were seeing between two and ten clients per week and presenting 1 to 10 clients in weekly supervision. How much time they spent in supervision or how many supervisors they had was not a question that was included on the DPCCQ-TPF. As will be shown, trainees rated supervision as having a very positive influence on their development.

Influences on Development

Table 19 *Positive & Negative influences on Therapist Development*

N=63	Observing therapists (Positive)	Observing. Therapists (Negative)	Getting & giving feedback (Positive)	Getting & giving feedback (Negative)	Practising role play (Positive)	Practising role play (Negative)	Getting personal therapy (Positive)	Getting personal therapy (Negative)	Work with Clients (Pos.)	Work with Clients (Neg.)
n	19	19	19	19	18	18	19	19	19	19
Missing	1	1	1	1	2	2	1	1	1	1
Mean	1.42	.05	1.89	.05	.11	.44	1.58	.00	2.37	.16
Median	2.00	.00	2.00	.00	.00	.00	2.00	.00	3.00	.00
SD	0.84	.23	.94	.23	.32	.86	.122	.00	.89	.37

	Informal case discussion (Positive)	Informal case discussion (Negative)	Reading books or journals (Positive)	Reading books or journals (Negative)	Attending courses or seminars (Positive)	Attending courses or seminars (Negative)	Supervision (Positive)	Supervision (Negative)
n	20	20	19	19	20	20	20	20
Missing	0	0	1	1	0	0	0	0
Mean	1.20	.00	1.95	.05	1.65	.00	2.90	.00
Median	1.00	.00	2.00	0.00	2.00	.00	3.00	.00
S.D.	.834	.000	.911	.229	2.00	.000	.308	.000

The trainees found work with clients and supervision to have a very positive influence on their development. All other aspects had a moderately positive influence. The most positive influence on trainee development at the end of training was supervision which had a mean score that was close to the maximum on this scale. Work with clients was the second highest score indicating that it had a moderately positive influence on development.

The findings for the main part of this investigation, i.e. the paired sample tests, will be presented next.

Table 20 *Summary of paired sample findings*

		Time 1		Time 2		95% CL					
	n	**M**	**SD**	**M**	**SD**	*UL*	*LL*	*T*	*df*	*P*	**ES** *(d)*
Congruence /Fluidity	18	2.98	.489	3.18	.47	-.44	.043	-1.73	17	.101	.49
Incongruence /Rigidity	18	2.73	.590	3.06	.52	-.62	-.036	-2.37	17	.030	.52
Healing Involvement	16	9.02	1.75	10.0	1.30	-1.81	-.096	-2.37	15	.032	.61
Therapeutic Skill	16	3.1	0.83	3.5	0.63	-.741	-.046	2.39	17	.029	.58
In-Session flow	18	1.75	0.49	2.06	0.47	-.563	-.048	-2.50	17	0.023	.59
In-Session Coping	18	2.48	0.59	3.09	0.98	-1.02	-.199	-3.17	15	0.006	.89
In-Session Anxiety	18	.708	.395	.472	.331	.043	.429	2.58	17	0.019	.61
In-Session Avoidant Coping	16	.610	.543	.948	.550	-.610	-.063	-2.62	15	0.019	.65
Professional Growth	18	2.78	.71	3.35	.653	-.868	-.277	-4.09	17	0.001	.97

p= < 0.05   *p=<0.025   **p=<0.0167

Table 21 *Distress in trainees*

Variable	*N*	**M**	*SD*	*M*	*SD*	*p*	*z*	*R*
Distress	20	.603	.432	.556	.346	0.469	-.724	0.1

p= < 0.05

Congruence and Incongruence

Change in levels of trainee congruence and incongruence were measured using the two component scales of the Strathclyde Inventory (SI). These specifically measure congruence i.e. experiential processing, fluidity, and self-acceptance, and incongruence i.e. sense of fear, interpersonal/experiential constriction. Higher scores on both scales indicate greater emotional functioning.

The increase in the beginning and end of training scores for congruence was not statistically significant and the small effect size indicates that training may have a small positive impact on trainee emotional fluidity. The hypothesis also predicted a decrease in emotional rigidity by the end of training but the paired t test calculation was not statistically significant. The medium effect size suggests that training may be moderately related to lower levels of emotional rigidity in trainees. On the basis of the ES this hypothesis is supported.

Levels of distress

The mean scores on the CORE-OM (34) placed most trainees outside the clinical range at both the beginning and end of training (see table 21 above). These scores are well below the average score for a non-clinical population which is 0.81. The Wilcoxon Signed Ranked (Asymptomatic, two tailed test) show that this decrease in the mean score was not statistically significant ($p > 0.05$). The results of the Cohen's r calculation however, indicate that training may have a small positive effect ($r = 0.1$) on levels of trainee distress. On the basis of the ES this hypothesis is supported but the strength of the relationship is slight. The absence of a statistically significant result supports the retention of the null hypothesis. These findings provide some support for the view that training may have a small positive impact on levels of distress in trainees.

Healing Involvement

Healing Involvement (HI) describes the positive therapeutic work experience of therapists. The maximum mean score for *Healing Involvement* is 15. The increase in HI at the end of training was statistically significant ($p < 0.05$) and there was a moderate effect size, ($d = 0.63$). This result indicates that a moderately strong relationship between

practitioner training and healing involvement styles exists. On the basis of these results this hypothesis is supported.

Therapeutic skill

The Current Therapeutic Skill scale is composed of questions that relate to the following topic areas: engaging with clients, authenticity in therapeutic relationships, empathy and effective communication. In-Session Flow is defined thus:

> "The optimum state of involvement is expected when a situational challenge closely matches a person's skills and demands that they be exercised fully, and at times stretched to new levels...this situation (referred to as 'flow') is one of intense absorption" (Orlinsky & Rønnestad, 2005,p.45).

Therapeutic Skill and In-Session Flow

The increases in the mean scores for both Therapeutic Skill and In-Session Flow were not statistically significant ($p > 0.0017$) but the medium effect sizes for Therapeutic Skill ($d= 0.58$) and for In-Session Flow ($d=0.59$) indicate that training may be at least moderately related to growth in therapeutic skill in trainees. On this basis the above hypothesis is moderately supported.

In-Session Coping

This scale measures the coping strategies used by therapists in response to difficulties that occur in their work with clients. The result of the paired samples *t* test was significant ($p^{**}<0.0017$) and ES when calculated was large ($d=0.89$). These findings strongly support the hypothesis that training has an impact on trainee therapists' ability to cope with the practical and emotional demands of practice.

Stressful practice

In-Session Anxiety

The In-Session Anxiety scale on the DPCCQ-TPF describes feelings experienced by therapists such as trapped, anxious or overwhelmed. This hypothesis predicted that In-Session Anxiety would have decreased by the end of training and this was the case. The mean score for In-Session Anxiety was low at both the beginning and end of training with a decrease of 0.23 but this was statistically significant *(p*<0.025).* The moderate effect size of 0.61, alongside this significant result suggests that training is strongly related to a reduction in In-Session Anxiety.

In-Session Avoidant Coping

This particular coping strategy is when therapists cope with difficulties with clients by avoiding therapeutic engagement for example question 3-27 on DPCCQ-TPF 'Simply hope that things will improve eventually'. The mean score for In-Session Avoidant Coping increased by 0.31 and this increase was statistically significant (*p*<0.025).* The medium effect size, alongside this significant result indicates that training has a moderate negative impact on trainee practitioner coping styles i.e. this negative coping strategy increased and this was in the opposite direction to that predicted.   On the basis only that part of the hypothesis is supported as in-session anxiety did increase but in-session avoidant coping which was predicted to decline, rose.

The final sub-hypothesis predicted that trainees would report an increase in professional growth at the end of their training. In order to investigate this, the mean scores for the Career Development scale on the DPCCQ-TPF were calculated. The Career Development scale "reflects therapists' experiences of improvement and decline over

the time since they began to practice their profession" (Orlinsky & Rønnestad 2005, p.163). Both the very significant result ($p=0.001$) of the paired t test and the large Effect Size ($d = 97$) indicate that training has a very strong relationship with professional growth.

Summary

This study of change in one student cohort contained trainees typical of the larger overall sample. Their levels of life satisfaction and life stress had changed little over the course of the training.

The main hypothesis for this investigation predicted that if formal training had a positive impact on trainees then, by the end of training informants would report higher levels of healing involvement, therapeutic skill, emotional fluidity, and professional growth and lower levels of in-session anxiety and distress. Trainees at the end training reported changes in all aspects of their personal and professional development. Half of these variables, when tested, were statistically significant and in the predicted direction. The exception to this was In-Session Avoidant Coping which increased rather than decreased and this was found to be both statistically significant and have a medium ES. The most significant finding was for professional growth which was statistically very significant and had a large ES. These results were almost equal to those for In-session coping with regards to level of significance and the magnitude of the relationship.

With the exception of distress which had a small ES, all other variables had moderate ES's. Taken together they provide moderate support for the main hypothesis but it is not possible to be more conclusive when the non-significant results are taken into account. What is clear is that at the end of training the informants reported very

significant increases in professional growth and felt more confident in managing

anxiety with their clients. They described positive healing relationships in their practice

despite a slight, but significant increase in the use of a negative coping strategy.

The End of Training Qualitative Study
of Trainee Change

This investigation was the second of the three studies which constitute the Longitudinal Examination of Trainee Change. This study set out to answer the two main questions i.e. How do trainee counsellors change? What helps trainee counsellors to change? And the following subsidiary questions:

- Who undertakes counsellor training?

- How does professional training impact on overall therapist development?

- Which aspects of training influence therapist development? Specifically: a) negative influences and b) positive influences.

Design

This study used a qualitative method to investigate changes in a small group of trainee counsellors who were enrolled on the person-centred full-time programme. The original intention had been to interview the same group of students at the beginning and end of training so that the qualitative data could be paired. However, not all informants who participated in the Beginning of Training Qualitative Study (BTS) were able to attend the End of Training Qualitative Study (ETS) interviews, although all were still enrolled on the programme at this time. As a result of this problem the design was changed from a qualitative paired design to two separate studies that provide in depth accounts of informant experience of practitioner training at its beginning and its end.

The aim of this study was to capture the experience of a group of trainee counsellors at the end of their training. This study explored the overall influence of practitioner training on the informants. Specifically, how their particular programme helped them to become therapists. Qualitative methods were used to investigate changes in four individual members of one student cohort. The informants were all enrolled on the same person-centred, full-time programme and were invited to take part in individual interviews towards the end of their final year. The group was part of the larger sample described in the Cross Sectional Investigation.

Informants

This group comprised one white male, one black woman and two white women. Their mean age was 31 years but the range was wide i.e. 24 to 50 years. Each of the informants was working with clients at the time of the interviews and engaged in supervision. They all expected to both complete the programme and to qualify as practitioners.

Method

Procedures

Selection

Six of the seven trainees who had participated in the beginning of training study had agreed at the end of these interviews to take part in the end of training study. They were contacted via email midway through their final term, four months later, and invited to attend an interview with the researcher. Appointments were then arranged by the

researcher and all interviews took place on university premises in a private room. Four of the original BTS group participated in the end of training interviews.

One person, who was given the name of Derek in the BTS interviews, had withdrawn from the study following the interview as he no longer wished to take part in the interviews. The two remaining informants from the BTS were Brian and Jane and they were both unable to attend the dates and times suggested. Both had agreed to attend the appointment times and were then delayed at the last minute. The end of the course is a particularly busy time for students and there are many demands of their time. There were also many opportunities at this stage of the course for trainees to reflect on their experience of their training and perhaps the interviews held little appeal on this basis. Participating in the research interviews may have offered few benefits for trainees at this stage in their training and could have been an additional and unwanted demand at a busy and perhaps difficult time.

Interviews

The interviews took place two weeks before the end of the taught part of the full-time person-centred training programme. The aim of the interviews was to provide participants with a reflective, supportive space that would not only facilitate the collection of qualitative data but would also be of some benefit to those participating. Each interview began with a detailed description of the investigation and the completion of a consent form. Interviews lasted for between 45 and 60 minutes. All interviews were audio recorded and transcribed.

Instruments

The trainees in this study completed the Development of Psychotherapists Common Core Questionnaire-Trainee Background Form (DPCCQ-TBF) form at the beginning of training. The Change Interview -Trainee Version (CI-TV) was used to facilitate semi-structured interviews. This version of the Change Interview schedule is described in detail in Chapter 4 above. No other measures were used and the only equipment employed was a digital voice recorder.

Data analysis

Demographic data from the DPCCQ-TBF were computed using SPSS version 16. The transcripts of each interview were analysed using the same generic qualitative method described in detail above in Chapter 4. Each stage of the qualitative analysis was audited by my research supervisor. This process is described above in the Beginning of Training Study section in Chapter 4.

The informants were given a pseudonym for the BTS and these will be used to present the ETS findings. The topic domains identified during the analysis for this study were the same as those described in BTS findings in Chapter 4 above except for the context domain as no meaning units were identified during the analysis that related to this subject. The domains for the ETS were:

- Change
- Helpful Processes
- Unhelpful Processes
- Anticipatory Reflections

Results

A summary of the results for this study are presented in Table 22 below.

