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Therapists' Feelings of Incompetence:

A Grounded Theory Analysis of Experienced Clinicians

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ABSTRACT

Feelings of incompetence are an ongoing part of the private experience of being a therapist. Although normative, they are often linked to therapist stress, distress, and to negative therapeutic processes and outcomes. Yet systematic inquiries into the subjective judgment of oneself as inadequate and incompetent in the role of therapist are virtually nonexistent and even more rare for experienced therapists. A qualitative approach was used in this study to obtain rich descriptions of therapists' encounters with feelings of incompetence. Eight therapists with ten years of experience or more were recruited for the study. Guided by a semi-structured interview protocol, they were interviewed for ninety minutes. The resulting transcripts were analysed with procedures based on grounded theory methodology (Strauss & Corbin, 1992). Results indicated that feelings of incompetence existed on a spectrum of intensity and that the experience was multiply determined. A dynamic, pan-theoretical, and multidimensional theory of feelings of incompetence is presented. The substantive theory summarises the relationship between the main categories of nature and depth of self-doubt, sources, consequences, and mediating factors. These categories are organised around the core category of intensity.

RÉSUMÉ

Les sentiments d'incompétence font partie intégrale de la vie subjective des thérapeutes. Normatives, ces émotions contribuent néanmoins aux expériences de stress et de détresse vécues par les cliniciens. De plus, ils ont parfois une influence néfaste sur certains processus et résultats de la thérapie. Pourtant, peu de recherches en tiennent compte. La présente étude aborde cet aspect de la vie subjective des cliniciens. Une approche qualitative a été utilisée dans le but d'obtenir des descriptions exhaustives concernant les sentiments d'incompétence des thérapeutes avec dix années d'expérience et plus. Huit cliniciens ont exploré leurs sentiments à cet égard lors d'entretiens d'une durée de 90 minutes. Guidés par les méthodes de la 'Grounded Theory' (Strauss & Corbin, 1992), l'analyse de ces données se résume dans une théorie dite substantive. Bref, les sentiments d'incompétence s'étalent sur une échelle d'intensité et sont déterminés par des facteurs multiples. Les catégories principales sont: la profondeur des doutes, les causes, les antécédents, les conséquences, et les facteurs de médiation organisés autour de la catégorie centrale qui est l'intensité. Cette étude propose une théorie dynamique et multidimensionnelle des sentiments d'incompétence tel que perçus et vécus par des thérapeutes d'expérience.

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INTRODUCTION

Background of the Problem

The therapist's character is a predominant factor in successful therapy: The magnitude of the therapeutic impact attributable to therapist personality factors is eight times greater than that associated with treatment technique (Lambert, 1989). In fact, therapists' emotional well-being is considered by many theorists