Table 22 *Summary of the ETS findings*

TOPIC DOMAIN Total DOMAIN N=4 & MU (204)	CATEGORIES FOR EACH DOMAIN	*N*=INFORMANTS *No.* MU PER CATEGORY
HELPFUL PROCESSES *(N=4,MU = 75)*	**General categories:** • Supervision: supportive scrutiny • Small group work leading to growth • Appropriate placements: supporting practice • Practice based workshops • Satisfying work with clients **Variant categories** • Group work: -supporting practice -learning about own boundaries - different ways of thinking & feeling • Sharing self-appraisals • Doing relational research. Therapy and research feeding each other • Giving feedback • Importance of supervisor style • Exploratory group supervision/group process	(N=4, MU=23) (N=3, MU =11) (N=3, MU=11) (N=3, MU=07) (N=3, MU=03) (N=1, MU=03) (N=1, MU=02) (N=1, MU=03) (N=1, MU=02) (N=1, MU=02) (N=1, MU=01) (N=1, MU=01) (N=1, MU=06)
UNHELPFUL ASPECTS OF TRAINING *(N=4, MU = 61)*	**General categories:** • Emotionally harmful aspects of training • Inappropriate placements **Typical categories:** • Ineffective, 'fact finding' supervision • Being 'used' in Group work • Limitations of syllabus **Variant categories** • Use of large group being inhibited by more inexperienced people	(N=4 MU=13) (N=3 MU=16) (N=2, MU=12) (N=2, MU=09) (N=2, MU= 08) (N=1, MU=03)
CHANGE *(N=4 MU=52)*	**General categories:** • Increasing clinical self- confidence • Radical personal change **Typical categories:** • Change in attitude to research • More tolerant attitudes **Variant categories** • More tolerant of working with [different] therapists • Improved personal relationships	(N=4, MU=21) (N=4, MU=21) (N=2 , MU=05) (N=2 , MU=03) (N=1 , MU=01) (N=1 , MU =01)

| TOPIC DOMAIN Total DOMAIN	CATEGORIES FOR EACH DOMAIN	*N*=INFORMANTS *NO*: MU PER CATEGORY
ANTICIPATORY REFLECTIONS *(N=4, MU=16)*	**General category:** • Needing further personal & professional development **Typical categories**: NONE **Variant categories**: • Unrealistic expectations? Being person-centred all the time. • Not returning to an old way of life • Unsure of what happens next • Hope to return to former career • Hoping to carry on with placement	(N=4, MU=11) (N=1 , MU =01) (N=1 , MU =01) (N=1 , MU =01) (N=1 , MU =01)
Core Idea	***Growth in Clinical self-confidence, grounded in reality***	(N=4, MU= 100)

The end of training findings

As shown in Figure 4 below, the analysis of the end of training interview transcripts generated 204 meaning units, 10 general categories, 5 typical categories and 14 variant categories. The large number of variant categories and the small number of informants indicates that saturation was not reached. However, the general categories i.e. where three or four informants contributed data, do capture the shared experience of the informants and therefore, although this analysis is likely to be incomplete these results capture important aspects of these trainees experience.

At the end of training the majority of the meaning units and categories concerned Helpful Processes, the first stage of analysis generated 75 meaning units for this topic area and from these, two categories were general and three were typical, (typical categories are where two of the informants had contributed data), were identified. For

the Unhelpful Processes domain, which had the next highest number of meaning units at 61, two general categories, three typical and two variant categories were found.

 The Change domain yielded two general, two typical, and two variant categories from the fifty-two Meaning Units that related to this subject. From the fifteen meaning units organised under Anticipatory Reflections one general and four variant categories were found. The distribution of the meaning units and categories are summarised in Figure 4 below.

Figure 4 Distribution of Meaning Units & Categories (ETS)
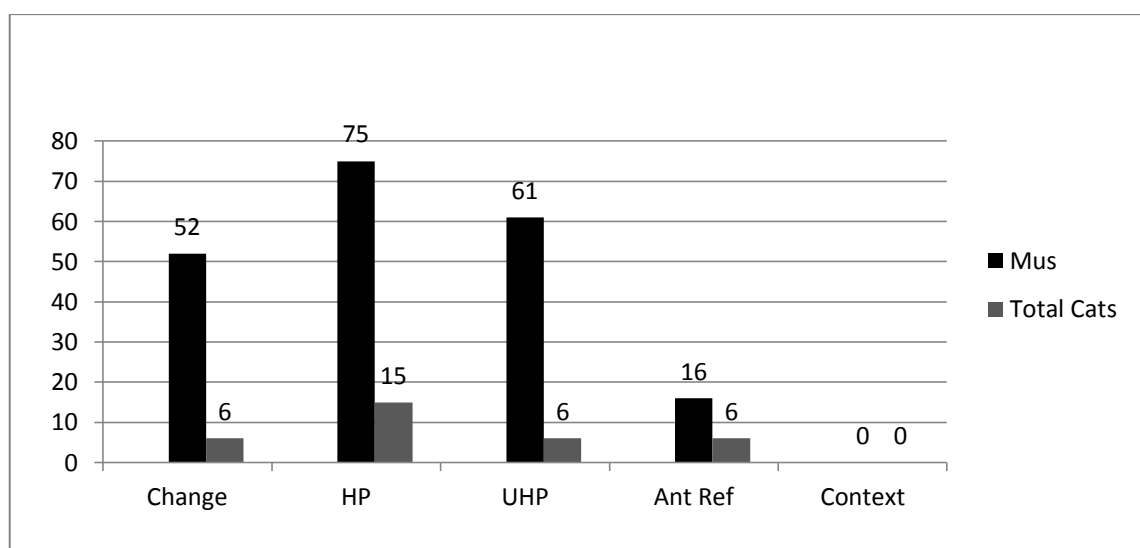
Narrative reconstruction

What follows is a narrative reconstruction of these trainees experience at the end of training. Given the small number of informants it is entirely based on the general categories i.e. where data was contributed by three or four informants. Each category will be included in the narrative and will be accompanied by details of the number of informants who contributed data to that category and the amount of Meaning Units upon which it is based.

Professional Development

One of the most important changes for these trainee counsellors was: *Increasing clinical self- confidence (Change: N4, MU: 21).* By the end of training they had experienced the satisfaction of helping clients to change. This had been achieved by overcoming self-doubt and feeling self-conscious in their work with clients. This had been brought about therefore, through becoming more confident with the therapy process and in themselves as therapists. The process of therapy in this way had become real.

> "I'm much more qualified and I've got a really kind of confident sense of my safeness with clients and definitely feel much more able and....yeah I would call myself a counsellor now without thinking "oh that's a bit weird" (Clare: 7.2).

Satisfying work with clients (Change: N3, MU: 3) was regarded as one of the best aspects of the training. The trainees in this study simply loved working with clients: "I love seeing clients" (Clare: 8.3), "Client work - that I have really enjoyed" (Susan: 10.1), "Client work has been the best thing for me" (John: 9.3).

Supervision was one of the most important aspects of training and was central to the informant's personal and professional development: *Supervision: supportive scrutiny (Helpful Processes: N4 MU: 23).* The trainees experienced different kinds of supervision: individual supervision with an external supervisor they had contracted with and paid for, group supervision that took place on the course, and supervision that was provided by an agency that was either group or individual. Regardless of the context or the format helpful supervision it had a positive impact on their professional development and their practice. The key features of helpful supervision were an open

exploratory style and a supportive relationship. Helpful supervisors were also able to offer honest feedback based on scrutiny of their supervisees' practice. The latter was achieved through the supervisor spending time listening to tapes, watching video recordings of client sessions and reading transcripts of client sessions both during the supervision meetings and outside.

> "I love supervision....like hearing other people's stuff but also other people's theories on what you have done and ideas and the whole dilemmas that come up and things that you think are really simple when the ramifications are thought about you learn different things"
> (John: 4.9).

> "We'd look at our videos, ... it was really good having somebody look at me on video and hear what was going on and give me information about 'yeah that was good the way you zoned in on that' and 'this is good' and just maybe 'say it again so the client really hears it' or 'put emphasis on this word" (Susan: 5.1).

The informants were realistic about their level of professional development. They were clear that they were only at the start of this process and they recognised an on-going need to invest in their: ***Further personal and professional development (Anticipatory Reflections: N4, MU: 11)***.

Appropriate placements: supporting practice (Helpful Processes: N3, MU: 7) took place in agencies that were well prepared for working with trainees. These organisations had clear lines of communication and provided an appropriate level of experience with suitable clients for their trainees. In this way placements provided an appropriate level of support for trainees. Positive placement experiences also created opportunities for trainees to develop professionally.

> "I'm part of the whole service and there's great communication with the whole service and there's regular supervision and, you know, a whole structure really and it's very supportive" (Clare: 10.1).

> "I was only getting clients with panic attacks who wanted quick fixes, and I was pulling my hair out because I wanted them to stay.... So I renegotiated with them" (Paula: 9.2-10.1).

Unhelpful aspects of training

Some negative experiences related to: *Inappropriate Placements (Unhelpful Processes*: **N3, MU: 16**). Placement agencies caused frustration and disappointment in informants when they failed to support trainees adequately. For example, when there was a breakdown in communication, or when they did not provide appropriate or sufficient clients.

> "My hours wouldn't be in the mess that they're in if they had allowed me to advertise the service, which they didn't ... I did not get an opportunity to talk to them at all, you know, they just didn't have time to talk to me, so I eventually stopped asking" (Clare: 8.6 - 8.7).

All informants reported that the training had also had been emotionally painful: *Emotionally harmful aspects of training (Unhelpful Processes: N4, MU: 13)*. They all spoke of witnessing the failure of a fellow student and felt negatively affected by this experience. They had all been involved in giving critical feedback to the same student through peer review, and personal development group work "Looking at him he probably felt crushed – it was distressing giving him the feedback" (Paula:3.2). There were some other examples of over exposure to personal pain and disappointment when the staff team did not provide sufficient protection to the trainees.

> "That so shocked me, that somebody could have been so insensitive to not hearing what had been, to me, blatantly voiced" (John: 3.1).

Personal Development

Radical personal change (Change: N3, MU: 16) was an integral part of the informants professional development. Trainees reported greater self-acceptance and self-awareness at the end of training. They felt that they were more emotionally resourceful and less defensive. Consequently, they were better able to take care of themselves emotionally and were more confident about ensuring that their own needs were met.

The trainees described the value of ***Small group work*** which resulted in ***growth (Helpful Processes: N3, MU: 11).*** These personal development groups were identified as spaces that facilitated work on personal issues at a deeper and more satisfying level than the larger course group meetings. These groups generated a feeling of being part of a common struggle to both succeed on the course and become a more fully-functioning person "I'm one of you" (John 4.4).

> "I think that a lot of stuff that came from the course was good because it ended up me processing stuff about myself" (Susan: 1.2).

> "Fantastic and I fully participated in that and I got a hell of a lot out of the smaller sized group which I think for me worked" (John: 3.4- 3.6).

The teaching groups were a valuable learning space: ***Practice based workshops (Helpful Processes: N3, MU: 7).*** These workshops focused on client problems or ethical dilemmas and provided access to new ways of thinking and resulted in a deeper understanding of different aspects of practice.

> "A couple of workshops have been really good ... opens my awareness in certain ways and in certain aspects and lets me see things differently" (Susan: 14.1).

> "There was a video and then one of the tutors, who is gay... and he came described how difficult it was to 'come out' at the beginning I didn't realise exactly how difficult it was for them" (Paula:16.3).

Core Idea

Based on the general categories the core idea at the end of training was constructed. Central to the experience of practitioner training for these informants therefore was:

Increasing clinical self-confidence, grounded in reality (*N=4, MU= 100*).

Theoretical conclusion

By the end of training these informants felt that they had become therapists. They recognised that they were at the beginning of their professional development and were committed to investing in this beyond the completion of the course. The factors that had brought this about were: work with clients, supervision, and personal change. Each of these elements was helpful when open, exploratory, and supportive conditions were provided by individuals, placements and course structures.

Unhelpful experiences were generally the opposite of these conditions with the exception of the harmful impact of witnessing the failure of a fellow student. By the end of training the informants understood what was required of them as therapists. They were under no illusion about how hard it was to do this work well. They had a real understanding of how satisfying and rewarding being a therapist can be and they were looking forward to becoming members of the profession.

Assimilation Model Analysis: the case of Mandy.

This study is the third and final investigation of the Longitudinal Examination of Trainee Change. In the case study that follows it will be shown that Mandy (not her real name), developed problematic experiences in response to the demands of practitioner training. How these experiences were identified and the extent to which they were assimilated will be described.

This study and set out to answer the two main questions i.e. How do trainee counsellors change? What helps trainee counsellors to change? And the following subsidiary questions:

- How do trainees assimilate different aspects of their training?
- How does professional training impact on overall therapist development?

The aim of this study was to identify change processes in the personal and professional development of one trainee during training. Given that the overall design of the research presented in this thesis is a nested study it should be noted that Mandy participated in every other investigation described in previous chapters the only exception being the single-subject case study of Margaret.

Design

A single case study design was chosen in order to track one trainee's experience of practitioner training. Elliott (2010) states that qualitative research that is used to investigate change processes in therapy is most useful when used, not to test existing theories of how change occurs, but for "developing and modifying rich theory grounded

in data" (p.128). He cites the assimilation model as exemplifying this approach. The assimilation model was developed by William B. Stiles and colleagues (Honos-Webb, & Stiles, 1998; Honos-Webb, Surko, Stiles, & Greenberg, 1999; Stiles, 1997; Stiles, Elliott, Llewelyn, Firth-Cozens, Margison, Shapiro, et al., 1990; Stiles, Meshot, Anderson, & Sloan 1992). It grew out of significant events research (Elliott, 2010) and has been modified through a series of published case studies e.g. Stiles et al. (1992), Honos-Webb et.al (1999), Brinegar, Salvi and Stiles (2008). The theory proposes that in successful therapy problematic experiences are integrated into a client's schema i.e. cognitive representations of the self that influence thoughts feelings and behaviour, and that this leads to a reduction in distress and greater emotional resourcefulness.

The assimilation model primarily draws on the work of Piaget (Dodwell, 1962; Wolff, 1960) and Rogers (1957) and defines a systematic sequence of change in the representation of a problematic experience. A problematic experience is a feeling, idea, memory, impulse, wish or attitude that is threatening to the client. The model proposes that a schema is gradually developed and changed during the therapist-client interaction in successful outcome cases. Experiences are identified as problematic when they lead to emotional distress that disturbs the client's security in what they know, feel or believe. These experiences are problematic because they are incompatible with the client's existing way of thinking, feeling and/or behaving. Such experiences are triggered by a range of events but they are predominantly linked to interpersonal problems.

The assimilation model proposes that these experiences may invoke such a strong reaction in the client that conscious thought becomes impossible. This results in the development of secondary problems such as feelings of anger, anxiety, and despair or

maladaptive behaviours such as avoidance, phobias, over compensation etc. It is these secondary problems that often prompt clients to seek help.

For example in the 'Case of John Jones' (Stiles, et al., 1992) three problematic experiences were identified: fear of homosexuality, dependence and passivity towards a partner and concern about adequacy and work. Over the course of the twenty sessions of psychodynamic therapy these problematic experiences were assimilated by John. The authors describe the process of assimilation as:

> "Much as a river system's tributaries that begin in different places and have different names eventually flow together and become indistinguishable from each other" (Stiles et al., 1992, p.99).

The assimilation model is an approach that changes in the light of new evidence or discoveries. Therefore, it does not aim to generate new theories, as is the case of grounded theory for example, but rather to develop the existing model. Stiles et al. (1991, 1992) proposes that psychological theories and treatments evolve through a process of abduction. This process enables changes to be made to existing theories in order to incorporate new understandings, methods or applications. The assimilation model therefore, provides a method that is in accord with how psychological approaches evolve and uses clinical case study evidence to develop the existing theory.

Stiles (1997) Honos-Webb et al. (1998) reformulated the Assimilation Model to describe the process of assimilation in terms of voices. The self, in this model, is a community of voices. Each voice is seen as the personification of a different facet of an individual's personality. Problematic experiences are expressed through specific voices

and in successful therapy these are assimilated and their assimilation contributes positively to the client's emotional resources (Stiles, 2001).

The assimilation model theory proposes that psychological distress is caused by difficulty in assimilating problematic experiences. It provides both a method for investigating client change, and an evolving theory that explains that process of change (Elliott, 2010). This method was chosen for two reasons: first, to identify the extent to which training provokes problematic experiences in trainees, and second, to track the process of change, as it is described in the assimilation model, in one trainee over the course of practitioner training.

Method

Selection

The information pack that was sent to all students at the start of training as described in Chapter 4 above included a description of a qualitative single case study and a request for participants. Three interested students contacted the researcher by email and interviews were then arranged. As stated above, the intention was to conduct a longitudinal, qualitative single case study.

Semi-structured interviews were conducted by the researcher with three trainee counsellors. Two informants were enrolled on the full-time person-centred programme and one on the part-time person-centred course. Given the time-scale of the study i.e. twice termly interviews over one academic year for the full-time students and 7 interviews over two academic years for the part-time student, more trainees were interviewed than was needed as a precaution. That is, in the hope that there would be at

least one complete set of qualitative data to analyse by the end of the study. In the event no informants withdrew from this investigation but the part-time student interviews could not be used due to problems with the final recording. Attempts to arrange another interview with the informant were made, but she was unable to attend. Of the two remaining students, both of whom had a complete data set, one was chosen as the subject of a single-subject case study investigation for the following reasons. Although both trainees could be described as good outcome cases i.e. both reported that training had a positive impact on their personal and professional development. The informant that was chosen for this study reported the most change. This was evaluated on the basis of the results of the qualitative analysis, using the method described above in Chapter 4, of her BTS and ETS interviews.

The informant

Mandy was a 28 year old white woman, who was living with a partner and had no children. Mandy had recently completed a Master's degree in psychology. At the start of training she allied herself strongly with person-centred and humanistic approaches.

Instruments

Mandy's demographic and background data was collected via the Development of Psychotherapists Common Core Questionnaire – Trainee Background Form (DPCCQ-TBF) which she completed at the start of training as part of the Cross Sectional Investigation described above in Chapter 4. The Change Interview Schedule – Trainee Version (CI-TV) was used in all interviews. The Assimilation of Problematic Experience Scale (APES) (Brinegar et al., 2008) was employed to as a descriptive tool by the researcher and formed the basis for the analysis of each interview.

Assimilation of Problematic Experience Scale (APES)

Published assimilation model case studies to date have only tracked client experiences. The use of APES to investigate change in non-clients has recently been proposed as theoretically possible.

> "The APES also applies to the process of change beyond clinical populations, including normal personality growth, incorporation of new learning, processes of adjustment to life changes"(Osatuke & Stiles, 2010, p.32).

The APES describes eight stages through which problematic experiences are assimilated, (see Table 23 below). Its purpose is to track the "evolution in the smooth and efficient psychological handling of multiple experiences" (Osatuke & Stiles, 2010, p.32). Each numerical value on the instrument is accompanied by a description of the typical behaviour or difficulty experienced by a client at that stage. Movement between lower and upper stages indicates an increase in awareness of the problematic experience and/or greater levels of assimilation. Intermediate ratings indicate that the level of assimilation is between levels. For example, 0.5 indicates a more limited level of awareness than a rating of 1.0 but that it is not completely warded off which would be the case if a score of 0 had been given.

Table 23 *Assimilation of Problematic Experiences Scale (APES) (Stiles, 2011)*

0. Warded off/dissociated. Client is unaware of the problem; the [problematic voice is silent or dissociated. Affect may be minimal, reflecting successful avoidance.

1. Unwanted thoughts/active avoidance. Client prefers not to think about the experience. Problematic voices emerge in response to therapist interventions or external circumstances and are suppressed or avoided. Affect is intensely negative but episodic and unfocused; the connection with the content may be unclear.

2. Vague awareness/emergence. Client is aware of a problematic experience but cannot formulate the problem clearly. Problematic voice emerges into sustained awareness. Affect includes acute psychological pain or panic associated with the problematic material.

3. Problem statement/clarification. Content includes a clear statement of a problem--something that can be worked on. Opposing voices are differentiated and can talk about each other. Affect is negative but manageable, not panicky.

4. Understanding/insight. The problematic experience is formulated and understood in some way. Voices reach an understanding with each other (a meaning bridge). Affect may be mixed, with some unpleasant recognition but also some pleasant surprise.

5. Application/working through. The understanding is used to work on a problem. Voices work together to address problems of living. Affective tone is positive, optimistic.

6. Resourcefulness/problem solution. The formerly problematic experience has become a resource, used for solving problems. Voices can be used flexibly. Affect is positive, satisfied.

7. Integration/mastery. Client automatically generalizes solutions; voices are fully integrated, serving as resources in new situations. Affect is positive or neutral (i.e., this is no longer something to get excited about).

Interviews

Unlike other published assimilation model case studies, interviews with Mandy took place twice each term i.e. around every six weeks. The reasons for this decision were practical but there were other influential factors. The aim of this study was to identify a general pattern of change. Therefore, conducting interviews less frequently was based on the assumption that a trainee counsellor, unlike a client in therapy, would have problematic experiences that were less intense and harder to observe in weekly meetings.

The first interview with Mandy took place at the end of her first term and this was

followed by two further, fifty minute interviews at the beginning and end of each term

until the completion of the taught part of training. The aim was to provide Mandy with

a reflective, supportive space that would not only facilitate the collection of data but that

would also contribute positively to her development as a reflective practitioner and

researcher. Five, fifty minute interviews took place between Mandy and the researcher

at the university where she was a student between December and June of one academic

year. All interviews were audio recorded and then transcribed.

Data Analysis

Data from the DPCCQ-TBF form was analysed using SPSS version 16. The interview

transcripts were analysed using the assimilation model method. The assimilation model

provides a clear set of methods for analysing transcripts along with the APES to

evaluate and identify change processes. The Brinegar et al. (2008) article is identified

by McLeod (2010) as "a valuable example of how to carry out this kind of research"

(p.173). The methods of analysis used in this study were those described in this paper.

The assimilation model analysis of the five interview transcripts comprised four steps.

The first step was Familiarisation and Categorization. The researcher familiarised

herself with the data through reading and re-reading the completed transcripts. All

transcripts were line numbered. This was followed by the compilation of a Catalogue of

Topics. Topics describe distinct thought units and each unit was given a numerical code

that referred to the session in which it occurred and its line number(s) to enable it to be

traced to its place in the interview transcript. The second stage of analysis was the

identification of one dominant, and at least two problematic voices based on the

catalogue of topics, the thought units and the transcripts. Voices were distinguished from each other by using the following criteria:

- content (what the voice talked about)
- intentionality (the voice's apparent motivation for speaking)
- affect (specific emotions associated with the voice)
- triggering characteristics (contextual events that seemed to elicit the expression of the voice)

From this analysis Voice Characterisations were written. These described each of Mandy's voices and their relationship with other voices or aspects of herself. In the third stage of the analysis words and phrases for each voice were identified and representative passages were selected and organised under each voice. In the final stage of the analysis APES ratings were assigned to all passages and these were accompanied by a written rationale for each rating. These ratings were summarised in a table and then compared to the APES to identify the pattern of change.

Mandy's voices

Mandy responded to the demands of training in three different ways, each of which was expressed through a distinct voice. Three of Mandy's voices: Idealistic Learner, Reflexive Learner, and Rejected Little Girl were identified.

Voice Characterisations

Reflective Learner

Mandy's dominant voice was named Reflective Learner. This was the voice of the hard working student and the reflective practitioner. This voice was characterised by intellectual curiosity, empathy and wisdom. Reflective Learner was able to help Mandy

to think about her experiences in a purposeful way. Its primary aim was to make connections between Mandy's current and past experiences and to use these insights to deepen her understanding of herself, other students, the course and her clients. Reflective Learner was compassionate to others and worked hard to offer relationships that were unconditional and accepting. This voice also hoped that such relationships would exist for Mandy and believed that this was what she truly deserved. It was also committed to understanding other voices in the community. This is who Mandy was most of the time. Reflective Learner typically spoke with a reasonable and mature tone of voice as the topics presented had been emotionally processed.

Idealistic Learner

Idealistic Learner was identified as a problematic voice in that it perpetuated ways of coping that Mandy, through her Reflective Learner voice, had identified as unhelpful. Idealistic Learner represented an idealised self. This voice had high expectations of others and was easy to disappoint. Idealistic Learner's primary purpose in her community of voices was to hide Mandy's painful memories of childhood bullying and exclusion. It enabled her to maintain an emotional distance that both protected her from being hurt and justified her retreat. Idealistic Learner also expressed Mandy's positive desire to make the world a better place. Idealistic Learner's tone of voice was sometimes angry or irritated, but also hopeful.

Rejected Little Girl

Rejected Little Girl was a problematic voice because of its belief that emotional intimacy would inevitably lead to hurt, humiliation and rejection. This voice created problems for Mandy as a trainee therapist on a course that required emotional openness and in a professional role where self-knowledge was essential. Rejected Little Girl's

tone of voice was that of a child trying to be brave and to not show her feelings, but who feels deeply wounded and was always sad.

Independent Reviewers

The characterisation of voices and the assimilation stage ratings were reviewed by two other researchers who had no other involvement in this study. The first reviewer was a white female doctoral student who was also an experienced psychodynamic therapist and who was not familiar with the assimilation model. The second reviewer was a white male, an experienced humanistic psychologist and academic with extensive knowledge of assimilation research and a lecturer at the same university where Mandy was a student. The reviewers were sent a document that contained the voice characterisations and excerpts from transcripts for the dominant and each problematic voice from all interviews. The researcher's APES ratings were not included. They were asked to judge the accuracy of the voice descriptions and rate all quotations using APES.

The voice characterisations were regarded by both reviewers as consistent with the interview excerpts they had been given. They each suggested changes to the name given to the same problematic voice and so in response to this suggestion it was changed from True Believer to Idealistic Learner. Changes to this voice were also made in response to the suggestion that Idealistic Fighter, initially identified as a non-problematic voice, become part of Idealistic Learner. A re-examination of the text by the researcher confirmed that this was where this voice belonged. Bringing together Idealistic Fighter and True Believer therefore, created Idealistic Learner which was a more accurate description of this problematic voice.

The APES ratings awarded by the reviewers for the first three interviews were similar to those of the researcher. Ratings for the Rejected Little Girl voice were lower than those of the researcher for the final two interviews. On reflection, this may have been due to the researcher's emotional involvement in the interviews which led to an over emphasis of the changes that occurred. Assimilation model studies are generally conducted on cases not carried out by the researchers and so having interviewed Mandy was a disadvantage in this respect. Finally, all APES ratings were reviewed and adjusted in line with the feedback from the reviewers.

Results

It will be shown that by the end of training Mandy was able to achieve insight and was beginning to assimilate the problematic voices of *Idealistic Learner* and *Rejected Little Girl into her community of voices.* For Mandy, practitioner training resulted in greater self-awareness and emotional resourcefulness.

Family background, current life stress and satisfaction of informant

Table 24 *Family background, life stress and satisfaction*

Felt cared for and supported	Experienced trauma or abuse	Family functioning	How satisfying is your life	Current life stress
4.00	1.00	3.00	4.00	3.00

Mandy's answers to the questions included in Table 24 above, which come from the DPCCQ-TBF and used the scale from: **0** = Not at all to 5 = Very much. The above

findings indicate that she grew up in a family in which she felt genuinely cared for and supported. Mandy described her family as functioning moderately well psychologically and emotionally but she had also experienced a small amount of trauma and/or abuse. Mandy described her life at the start of training as highly satisfying and that she was experiencing moderate levels of stress. These scores were the same as those, in most respects, as the wider sample of trainees who participated in the above studies.

Mandy was enrolled on the full-time person-centred counsellor training programme. Following the first six weeks of intensive skills and theory training Mandy then spent two days in placement agencies and three days attending seminars, workshops, encounter style personal and professional development groups, course meetings, and case study groups. Students were also required to attend a three day residential course. The course was taught by a staff team who were also practicing person-centred and humanistic therapists. They provided informal tutorial support to individual students as needed. Students were required to: attend and fully participate in the course, complete written assignments, maintain an on-going practice placement, attain 120 hours or more of client experience, submit audio tapes of client work and complete a self-appraisal process with peers and tutors. Following the first interview Mandy began her counselling placements. One was at a university counselling and psychotherapy service and the other was in a G.P. surgery.

Supervision of client work took place outside of the course with supervisors who had been recommended by the training programme, the cost of which was met by each individual trainee. Clients were also discussed with fellow students and course staff as part of case study group meetings and with her mentors who supported her work with clients at her university placement.

The Process of Assimilation

Mandy's ability to assimilate conceptual knowledge, skills and self-knowledge occurred in response to the external demands of personal development work, supervision and work with clients. It is proposed that this process of change was impeded by problematic emotional experiences that occurred in response to those demands. At the beginning of training Mandy's instinct was to avoid exposing Rejected Little Girl, a problematic experience from her childhood, at all costs. Her problematic voice of Idealistic Learner emerged in response to the emotional demands of training and to Mandy's longstanding difficulties in trusting others. This voice represented Mandy's habitual response which was to isolate her-self. Ultimately, Mandy was able to change her normal way of coping with painful emotions and of relating to others through the assimilation of her problematic voices. As will be shown, through this process she became a more resourceful and reflective practitioner.

What follows are the results of this study. A summary of each interview topics will be given and then excerpts of the transcripts which relate to each voice will be presented alongside the APES ratings that were assigned. The Findings for each interview are summarised in the Table 25 below.

Table 25 *Summary of Mandy's Assimilation Ratings*

Interview Number & Month	Voices Identified	Degree of Assimilation	APES Rating
Interview 1 (December)	Idealistic Learner	Problematic - Warded off /Vague	1.5
	Rejected Little Girl	Problematic (Mostly Silent) Warded off	0.5
Interview Two (February)	Idealistic Learner	Problematic – active avoidance	2
	Rejected Little Girl	Problematic (Silent) Warded off	0
Interview Three (March)	Idealistic Learner	Problematic –Vague awareness & some problem clarification	2
	Rejected Little Girl	Problematic - painful awareness and problem statement.	2.5
Interview Four (May)	Idealistic Learner	Problematic – working through	4.5
	Rejected Little Girl	Problematic - resourcefulness	3.5
Interview Five (June)	Idealistic Learner	Problematic – working through more resourceful	5.5
	Rejected Little Girl	Problematic - Insight, some working through, optimistic	4.5

Interview One

At the time of the first interview Mandy was not working with clients but had just

completed six weeks of full-time preparatory training.

Reflective Learner

> "It was like for the first time in my life my head cleared and I could
> actually think clearly and concisely and I knew what I wanted to say"
> (Lines: 146-148).

In the first interview Mandy's voices were clearly distinguishable. Reflective Learner

was evident throughout and the above passage is typical of this voice. It begins with a

statement which looks at current experience in the light of past events and this leads to a

conclusion from which insight is gained.

Problematic Voices

> "One of the tutors [gave a client example]... And I felt [what she did] it
> was wrong because I felt that the whole purpose of [being] person
> centred is to....to empower the person to be able to do it for themselves
> and to realise that they have their own resources" (Lines: 638-644).

This statement is typical of Mandy's Idealistic Learner voice in that it makes a

judgement of another person who fails to adhere to the way something 'should' be done.

This voice not only expressed what Mandy believed but also prompted her to stand up

for others.

> "And I was just holding everything inside me... So I said to him 'well
> you can but you have to take other people into consideration!" (Lines:
> 294-299).

The above quote was typical of Idealistic Learner. Mandy was conscious of the impact

her decision to stand up for herself. Mandy also wanted to protect her fellow students

but this had the effect of setting her apart from them. There was little communication

between voices at this stage and the tone was irritated and disappointed. For this reason

an APES rating of 1.5 was given.

Rejected Little Girl

Rejected Little Girl was mostly silent in the first interview and this was an indication that this voice had been warded off. There was only one example in the first interview of this voice speaking to express anger which resulted in embarrassment.

> "When he stood up I felt so disempowered … and the whole group just
> kind of looked at me and I thought "oops" and my face was really red"
> (Lines: 299-302)

Mandy had some vague awareness of this voice's existence. For this reason this voice was rated at 0.5

Interview Two

By February Mandy had started both of her practice placements and had been working with her first clients for six weeks.

Reflective Learner

> "It's interesting because I found quite a lot of parallels with clients and
> with the stages that I'm going through as well" (Lines: 149-151).

During this interview Mandy's voices came together and began to express their feelings about training and the impact it was having on her emotionally and professional development. Mandy recognised some parallels between her experiences and those of her clients and wondered if there was a connection. In this way Mandy was working through the problem and gaining some insight. The problem, at this stage, was something that was a consequence of the course i.e. it was provoked by the training. This is clearly expressed through her problematic voices.

Problematic Voice – Idealistic Learner

> "I suppose it's kind of like the 'self-actualising tendency'....the tutor was taking control when they were being directive" (Lines: 277-279)

In this passage Mandy described how she would have run the workshop session and how disappointed she was with the tutor took control rather than allowing the students more space for self-actualisation. This may have been a reasonable observation but more importantly, Idealistic Learner succeeded in isolating Mandy. This gave Mandy grounds to not participate fully in the workshop. In this interview this voice spoke in a reasonable tone and Mandy was able to acknowledge some value in allowing a less structured space and she links this to theory i.e. the value of the self-actualising tendency. This indicated that this voice was becoming a little more assimilated into Reflective Learner than in the first interview and so it was given an APES rating of 2 because Mandy had some vague awareness of problem but could not formulate it properly. Rejected Little Girl was silent and so was assigned an APES rating of 0.

Interview Three

At this stage Mandy's dominant voice, Reflective Learner focused on the changes that were occurring in her-self and in her work as a therapist. In the following passage Mandy demonstrates her ability to reflect on difficult feelings and to work on these. Mandy had some insight at this stage of her training and was beginning to work through feelings of self- doubt. Mandy was also able to use the help and support that was offered by her supervisor.

> "I brought in the tapes to let my supervisor listen to it I was really apprehensive about it, …I was feeling quite vulnerable, and that she was quite....I suppose caring with how she did it.... It was constructive, yeah definitely, which allowed me to be more positive about how I look at it" (Lines: 781-793).

Reflective Learner revealed Mandy's ability to acknowledge her vulnerability, that she needed help and constructive feedback from her supervisor. In this interview Mandy had some insight into this process and this problem was being worked through.

Idealistic Learner

Mandy's problematic voice Idealistic Learner was less in evidence than in the preceding interviews and was largely kept out of awareness. In relation to one topic, the course residential, it was very vocal. Mandy had decided not stay overnight and to only attend the formal sessions in the day. This event had mobilised Idealistic Learner into action in providing reasons why Mandy should set herself apart from her peers and the course.

> "I never really liked alcohol. So when they were speaking about the residential it was very much 'After we have dinner we'll all go and get drunk' and whatever else…I didn't really want to be around that. So I knew that if I stayed at the residential I would end up just going to bed earlier or going to my room" (Lines: 171-191).

In the above passage Idealistic Learner provided a rationale for going home at the end of each day and for keeping her distance. There was awareness of what the problem was but also a warding off of painful emotions. Mandy had only a vague level of awareness of these but is beginning to think about the problem. The APES rating given at this stage, for this voice was 2.

Rejected Little Girl

"I felt that I wasn't like really loved by my mother, ...I was not like a little girl who was just having fun, I think I always kind of lived in a fear, I was always waiting to get in trouble or I was always waiting to be told that I had done something wrong. And I think that by becoming more aware of this and really realising this that that vulnerable girl came out and she was like really, really timid and fragile and afraid, and it was like all she wanted was to be accepted. And I think for her to come out on the course, which she hasn't yet , would be absolutely awful if she was met with the same conditions that she had experienced when she was at home" (Lines: 342- 347).

Meaning Bridge with Reflective Learner

"And I kind of think from that point of view that the course really needs to be more kind of compassionate and more unconditional and more holding" (Lines: 347-352).

A meaning bridge, as described in Stage 4 of the assimilation process (see Table 25 above). This is when voices begin to reach an understanding of each other. In this interview Mandy realises that Idealistic Learner was being used to hide Rejected Little Girl. This voice gave her a legitimate reason to stay in the shadows i.e. the course was not compassionate enough. Idealistic Learner vents the anger and hurt she feels but also rejects others in the way that she had been rejected in the past i.e. they are not good enough.

Mandy was able to recognise her vulnerability and connect with painful emotions. Mandy then describes the conditions under which Rejected Little Girl could be revealed on the course. The above passages signal the creation of a meaning bridge between

Rejected Little Girl and Reflective Learner. Therefore, Rejected Little Girl was assigned an APES rating of 4.

At this stage, Mandy's voices were working together to address the problems of training and living. In particular: how Mandy related to others, her decision to not 'join in' and her struggle with revealing her emotional vulnerability. Mandy's voices were working together to understand her experience. An example of this is given below. These passages relate to the reaction of Mandy's peers to her decision to not stay overnight at the course residential. Each voice is labelled and presented in different font styles to make them distinct.

> (Reflective Learner) "I've kind of realised that it was the relationships with other people that were threatening because I was actually re-learning how to engage with people, (Rejected Little Girl) and I think that that was what was scary because I was so vulnerable and I was trying to figure out a way that would make me feel OK of relating to people, at the same time hearing back what they thought of me and being poked, about in certain ways" (Lines: 5-12).

> "I could sense that people were quite angry with me and I got this feeling of being excluded from the group. (Idealistic Learner) and we did self-appraisals recently and people had said how angry they were at me they had actually said it, and I kind of thought 'well nobody really took the time to say ...how come you don't want to go on it' ... and now they're still not asking me but they're telling me how they felt. (Reflective Learner) And it was good because then I was able to say why I didn't want to go on it was the fact that I had realised myself that all I ever did was blend in with a group, all I ever did was do what the group wanted me to" (Lines: 27-35).

> "[They said that] I missed out on that valuable experience and I was like (Idealistic Learner) 'but you don't know what I have experienced' and 'what I experienced from it was far more fulfilling for me', [but] (Reflective Learner) now I feel that if someone says 'let's go on a residential next week' that I could go on it because I could say 'OK well let's do it as a group'" (Lines: 45-49)

Mandy was able to express her feelings and describe the problem, she wanted her fellow

students to try and understand the reasons for her decision, but she was also resentful

about having to blend in with the group. Not staying over on the residential is presented

as an attempt at assert her autonomy but she also felt rejected and unwanted.

At this time Mandy was able to draw on Rejected Little Girl as resource in her work

with clients.

> "I was working with a client ... I had got kind of insight into it and
> recognised stuff and I could see that she was still just starting to explore
> it. And it was like I had finished the race and kept shouting at her to run
> faster. And I saw....I wasn't sitting with her where she was ... I brought
> this into the [supervision] session and we had listened to it was just such
> a shock, and it was great to be able to listen to" (Lines: 564-575).

Mandy's new understanding of herself was also having an impact on her personal

relationship with her partner.

> "And it was actually the bits that I was trying to block out were the bits
> that he wanted to see. ...if possible he loves me even more because of
> it..... being accepted for that was probably the most significant thing in
> all the changes" (Lines: 743-746).

In this interview Mandy's voices began to work together and there is greater insight into

her understanding of herself, her relationships with others and her work with clients.

Mandy had greater awareness of her problematic voices. Idealistic Learner

demonstrated insight and working through and as consequence, Rejected Little Girl was

more in evidence. Although this caused Mandy some distress, she was beginning to

experience the benefits of expressing rather than hiding her vulnerability and was

becoming more resourceful as a therapist.

Interview Five

The final interview took place two weeks before the end of the course which was one month after the previous interview. The voices were more assimilated. The APES ratings are included in the passages below to show the degree to which problematic voice had been assimilated at the end of training. Voices at times merge but are largely still distinct.

> "(Rejected Little Girl/Reflective Learner) The group as well helped me realise that in the fact that when the going got tough I withdrew from the group **[APES 4, Insight]**. (Rejected Little Girl) And because we were constantly meeting up all the time and was in your face the whole time, it was like sometimes I just couldn't do that, sometimes I was so upset that I didn't have an opportunity or the chance to just leave **[APES 1, Warding off]**. (Idealistic Learner) And then I remember that I'm thinking 'oh yeah well they didn't handle it very well' or 'they didn't really hold me very well' or whatever **[APES2, Vague awareness]**. (Reflective Learner) And then I think it was just because that was the anger that was all coming out, and when I looked back on it I thought 'well actually they did' **[APES 4, Insight]**. (Rejected Little Girl) I didn't want them to, I didn't want to see them doing it because it was just not acceptable for me at the time, I just wanted them to be mean or to react or something **[APES1, warded off]**. And I think because the times that I did cry... each time I was met with that kind of love and care and acceptance, it just made me change. It allowed me to feel freer, it allowed that vulnerable little girl to come out more and to find comfortable ground, [somewhere] that she doesn't have to hide **[APES4, Insight]**" (Lines: 630-643).

At the end of training Mandy reported that she was more accepting of herself and that she had better relationships with others:

> "I think the biggest thing is actually finding love in myself...I didn't realise the amount of pain that I just caused myself just because I didn't think that I deserved happiness... I was so closed off and shut down and to just think that I could be a person that has so much love inside for myself and for others was just fantastic" (Lines: 586-93).

In the last interview there was also evidence Mandy's conscious use of Idealistic Learner to stand up for her clients rights.

"[The Doctor said to my client] 'You know there's a waiting list for... there are a lot of other people who need it' and the client didn't turn up for her session... So when I had spoken to the client she had decided that she wasn't ready to forego the therapy and the only reason she hadn't come was because the doctor had told her [not to]...I spoke to the Practice Manager and she agreed with me" (Line: 291-324)

The overall APES rating for each voice at this interview reflect the insight Mandy had developed by the end of training. This was expressed through the creation of meaning bridges between her dominant voice and her problematic experiences (APES 5). Her courage to expose her vulnerability through Rejected Little Girl resulted in greater insight and optimism (APES 4.5). The overall pattern of assimilation is illustrated in Figure below.
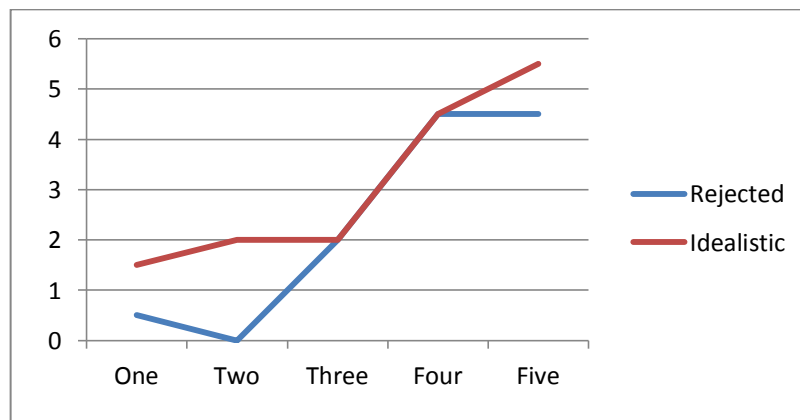

Figure 5   Mandy's Pattern of Assimilation

Conclusion

The problematic experiences which emerged at the beginning of training created dilemmas for Mandy in relation to her course, her professional development and her feelings about herself. The pattern of change revealed through the Assimilation Model analysis was positive. As Mandy progressed through her training she was able to gain insight and understanding that had positive benefits for her personal and professional relationships, but most importantly her relationship with her-self. Mandy was able to assimilate theoretical and personal knowledge sufficiently into her community of voices, for her to use this understanding positively in her work with clients and in her personal relationships with her partner and her peers. Consequently, although not completely free of her problematic voices, Mandy left training better prepared for life and professional practice.

A Longitudinal Examination of Trainee Change

Summary of Findings

How did these trainees change?

Trainees experienced growth in clinical self-confidence, emotional resourcefulness and decline in anxiety and an increase in (occasional) avoidant coping. Training was positively related to an increase in the ability to cope with the emotional and the practical demands of being a therapist and increased therapeutic skill. Trainees were psychologically robust.

They had low levels of distress, well outside those of a clinical range at the end of training. Training had a small positive effect on further reducing low levels of distress. Trainees reported moderate levels of stress at both the beginning and end of training but they also described high levels of satisfaction in their personal lives.

Trainees had moderate to high levels of emotional fluidity at the end of training. At the end of training, trainees were committed to personal growth and were more fully functioning. Training had a large effect on professional growth. Trainees moved from Altruistic Reflexivity at the start of training to Increasing Clinical Self- Confidence grounded in reality, at its end.

What helped/hindered trainee change?

Early in training: negative experiences were related to negative group work experiences, course expectations or demands that conflicted with personal beliefs or understanding of the model. Work with clients may also lead to a small but significant increase in the use of avoidant ways of coping. At the end of training negative experiences related to

inadequate practice placements and painful emotional experiences. Training is likely to provoke emotional problematic experiences.

At beginning of training personal development group work and skills training were regarded as essential preparation for practice. By its end, supervision, work with clients, personal development groups and workshops on practice based topics were the most positive influences. Feeling accepted, understood and supported unconditionally had a very positive influence on Mandy's development.

How do trainees assimilate different aspects of their training?

The assimilation of different kinds of knowledge comes about through a personal and professional struggle. The ability to learn to be a therapist is hampered, particularly at the start of training by past problematic experiences that are triggered by practitioner training. Through work with clients, supportive supervision and increased self-knowledge, the assimilation of problematic voices takes place. This results in greater resourcefulness as both a therapist and a person.

Discussion

The findings for the Longitudinal Examination of Trainee Change (LETC) show that training had a positive impact on the personal and the professional growth of these trainees. At the end of training these informants had not only become therapists but felt that they were more fully-functioning people. These findings will be discussed in relation to Stiles's responsiveness theory and the findings of relevant research studies. The aim is to explore the contribution these results make to the existing literature and to consider whether the process of change that occurs during practitioner training is similar to that of therapy. This will be followed by: a final conclusion and a description of the limitations of this study.

The LETC findings support the view that, like psychotherapy, training is not ballistic i.e. pre-determined, but a responsive activity (Stiles, Honos-Webb, & Surko, 1998). Elliott (2010, p. 125) summarises Stiles's theory thus:

> "1. Clients with fewer internal resources (e.g. less self-insight) are likely to have poorer outcomes than clients with more internal resources.
>
> 2. When confronted with clients with fewer resources, skilled therapists will be responsive and will thus routinely offer more of the putative active ingredient to the clients (e.g. interpretation).
>
> 3. If therapists are perfectly and successfully responsive, all clients will have the same outcome, and the correlation between the theorized effective ingredient and outcome will be zero.
>
> 4. If therapists are only partially successful in their responsiveness, they will be unable to totally ameliorate their clients' initial limitations, and clients offered more of the effective ingredient will actually have poorer outcomes; that is, there will be a negative correlation."

How emotionally resourceful were these trainees?

Trainees, unlike clients, are likely to have been selected for training because they have been judged to be emotionally resourceful (Orlinsky and Rønnestad, 2005). The findings show that the majority of the trainees who took part in this study were emotionally resourceful at the beginning of training. This low level of distress had declined further by the end of their training. The majority of trainees in the Longitudinal Investigation of Trainee Change (LQI) had moderate to high levels of function at the beginning of training and even higher levels of emotional fluidity at its end. These findings are further supported by the moderate levels of stress, alongside high levels of life satisfaction that were reported by trainees at both the beginning and end of training.

The informants in the End of Training Qualitative Study (ETS) also described personal and professional growth. These informants provided a number of examples of how they managed challenging situations and work with clients that are consistent with being emotionally resourceful. The results of the Assimilation Model Analysis: the Case of Mandy (AMA) suggests that trainees may be more resourceful at the end of training if they are able to assimilate problematic experiences that emerge during this time. The findings of each of the LETC studies reveal that the trainees that completed training were emotionally resourceful and had very low levels of distress.

That training is stressful and places trainee therapists under considerable pressure is agreed in the research literature (Bischoff & Harris, 2004; Howard, Inman, & Altman, 2006; Moller, Timms, & Alilovic, 2009; Skovholt & Rønnestad, 2003; Truell, 2001). Yet, stress in itself does not necessarily indicate a lack of resourcefulness but is rather

something that occurs in response to external circumstances. Stress is not necessarily negative but a normal part of life.

A few published studies that have examined the emotional impact of working with challenging clients, for example the incidence of secondary trauma (Gottesman, 2008) or levels of stress in trainee therapists working with clients with suicidal ideation and personality disorder (Miller et al., 2010), have shown temporary elevated levels of stress in trainee therapists. These studies have however, highlighted trainee resilience rather than vulnerability. There are two exceptions to this trend.

Kumary and Baker (2008) investigated stress in British counselling psychology trainees. They devised a questionnaire to investigate trainee stress. The Counselling Psychology Trainee Stress Survey (CPTSS) measure is comprised of four topic areas: academic demands; lack of support systems, placement stressors, and personal and professional development. This questionnaire along with a General Health Questionnaire (12) (GHQ12), were used to identify which aspects of training were stressful and to measure levels of distress. The GHQ12 was used to identify those informants who would meet the criteria for a psychiatric diagnosis i.e. caseness. These measures were distributed to 269 trainee counselling psychologists by post and 109 completed questionnaires were returned.

The female trainees, who accounted for 87% of the sample, reported higher levels of stress on the CPTSS than their male peers (p=0.003). The highest levels of stress were reported by the youngest trainees i.e. those below the age of 30 who accounted for 43% of the sample. Lower levels of stress were found in older trainees i.e. those over thirty and those over 40. Stress ratings on the CPTSS positively correlated with levels of

distress on the GHQ12. Therefore, the younger trainees also had higher levels of caseness. Trainees at different stages of their training had similar levels of distress and the authors conclude that this finding indicates that stress levels remained constant throughout training.

These findings differ significantly from those of the LQI. The level of life stress, as measured on the DPCCQ-TPF was the same at the beginning of training and at its end. It may have remained constant over the course of the training but if this was the case it was at a moderate level. Levels of stress need to be considered in the context of the high levels of Life Satisfaction that were reported alongside the Life Stress scores.

The level of distress and emotional rigidity for the majority of trainees at the beginning of training, and for all informants at its end, was well below that of a clinical population. The fact the informants in the LQI were older i.e. they had a mean age of 42 (range of 31-55 years), may account for the disparity between these results and those of the Kumary and Baker (2008) study. The LQI results, when compared to these findings, suggest that older trainees may cope better with the stress of training but they may also begin training in a psychologically healthier state. The Kumary and Baker (2008) investigation found that levels of distress did not differ by year group but unlike the LQI they did not test the same trainees at each stage of their training.

Their findings indicate that each stage of practitioner training is equally stressful but this was not the case with the findings of the LECT studies. Levels of life stress and life satisfaction remained the same throughout training, as measured on the DPCCQ-TPF but levels of distress declined over time when this was measured on the clinical outcome measures. In the Kumary and Baker (2008) study high levels of training stress

was associated with caseness, "The higher the stress rated for any aspect of counselling psychology training, the clearer the indicators of psychiatric distress became" (Kumary & Baker, 2008, p.24). No informants in the LQI study had levels of distress within the clinical range on the two measures used at the end of training. The mean score was below that of the mean for a non-clinical population on both questionnaires at this time. This suggests that not only did these trainees not suffer to the same extent as those in the above studies, but that their level of well-being and emotional resourcefulness actually increased over the course of their training.

The Kumary and Baker (2008) study produced findings that are similar to those of an earlier study of British clinical psychologists. Cushway and Tyler (1996) also identified sources of stress in a sample of British clinical psychology trainees and conclude, like Kumary and Baker (2008) that it is the cumulative effect of a combination of stressful factors that needs to be understood rather than the impact of individual stressors. Cushway and Tyler (1996) found that high levels of stress were associated with lack of experience, but that low job satisfaction, poor personal relationship and the use of avoidant defences were also important contributory factors. Being a younger, less experienced trainee was the typical profile of the most stressed students.

The trainees in the LETC studies differed from those in both the Kumary and Baker (2008) and the Cushway and Tyler (1996) investigation in that they were older, had more life experience and, as described by the informants in the ETS and indicated by the Healing Involvement scores in the LQI, were finding satisfaction in their work with clients. At twenty-eight, Mandy (who was the informant in the assimilation model analysis) was one of the youngest trainees in her cohort and had little professional experience. Like the majority of the trainees in the Kumary and Baker (2008)

investigation she had spent most of her adult life as a student. Mandy had little work experience. This lack of experience, based on the findings of the Cushway and Tyler (1996) and the Kumary and Baker (2008), may have made training more challenging and destabilising for Mandy. Ameliorating factors such as positive placement experiences, satisfaction in her work with clients, peer support and a supportive partner may have helped her to cope with the stresses of the training. Her avoidant copying strategies were typical of those trainees who suffered the most in the Kumary and Baker (2008) and the Cushway and Tyler (1996) studies. Mandy may, therefore, have differed significantly from some of her peers in this respect.

The informants in the LETC studies were able to use their emotional and personal resources to respond appropriately to the demands made on them by on their courses. These findings indicate that rather than depletion, training positively contributes to a reduction in levels of distress and increases trainee resourcefulness. However, the extent to which distress led to non-completion is not known as data on attrition rates for the courses studied was not collected.

Trainees in the LETC study may have benefitted more from training in the same way those clients who come to therapy with greater emotional resources are likely to have better outcomes than those with fewer internal resources (Stiles et al., 1998). These informants may have been able to respond more to the opportunities training offered than the other trainees in the Kumary and Baker (2008) and the Cushway and Tyler (1996) studies.

Contribution to knowledge

These findings confirm that training is stressful but conclude that perceived stress and actual distress may differ. These findings make an original contribution to the existing research literature in that they provide some evidence that older, more experienced trainees may be better able to deal with the demands of training and professional practice than younger in-experienced trainees. The influence of age and experience on the process of training has not been previously studied.

This is one of the first studies to use the SI measure on a non-clinical population and these findings reveal its usefulness for describing a non-pathological view of distress. This is the first British study that has investigated levels of stress and distress in trainee counsellors enrolled on BACP accredited part time counsellor practitioner programmes. These findings suggest that these informants may differ from trainee psychologists in some important respects: levels of stress are constant but levels of distress are low for the majority of trainees and these have declined a little at the end of training. Training may have a positive impact on trainee well-being and improve levels of emotional functioning. Findings indicate that rather than depletion, training positively contributes to a reduction in levels of distress and increases trainee resourcefulness. These findings provide some support to the proposition that emotionally resourceful trainees may be able to gain more benefit from training than those who are more limited.

The use of mixed methods, provide a good example of the value of using a variety of methods to study phenomena across different groups and individuals.

How does training impact on trainee professional development?

Therapeutic Skill

The informants in the LETC studies attributed the personal and professional growth they had experienced to the training they had engaged in. These students felt that they had become therapists by the end of their training. They reported increased levels of healing involvement with clients and significant levels of personal and professional growth. The trainees in the ETS were confident in their practice and eager to learn more. Similarly, the impact of training on Mandy had resulted in personal and professional growth. From the point of view of these trainees practitioner training had a significant impact on their work with clients and upon their professional development. These findings are similar to those of other studies (Bischoff, 1997; Bischoff & Barton, 2002; Howard et al., 2006; Skovholt, Rønnestad, & Jennings, 1997; Skovholt & Rønnestad, 2003) that have investigated trainee experience of practitioner training programmes. However, these are at odds with those that have attempted to measure the impact of training on practice.

Ladany (2007) entitled his editorial of a special issue on training thus: "Does psychotherapy training matter? Maybe not." The implication being that training makes little or no difference to therapists' ability to help clients. Based on the existing research evidence this conclusion accurately reflects the insubstantial evidence base for practitioner training with regards to its influence on therapy outcome. Research studies that have attempted to investigate the impact of training on therapist effectiveness have largely been flawed because they have based on a perception of training as ballistic rather than one that depends on a responsive relationship between trainees and the training programme. Being able to put what has been learned into practice may also be

limited by the needs and abilities of clients and so therapy outcome may not be an accurate measure of the benefits of training. The notion that training is a ballistic process which transforms students into practitioners has meant that most studies have paid little attention to the composition of training programmes and their impact.

Following an extensive review of the literature Beutler et al. (2004) conclude that it is not possible to assume that therapeutic skill is an inevitable consequence of practitioner training. How training has been used by trainees and how they respond to training has largely been ignored.   The findings of early controversial studies (Hattie, Sharpley, & Rogers, 1984; Strupp & Hadley, 1979) created doubts about the value of therapist training that have continued to grow over the past thirty years.

The findings of the Hattie et al. (1984) meta-analysis indicated that untrained paraprofessionals were more effective than trained therapists. These findings were later refuted. Berman and Norton, (1985) identified serious methodological flaws in the Hattie et al. (1984) study. After addressing these design flaws they repeated the meta-analysis and found that trained therapists had better outcomes. However, the difference between trained practitioners and paraprofessionals was not substantial. Strupp and Hadley (1979) compared outcomes between experienced therapists and untrained college professors and found little difference in treatment outcome. Strupp later suggested that the design of his study was problematic and that with some adjustment to the length of therapy offered for example, the findings may have been different (Strupp, 1993). He also postulated that given that the early stages of therapy are largely concerned with building an alliance the difference between trained therapists and untrained volunteers would be harder to detect. In addition, he acknowledges that his

choice of control, college professors who were regarded as warm and empathic people was far from ideal.

Psychotherapy is a personal-professional relationship (Orlinsky & Rønnestad , 2005) and is inevitably founded on skills that are present in most human relationship (Rogers, 1957). Elliott (2010) states that even if it were possible to create an experimental control devoid of empathy that it would not be ethical to do so. More recent studies have failed to reveal the positive impact of practitioner training on routine practice e.g. Boswell, Castonguay, and Wasserman (2010). But the impact of training in specific techniques or models has been demonstrated in both naturalistic settings e.g.(Crits-Christoph, Connolly Gibbons, Crits-Christoph, Narducci,Schamberger, & Gallop, 2006) and in manualised treatments in RCT's (Elkin et al., 1989; Elkin, Shea, Watkins, & Imber, 1989; Shaw et al., 1999; Shea et al., 1992; Shea, Elkin, Imber, & Sotsky, 1992).

Most studies that have attempted to evaluate the impact of therapist variables, such as training, on therapy outcomes in routine practice have largely been unsuccessful. Lambert and Baldwin (2009) propose that in order to identify specific therapist variables large samples of both therapists and clients are needed. As therapy outcomes vary, clients need to be nested by therapist before it is possible to identify the impact of therapist variables, including specific training, on outcome. The Okiishi, Lambert, Nielson, and Ogles (2003) study used this approach. They found substantial evidence for variability in outcome by therapist but were not able to identify therapist variables that explained these differences. They included some comparisons of therapists by level of training and modality but found no evidence to support the view that training had any bearing on therapist effectiveness. However, how training was defined e.g. stage of

training and qualification did not take into account how each therapist had benefitted from their training or recognised variability in training outcome.

As shown above, trainee resourcefulness is likely to play an important part in determining training outcome. However, it is not only how trainees respond to the academic and professional demands that may make training effective but the support and guidance that is provided. Ladany (2007) states that:

> "the root of this problem rests on two general factors: (a) variability in competence among psychotherapy trainers and supervisors and (b) variability in motivation to learn among students and supervisees" (p. 395).

This view of training is one that recognises that practitioner training is essentially responsive and that it will inevitably lead to variability in outcome. Beutler (1995) explores the myth of homogeneity as it relates to therapy outcome but this argument is one that also explains perceptions of therapist training, i.e. that all therapists are made equal through the successful completion of training. This notion has beset attempts to investigate the impact of training on therapy outcome.

The results of the LQI, for all but one test, (Healing involvement which had an SD of 1.302, which was still not that large), were within one standard deviation at the end of training and this suggests homogeneity rather than variability. Similarly, despite the small number of informants in the ETS qualitative study, the analysis produced some general and core categories and these findings reflected common aspects of their experience. The findings of these studies indicate that these trainees had a common experience of training and it had a similar impact on their personal and professional development. These findings suggest variability in training outcome may exist between

training programmes rather than within student cohorts. However, further research is needed to test this hypothesis.

The findings with regard to the impact of training on therapeutic skill are based entirely on trainee perceptions of their practice. Trainee evaluations of their therapeutic abilities are inevitably influenced by feedback they had been given in supervision and from other aspects of their course. No client data was collected and so these findings capture trainee perceptions of changes in therapeutic skill. These findings are positive but not over stated, they reveal moderate levels of therapeutic ability. The trainees recognised their need for further professional development.

There is some evidence that therapists are necessarily optimistic in their work with clients but poor at predicting or recognising client deterioration (Hannan et al., 2005; Harmon et al., 2007; Hatfield, McCullough, Frantz, & Krieger, 2010; Lambert, 2010). That only a minority of clients deteriorate, between five and eight per cent (Lambert, 2010), is little comfort when the findings show that even dramatic deterioration is hard for therapists to identify.

Orlinsky and Rønnestad's (2005) findings describe variability in the practice patterns of therapists. Therapeutic work is most stressful during early practice and becomes more rewarding as therapists develop. The fact these trainees were finding some satisfaction and meaning in their work with clients is likely to be an accurate reflection of their experience but it is not possible to determine from these findings how successful these trainees were with regards treatment outcome.

Contribution to knowledge

The findings of the LQI study show homogeneity in training outcome rather than variability. This is the only study of a student cohort that has been identified in the literature which has investigated the process of change in trainees over the course of practitioner training. The results for this study and the ETS suggest that variability may be more likely to exist between cohorts and/or training programmes than within cohorts. It is not possible from these findings to evaluate therapist effectiveness but these results are consistent with larger studies of therapist development which show that despite the stresses of early practice trainees find work with clients rewarding.

Which aspects of training influence therapist development?

By the end of training the most positive influence cited by informants in the LQI study was supervision. Supervision, work with clients, personal development groups and workshops on practice based topics were identified as having a positive impact by the informants in ETS. Mandy in the AMA study also described the value of supervision and personal development work, particularly the influence of peers on her personal development. However, the most positive influence on trainee development identified by each of the three LETC studies was supervision.

Orlinsky and Rønnestad (2005) found that supervision had the greatest influence on trainee development whereas work with clients was the most positive influence on the professional development of experienced therapists. For the majority of the informants in their study, supervision would have ended once they had qualified, so it is not surprising that supervision had less influence on their overall professional development. For the informants in the LECT studies their membership of BACP would require them

to engage in a minimum of an hour and a half of supervision each month while in practice. Therefore, supervision during training marks the beginning of a key component of on-going practice and is likely to be perceived differently from their professional peers in countries where supervision is primarily a training tool.

The purpose of training supervision is to help trainees to learn how to be therapists (Ladany, Walker, Pate-Carolan, & Evans, 2008). For British trainees who intend to practice as members of BACP supervision during training also aims to teach them how to use supervision once they are qualified practitioners.

Lydia (Ladany et al., 2008) had two supervisors during her first year of training; one who was didactic in her approach and the other who focussed on therapy process issues and the influence of Lydia's personal history on her work with clients. The authors conclude that supervisors need to strike a balance between practical guidance and the exploration of process. Other research findings suggest that greater trainee autonomy in supervision is likely to result in increased levels of therapeutic confidence.

Bischoff and Barton (2002) constructed a three stage model of the development of therapeutic confidence in trainees. This model was informed by the findings of a grounded theory analysis of qualitative telephone interviews with 39 recent graduates. The informants had recently completed a Master's level accredited practitioner training in family and marriage therapy. Bischoff and Barton (2002) propose that supervision is central to the development of therapeutic confidence. At the beginning of training it provides feedback to trainees, is most helpful when it emphasises their strengths and draws the trainee's attention to treatment success. The second and third stages in the Bischoff and Barton (2002) model overlap and these are entitled Emerging Confidence

and Fragile Ability in Confidence. These stages occur between three and six months of the full-time training. At these stages supervision has a stabilizing function but also provides space for trainees to begin to recognise treatment success without the help of their supervisor or peers. The support of peers, as well as that of supervisors is important. Supervision at these stages has a validating function as it helps the supervisee to trust their instincts and judgements and discourages dependency on the knowledge and opinions of others. Throughout the training the most important aspect of supervision is its stabilising influence. Supervisors, facilitate the gradual development of therapeutic confidence through a process of validation, support and trust in each trainee's abilities.

Other studies have identified similar patterns of change for example; Kozina, Grabovari, De Stefano, and Drapeau (2010) identified an increase if self-efficacy in twenty MA counselling trainees over the course of their training. Thériault and Gazzola, (2010) conclude, following their qualitative analysis, that feelings of incompetence are likely to be common amongst trainee therapists but that these vary in intensity. De Stefano et al.'s (2007) qualitative investigation concluded that trainees sought validation from supervisors when they experienced impasses in their work with clients. Ögren, Jonsson, and Sundin (2005) found that the learning environment or group climate influenced each trainee therapist's ability to benefit from supervision.

Contribution to literature and recommendations

The findings of the LETC studies provide evidence of the positive influence of supervision on trainee development. These results, along with those of these other studies provide further evidence of the centrality of supervision to therapist

development. It is the most helpful aspect of training. They provide further evidence that the most helpful supervisory style is one that enables the development of therapeutic confidence and autonomy whilst providing guidance and support. These studies describe a UK model of supervision for trainee therapists that is both a training tool and part of on-going practice.

Negative influences on trainee development

The centrality of work with clients and supervision to the training of therapists is clear. However, given that trainees are being assessed during supervision and that this assessment is likely to be based on a small number of clients, faith in the power of supervision can be misplaced. Supervision may also be the source of negative experiences.

The case of Lydia provides a vivid example of the negative influence that ineffective supervision can have on trainee development, (Ladany et al., 2008). As described by Bischoff and Barton (2002) it is during this period of therapist development when trainees have little confidence in their abilities and experience considerable instability in their practice. This pattern is similar to that described in Stiles's responsiveness theory (Stiles et al., 1998). This is when therapists over respond to clients who are struggling. They give more of what they perceive as helpful e.g. interpretation to their clients. However, as demonstrated in the case of Lydia and the findings of the above studies this response is likely to smother rather than facilitate growth in trainees.

Ladany (2007) states that very good supervision occurs for only a third of the time and that mediocre or poor supervision is more common. Two of the informants in the ETS reported a negative experience of supervision which was provided by their placement

agencies. One trainee described their supervisor as someone who told the supervisees what to do and after some early attempts to find a way to influence this, like Lydia (Ladany et al., 2008) this trainee gave up. The trainee remained in supervision but did what the supervisor expected i.e. present facts rather than explore process. This reaction is similar to a number of studies that suggest that trainees avoid exploration and disclosure (Mehr, Ladany, & Caskie, 2010) if they have a negative or (Hess et al., 2008) an unresponsive relationship with their supervisor. Ultimately avoidance and anxiety may lead to the erosion of therapeutic confidence and result in what Orlinsky and Rønnestad (2005) describe as double traumatisation, i.e. the trauma of failing with clients and failing in supervision.

The most negative influence identified by the informants in the ETS was negative placement experiences. Problems with placements were negative in that they delayed trainee development and threatened their hopes of successfully completing training. Poor placements damaged therapeutic confidence and frustrated trainees. These experiences however, did provide opportunities for new learning, and although stressful, the trainees were able to resolve these situations. Therefore, although not ideal, poor placement experiences gave them an opportunity to develop negotiation skills and provided valuable experiences of agencies that fall short of existing professional standards or course requirements. That is, they learned important lessons about how not to run a therapy agency and how not to support staff. Such lessons, particularly at the start of practice, are best avoided as early therapeutic confidence can be easily damaged.

Problems with placements are serious for without practice trainees cannot become practitioners. Placements play a key role in supporting early practice and professional development but very little research has been conducted on this aspect of practitioner

training. Bieschke et al., (2011) describe their experience of running clinical psychology programmes in the US and state that finding student placements is a constant source of stress for both staff and students. The authors state that issues regarding placements and student anxieties about achieving clinical hours dominate full-time training programmes and obstruct student development. The informants in The trainees in Bennetts's (2003) study felt that "help in arranging placements…was seen as the single most important change that could be made on students' behalf" (p.310)

The above findings are consistent with those of the ETS. Placements were a source of stress but they are also provided positive experiences as the general categories for both the helpful and unhelpful processes topic domains show. This account is rare in that it describes the problems that students encounter in their placements. Lack of understanding about the nature of the therapy the trainee was able to offer resulted in inappropriate client referrals. There was a lack of planning on the part of one agency that meant they had no clients to refer to another trainee.

The trainees in Bennetts's (2003) study felt that working for free or as a volunteer undermined their status in organisations where they were on placement. That trainees work for free may make them attractive to agencies but they need to invest resources in their management and support to ensure a good standard of service to their clients. These are characteristic of the good placement experiences described by the informants in the ETS and by Mandy in the AMA case-study.

These findings further support the view that however talented the trainee, poor practice placements are likely to delay trainee development. Trainees need placements that

provide them with an environment in which they can grow professionally and develop confidence, rather than struggle.

Contribution to literature and recommendations

These findings make a significant contribution to the existing research literature. They support the view that inappropriate placements are a significant source of stress to trainees and provide rare accounts of negative experiences. These findings highlight the importance of placement agencies investing resources in trainees and that they should not be regarded as cost free. They also stress the need for training programmes to provide adequate support to trainees to help them to secure appropriate placements.

What Constitutes A Good Training Outcome? Is competence enough?

The findings of the LETC studies show that by the end of training these informants had grown in therapeutic confidence and felt ready to embark on a career as therapists. They regarded their time in training as period of significant professional development. From the perspective of the informants in the LETC they had achieved an acceptable level of competence as practitioners.

The ultimate aim of practitioner training is to produce competent graduates in the hope that they will be effective with clients. Professional standards for accredited counselling and psychotherapy training courses in the UK are concerned with the achievement of competence, that is the development of expertise (Palmieri et al., 2007) and assume that this will lead to effectiveness i.e. have a measurable positive impact on their clients. There is however, little evidence to support this assumption (Trepka, Rees, Shapiro, Hardy, & Barkham, 2004).

Trepka et al. (2004) measured therapist competence and alliance over the course of routine therapy with twenty-three NHS clients who were seen for between 12 and 20 sessions by six CBT therapists. The therapist's level of competence varied. Twenty-seven per cent of all client sessions fell below the minimum level of competence whilst three of the therapists in the sample consistently scored highly. The average score for competence across the sample exceeded the minimum standard set. Both therapeutic alliance and therapist competence were found to be related to outcome but when alliance was controlled for, the significant relationship between competence and improved client outcome was not maintained (Trepka et al., 2004). These findings are not surprising when the sample sizes are considered as these are typical of many studies that have attempted to investigate therapist variables and failed. As discussed above much larger samples are needed to detect the influences of any therapist variable, including competence, on therapy outcome.

BACP accredited programmes, like the ones on which the LETC informants were enrolled assess trainees on the basis of their competence to practice which is assumed to be closely related to effectiveness. Competence is evaluated through course assignments, supervision and placement reports etc. Most trainees rely on feedback from their supervisors, tutors and peers regarding their practice and are unlikely to be working in agencies where client progress and outcome are systematically measured. Supervisors tend to be more positive about their supervisees' abilities than trainees themselves (Ögren & Jonsson, 2003; Ögren et al., 2005). Supervisors may be in danger of over estimating their supervisees' abilities, particularly when they are totally reliant on the therapist's account of the therapy they have provided. Clients may of course provide feedback to their therapists either directly or through formal service evaluation procedures but however genuine, these reports are likely to be censured by gratitude or

desire for a speedy exit. As shown by Rennie (1994) clients may adapt their therapy to the needs of the therapist and so in ending therapy they are more likely to be grateful than critical. Trainees and course staff have a limited range of ways by which they can evaluate competence as it relates to actual practice.

BACP, BPS and UKCP accredited course criteria, as described in the literature review in Chapter 2 above, require courses to evaluate competence not effectiveness. The conventions of practitioner training include completing a set number of client hours or attending a given number of taught seminars, workshops or personal development groups which are generally regarded as beneficial by both trainees and professional organisations. However, these have not been evaluated on the basis of how they each contribute to therapist effectiveness.

Common factors research has demonstrated that psychotherapy is largely effective and has identified factors that are most likely to contribute to a good outcome for clients (Norcross & Wampold, 2011). There is, as yet, no empirical evidence to support the view that practitioner training makes therapists effective practitioners when their effectiveness is measured on the basis of client outcomes alone. The large sample sizes that are needed to measure therapist effects are further complicated by the variability in: clients, training programmes, contexts and therapeutic talent. Training, like therapy, is essentially responsive and only where training programmes, trainees and clients are perfectly responsive would it be possible to guarantee that practitioner programmes only produce graduates who are effective.

Even if it were possible to include in final assessments data on the clients trainees have seen client numbers are likely to be insufficient to make an accurate evaluation of their

abilities. For example, the number of clients seen by the trainees in the LQI over the course of their training i.e. two years was 17 and they spent an average of four hours per week seeing clients. One solution to this problem is to abandon efforts to demonstrate that training makes therapists effective in favour of developing training programmes that are based on factors that have been identified as crucial to producing positive therapy outcomes.

There is a drive to develop of evidence based models of training (Castonguay, 2000; Norcross & Wampold, 2011; Rakovshik & McManus, 2010; Sexton, 2000) these models are not based on training research but on the evidence produced by therapy outcome studies that have identified the elements of effective treatment. The advent of Evidence Based Training (EBT) is exemplified by the American Psychological Association (APA) (Norcross & Wampold, 2011) attempt to provide clear goals for what trainees need to be able to do in order to increase their chances of being effective.

The APA task force propose that their accredited practitioner training courses develop competency based programmes that focus on common therapy factors that are demonstrably effective. Evidence based practices include; the development of a positive working alliance with clients, the demonstration of empathy and the use of client feedback. The probably effective factors are the use of therapist and client goal consensus, collaboration and positive regard. The problem with this model is that no guidance is given on the most effective ways for courses or trainers to help trainees to acquire these abilities or what constitutes an acceptable level of competence. The APA recommendations mark a step forward in the training of therapists in that they at least provide an empirically supported focus around which practitioner training can be organised.

Conceptualisation may provide another way by which training outcome could be evaluated. Betan and Binder (2010), Eells et al. (2011) and others propose that expert therapists consistently demonstrate greater skill with regards to the depth and range of knowledge that they utilise to think about clients. Kivlighan and Kivlighan (2009 demonstrated how through intensive supervision and supervised clinical experience the knowledge structures of trainees could be improved to the extent that their ability to conceptualise client difficulties was similar to that of expert practitioners by the end of the training. The findings from this area of research indicate that competency based training in unlikely to be sufficient on its own, even if these competencies are derived from reliable evidence.

The assimilation model analysis of Mandy tracked her movement from a simplistic view of what being a therapist was i.e. someone who adheres rigidly to their chosen model, to a more complex picture of the therapist and of therapy. Mandy's growth in maturity as both a practitioner is evident at the end of her training, as is her love of working with clients. The findings of the ETS also communicate the integrity and passion these trainees drew upon in their work with clients. Although it is necessary to create training programmes that provide trainees with an opportunity to become therapists their ability to respond to both the training and their clients are likely to be influenced by these two human factors: integrity and the desire to help.

Freud (1926) and Rogers (1949) regarded the primary purpose of practitioner training as assisting trainees to understand and manage their instincts or, in client-centred therapy to help them to adapt their philosophical attitudes to one that was consistent with the therapeutic approach. In this way the therapist becomes the therapy. The true measure of the quality of training may ultimately be best evaluated on the personal qualities of

the graduates it produces. These findings describe individuals who were dedicated to becoming the best they could be for their clients. They undertook training with little hope of substantial financial reward or even the guarantee of paid work. To paraphrase Ladany (2008) being a therapist, for these trainees, was regarded as the best job there is.

Is competence enough?

The findings of large studies of routine practice e.g. Stiles, Barkham, Mellor-Clark, and Connell(2007), Okiishi et al., (2003) consistently demonstrate that therapy is effective. Given that in the UK and the US therapists undertake formal practitioner training these results, at least in part suggest that competence is likely to have some bearing on effectiveness. Therefore, on this basis competence is probably enough for the majority of clients but the use of session by session feedback, rather than changes to the training of therapists, may help therapists to improve their practice and to identify the minority of clients who will deteriorate during therapy (Lambert, 2010) as even the most effective and competent therapists have their limitations.

Contribution to existing knowledge and recommendations.

These findings provide evidence that routine practitioner training is likely to lead to the development of competence in those trainees who complete training. They highlight the need to examine the relationship between competence and efficacy. Evidence Based models of training provide a helpful focus for practitioner training but the ability to assimilate core competences and conceptualise client difficulties may prove to be a more helpful indicator on which to evaluate the benefits of training for both clients and trainees.

Limitations of the LETC study.

These findings were limited by the fact that the trainees studied were all enrolled on BACP accredited courses at two British universities. The sample sizes were small e.g. one cohort of trainees, a single subject case-study and 4 informants who participated in the End of Training Study. The small number of informants in the ETS did not provide the opportunity to develop the categories further or to test the theory presented through interviews with other trainees within the same cohort or from other courses.

The assimilation model analysis interviews did not take place weekly as is usually the case for studies of this kind and the design may have meant that some aspects of the change process experienced by Mandy were missed. However, probably the greatest limitation was that this investigation only included students who successfully completed training.

Therapist training is responsive and is therefore reliant on a number of factors to make a positive outcome more likely. These trainees responded well to the training programmes on which they were enrolled and these programmes were provided in institutions and by staff who were not studied. The inclusion of the course staff in this study, in particular the nature of their relationship with students would have provided a deeper understanding of the training context and its impact on the personal and professional development of trainees.

Conclusion

Personal change and professional development during training are consequences of complex processes that depend on many factors. The most important factor of all is the ability of trainees, training institutions and staff to respond in ways that facilitate change. Clients that experience positive change are equally important in that they unwittingly contribute to the personal and professional development of trainee therapists. Placement agencies and other extra-training factors such as partners and friends are also likely to make an important contribution to this process.

These findings capture emphasise that training, like therapy, is essentially a responsive activity. The informants in this study were able to respond to the opportunities that the training programme offered and were able to benefit from it. Research is needed into the characteristics and experiences of trainees who do not complete training in order to understand patterns of non-change and the part training institutions and staff play in this process.

Chapter 6: Discussion and Conclusions

An overview of key ideas and findings will be presented. This will be followed by a final conclusion which examines the meaning of these findings from a critical realist perspective.

Overview of Thesis

In this chapter an overview of the research methodology, design, and findings will be presented. This will be followed with a final conclusion in which a theoretical integration of key ideas will be presented.

This thesis began in Chapter 1 with a brief description of the personal and professional context from which the research topic emerged. The main impetus for this research was that despite the important role that practitioner training plays in the personal and professional development of therapists, the process by which training enables students to become therapists is largely unexplored in empirical research studies. The aim of this investigation therefore was to understand how trainee counsellors change and what helps them to change. The purpose of the study was to identify how British professional counsellor training programmes help or hinder student trainees to become counsellors. This research set out to identify change processes that occur during practitioner training and to investigate the relationship between personal change and professional growth.

In Chapter 2 the research literature was examined. The first section investigated the current context of practitioner training in counselling and psychotherapy in the UK. It was proposed that the absence of statutory regulation or even a minimum qualification for practice for the majority of counsellors and psychotherapists has had little impact on

legitimate practitioners i.e. those who belong to recognised professional organisations, who have, with few exceptions, completed professional training.

The second section of the literature review stated that anyone attempting to review research into the training of therapists needs first to define what constitutes practitioner training in counselling and psychotherapy i.e. training that provides a route of entry to practice. This is challenging because there is no one profession of psychotherapy and many practitioners of it. Despite its popularity how practitioner training works, in particular the process of trainee change is a neglected area of research. Orlinsky and Rønnestad (2005) explain the paucity of research into therapist development as the result of a misconception of therapy as a treatment that is administered by therapists, rather than a treatment that is reliant on the creation of a "professional-personal relationship" (p.6). The latter emphasises the importance of the personality of therapist whilst the former leads to research that excludes the personal aspects of the professional relationship.

Most research studies have investigated discrete aspects of training such as personal development groups or supervision. These findings reveal that training has a positive impact on professional growth. However, given that training courses are largely founded on models of integrated learning little research has examined how these different elements are combined by trainees, particularly in their work with clients. As Betan and Binder (2010) state, proficiency in any one competency is insufficient. It is how these core competencies are combined by the therapist that enables them to be effective. This theory, along with those relating to conceptualisation and knowledge structures are predicated on the notion that psychotherapy is not a linear process but a complex responsive activity.

In Chapter 3 began with an examination of researcher reflexivity in relation to the development of the research design. Researcher, expectations, and use of reflexive self-awareness in conducting this research are explored. Then the research methodology was presented and the overall research design was described.

This research was conducted from a critical realist perspective. The aim of research from a critical realist perspective is to reveal the deeper meaning of mechanisms or structures that cause phenomena. Research from a critical realist perspective is not contingent upon the use of specific methods. It proposes that the most appropriate methods be used.

This research study employed a hierarchical nested design. It used mixed method methods to study change in both individual trainees and across student cohorts and utilised quantitative and qualitative methods. The intention was to triangulate findings in order to produce completeness that is, to provide a detailed picture of training. This study was comprised of six investigations that examined two aspects of practitioner training: The Early Effects of Practitioner Training and The Longitudinal Examination of Trainee Change

The findings of the first study were presented in Chapter 4. They revealed that over the first two months of training, prior to beginning work with clients, training played a positive role in preparing trainees for practice. The informants, by the end of their first term, felt they were making much progress and had a much deeper understanding of therapy than they had at the start of their training. They reported feeling more skilful and that they were overcoming their limitations. There was no decline or disillusionment. There were some negative aspects of the training and these related

primarily to the experience of the informants who took part in the Beginning of Training Qualitative Investigation. Being silenced by silence was the experience of two black trainees who felt that topics of race or culture could not be explored as these were not openly discussed by white students or staff. This prevented these trainees from raising such issues themselves.

These findings present a detailed picture of UK trainee counsellors enrolled on three HE BACP accredited programmes. The qualitative studies found that trainees experienced the beginning of training as a time of intense self-scrutiny. The single subject case study of Margaret depicted how her training programme helped her to prepare for practice through tutor modeling and guidance and a deepening of her understanding of psychodynamic theory. At the end of her first term supervision had the most influence on Margaret as this was helping her to survive the negative impact of stressful involvement with a client.

The findings of the Longitudinal Examination of Trainee Change were presented in Chapter 5. These findings suggest that training had a positive impact on trainees work with clients and trainee professional and personal development. Training may also slightly improve well-being and emotional resilience in trainees. However, training may also provoke problematic experiences for trainees and their ability to respond to emotional challenges may ultimately determine their success as practitioners.

That the informants in the above studies experienced significant and positive change is likely to been influenced by a number of factors. These findings capture the complexity of this process and emphasise that training, like therapy, is essentially a responsive activity. Personal change and professional development during training are

consequences of complex processes that depend on many factors but the most important factor of all is the ability of trainees, training institutions and staff to respond in ways that facilitate rather than obstruct change. In this respect changes experienced by trainee counsellors are similar to those changes that occur in therapy.

Change takes place in the context of a personal professional relationship between the client and the therapist. Change in therapy is largely determined by the ability of both the client and the therapist to respond to this process and to each other. The trainee counsellors who participated in the research studies described above reported significant personal change and professional growth at both the beginning and end of training. The underlying structure or mechanisms that produced these changes were not observable but through a process of abduction can be guessed at. 'Training' implies a passive process by which students are made into therapists by others. Similarly, therapy has been misconstrued as a treatment in doing so it has been reduced to a linear process where clients become products and therapists are technicians. The real reality of training is that like therapy, training is responsive and complex and that professional growth depends upon personal change.

This model of training began with Freud (1926). The primary way that analysts were prepared for practice was through a training analysis. The aim being to rid the analyst of personal factors that would obstruct the therapy process, therefore personal change was the most important qualification for the analyst. Similarly, Rogers (1949) regarded training as a process by which trainees developed attitudes and a philosophical orientation that enabled them to be person-centred therapists. Rogers (1949) proposed that trainees who began training with attitudes and a philosophy closer to the approach would make quicker progress. The trainees in this study began training with a strong

attraction to their chosen approach. The informants in these studies began training with a clear understanding that to become therapists they would need to adapt or change aspects of their personalities. Training is a personal and professional process that is successful when it produces therapists who can change. Key to this process is the ability of trainees to acquire intellectual knowledge, self-awareness and therapeutic skill and to assimilate these through the problematic personal experiences that formal training inevitably provokes. The following quotation captures the essence of both the aim of practitioner training but also the key to a successful outcome for trainees. Rogers (1949, p.82) states:

> "the counselor who is effective ...holds a coherent and developing set of attitudes deeply imbedded in his personal organization, a system of attitudes which is implemented by techniques and methods consistent with it. It has been our experience that the counselor who tries to use a "method" is doomed to be unsuccessful unless this method is genuinely in line with his own attitudes."

Theoretical Integration

Practitioner level counsellor training in the UK has a number of meanings: political, medical and personal. Each of these will be examined in this section. Politically, training is a means by which allied professional groups and activities can be controlled. Most of the debates about therapist training have taken place in relation to the NHS over the past decade. For this reason the political and medical meaning of training will be examined in this context.

Academic level is used to confer professional status as exemplified by the Agenda for Change reforms in the NHS in 2004 which resulted in a single nine point pay scale for all employees with the exception of doctors, dentists and senior managers (NHS Careers, 2012). In this hierarchy, counsellors generally receive less pay and have a lower status than other therapists. Most counsellors are employed on band 6 while psychotherapists and counselling psychologists are on bands 7 or 8. Currently, trainee clinical psychologists are paid on the same band as qualified and experienced counsellors. In this system, status is conferred explicitly on the basis of the minimum level of qualification set by the NHS or regulatory bodies. For counsellors this is currently an undergraduate H.E. diploma. This level of qualification and status does not reflect the reality of both the qualifications of many practitioners or the work in which they are engaged. For example, many counsellors are graduates who practice psychotherapy. Therapists who practice CBT have become a higher status group within the NHS. Counsellors, nurses, social workers, psychologists and psychotherapists who have completed specific BABCP post-graduate training have become part of a new,

highly paid, (Band 7), professional group of High Intensity Therapists within IAPT services.

Over the past decade, training has been used to establish a hierarchy of counselling and psychotherapy professionals who are essentially doing the same work and to create new groups of high status practitioners based on therapeutic model. Counsellors have not benefitted from these changes.

Counsellors have suffered from a policy of inclusion, as embodied in the BACP course accreditation criteria, where academic level is not specified. This policy is contrary to the general trend towards raising the basic entry level for the majority of professions in the UK to a degree or higher. For counsellors, this has resulted in semi-professional status within the NHS and poorer employment prospects compared to other psychological therapists. The failure of BACP to raise the minimum academic level is likely to have long term consequences for the professional status of counsellors where level of expertise is equated with academic qualifications.

The BACP put forward the argument to the HPC, that there is no difference between counselling and psychotherapy and therefore not difference in status between counsellors and psychotherapists. Although true with respect to research evidence, it was naive in a context where political institutions have shown little interest in the reality of either training or practice. On the other hand, the UKCP's success in presenting its members as specialists who have completed post-graduate training, even though few courses confer qualifications that are validated by academic institutions, was successful despite being spurious, because it was couched in the language of professionalization i.e. exclusivity and speciality. The reality of counselling practice has had little or no

bearing on its lower status. However, the absence of a minimum level of qualification outside of the NHS and the benchmark of a HE diploma within it does. Until standards in this respect are raised, counsellors will continue be denied parity with other psychological therapists.

From a medical perspective, government bodies focussed on NHS service provision have ignored the fact that the aim of most counsellor and psychotherapist training programmes has been to produce generic practitioners rather than specialists. Instead, all psychological therapists have come to be regarded as the product of distinct types of training which enable them to deliver specific treatments. Training is regarded by policy makers and by NICE as a means of making technicians who can consistently deliver the required therapy to patients. The current drive therefore, is to produce evidence based treatments through training, rather than to develop evidence based practices. BACP accredited practitioner counsellor training programmes are primarily focussed on how therapy is practiced. This is evidenced by the emphasis placed by both practitioners and trainers on theoretical modality and the explicit aim of all accredited courses of producing reflective practitioners rather than technicians.

In the current climate, the findings of the research presented in this thesis are largely irrelevant to both the political and medical establishments. How trainee counsellors change and how training helps students to become therapists is only important if first; therapy is recognised as a complex process where positive treatment outcomes rely upon the therapists ability to adapt themselves and their training to the needs of the client and second; that therapy outcome is also determined by the client's ability to respond to what is offered. The ability to metabolise learning and to adapt to the needs of clients far exceeds what is required of a technician. Positive therapy outcomes are

unlikely to be a consequence of consistently delivering the same treatment to all clients, unless the therapists and the clients have been carefully selected and/or trained to take part in a clinical trial.

In the current context, given that the NHS is the largest employer of counsellors, ambitious candidates would be unwise to opt for a BACP accredited programme that offers a generic training. However, as shown in the findings presented above, trainees are likely to be motivated to train for reasons other than ambition. As mature students, many had already succeeded in one career. These trainees clearly understood, perhaps because of the preparatory skills training, that practitioner training was not an easy career choice or one that promised significant financial rewards. The informants in the qualitative studies clearly describe being motivated by the desire to help others but also to find a way to working and living that was personally, more satisfying and meaningful.

The meaning of training for students is that it provides them with the opportunity of becoming a therapist. Practitioner counsellor training exceeds what would be required if the aim was to train technicians. As shown in the findings of helping skills training research most students can quickly become competent in these skills and there is no reason to assume that even more advanced techniques can acquired. However, what is more difficult is to develop strong working alliances with clients and to apply those techniques effectively. Practitioner training programmes demand far more of students than the development of technical skill and intellectual knowledge. To become a therapist requires intra-psychic adaptation and this is a consequence of increased self-knowledge which in turn leads to a more sophisticated understanding of the process and more skilful use of technique.

This method of training began with Freud and was continued by Rogers. Freud (1926) supported the tripartite system of analysis, theory and supervision. Rogers (1949) emphasised practical experience, self-knowledge, supervision and research. Both regarded preparatory training as a process by which trainees developed an intuitive understanding of therapeutic change through personal experience. This, rather than technique, is what defines a successful graduate as it provides the foundation for professional practice.

This process is what both attracts and intimidates trainees. The meaning of training for students is that it presents an opportunity for personal change in the context of professional development. Personal change is driven by the needs of clients rather than those of trainees. The meaning of training for students is it presents an opportunity for personal change and professional growth and that sufficient change will enable them to become effective therapists. This view of training is essentially philosophically, it is grounded in a world view in which change is possible and where individual autonomy is respected and human relationships are valued. In short, counsellor training is primarily a responsive activity rather than primarily concerned with technical skill.

When attempts to measure the impact of practitioner training on therapy outcome failed the conclusion was that it made little or no difference to therapeutic skill. These early researchers took a narrow and simplistic focus. The research designs were flawed. However, the conclusion drawn personifies the ballistic view of therapy, that therapists are the most important component of treatment success. As depicted in Lambert's pie chart (Asay & Lambert, 1999) 15 % of outcome is attributed to placebo alone and 40% to extra therapy/client factors. Only 15% of therapeutic success is likely to be influenced by technique and the remaining 30% to common therapeutic factors.

Therapists make an important contribution to the process of client change but they are not solely responsible for that change.

In the same way training programmes facilitate and contribute to trainee change. Based on the findings presented above it is proposed that trainees begin training in a state of change that has been triggered by a recent stressful event or turning point. Trainee counsellors are likely to have had abusive or traumatic childhood experiences but over the course of their lives suitable candidates have been able to recover and become emotionally resourceful. People become therapists because they have experienced positive personal change and they want to help others to do the same. Two important questions to be asked at selection regarding candidate's suitability therefore, are what difficulties have you faced in your life, (to assess capacity for empathy), and how have you changed? (to assess emotional resourcefulness). The experience of personal change fosters the belief that others can change. Therapist optimism in this respect is essential.

Change is central to the training process described in the findings presented above. Practitioner training is effective with suitable trainees in the same way that therapy is effective with suitable clients. Training is a complex process that mirrors the therapy process. Courses provide a therapeutic environment in which change can occur but unlike clients in therapy, training programmes facilitate normal change, (normal change is defined as change that happens in a non-clinical population). Normal change can be pathologised by both students and staff because like normal grief, it can be a dramatic and disturbing. Despite these emotional upheavals trainees that succeed are likely to be

emotionally robust at both the beginning and end of training. The findings of this study challenge the notion of therapists as wounded healers.

Trainees are likely to have suffered at different times in their lives. Personal suffering is the impetus to help others and the source of empathic attunement. Candidates enter training primed for change by both recent stressful events that have prompted them to undertake training, and by their personal histories which are likely to be characterised by personal suffering, trauma and change. The majority of trainees are emotionally high functioning individuals rather than vulnerable wounded healers. The findings of the studies presented in this thesis suggest that low levels of distress and high levels of emotional fluidity are the norm for the majority of trainees who as a consequence, are emotionally resilient.

Trainee counsellors are likely to have assimilated problematic experiences in the past and are able to repeat this process during practitioner training. Training courses are most effective when they facilitate normal change and avoid pathologising trainee distress. Trainee counsellors use the learning environment and learning opportunities to become therapists. The majority are able to make the necessary personal, intellectual and skill based adaptions needed because they are motivated by their desire to help clients and are emotionally robust.

Training in this context is radically different from the reductive meanings currently assigned to it in the UK. Counsellor training is an emotionally charged and complex process that is challenging to trainees and meaningful to practitioners. This training method is likely to support the development of sophisticated knowledge structures and the metabolization of knowledge because trainees come to embody a change process

and it is this intuitive knowledge that is likely to help therapists to respond accurately to the needs of clients. It is this embodiment of the change process, rather than the acquisition of academic qualifications or technical skill, that is likely to produce therapists who can help clients.

Appendix A: Instruments

Appendix B: Dissemination of Findings

Dissemination of findings

Peer reviewed journals

FOLKES-SKINNER, J., ELLIOTT, R., WHEELER, S., (2010). "*A baptism of fire*: A qualitative investigation of a trainee counsellor's experience at the start of training". *Counselling & Psychotherapy Research,* 10 (2), pp. 83-92.

Other publications

FOLKES-SKINNER, J.A., (2007). Making Progress. *Therapy Today,* 18(5), pp. 38-40.

FOLKES-SKINNER, J.A., (2010). Becoming a Counsellor. *Therapy Today* 21(8), pp.20-23.

Conference proceedings

FOLKES-SKINNER, J.A. (2007). *N=1 Case Study: the early impact of counsellor training.* Poster presentation at the British Association for Counselling and Psychotherapy, Annual Research Conference, 11-12 May 2007.York Marriott Hotel, York, UK.

FOLKES-SKINNER, J.A; ELLIOTT, R. (2009a). *The early effects of professional counsellor training: a mixed method study.* Poster presentation at the British Association for Counselling and Psychotherapy, Annual Research Conference, 15-16 May 2009, Portsmouth, UK.

FOLKES-SKINNER, J.A.; ELLIOTT, R., (2009b). *The early effects of professional counsellor training: a mixed method study.* A brief communication paper at the Society for Psychotherapy Research, 40th International conference, June 24 – 29th 2009, Santiago, Chile.

FOLKES-SKINNER, J.A.; ELLIOTT, R., (2010). *The early effects of counsellor training: a qualitative study.* Paper presentation at the British Association for Counselling and Psychotherapy, Annual Research Conference, May 14-15th 2010, Heathrow, U.K.

FOLKES-SKINNER, J.A.; ELLIOTT, R., (2010). *Stressful involvement in trainees: An investigation into the impact of training on a cohort of person-centred trainee counsellors.* Paper presentation at the Society for Psychotherapy Research, 41st International Research Conference, June 23- 27th, 2010, Asilomar, CA, USA.

FOLKES-SKINNER, J.A., (2011) *Assimilation of Problematic Experience: the case of Mandy.* Paper presentation at the Society for Psychotherapy Research, 42nd International conference, Bern, Switzerland, June 29th – 2nd July 2011.

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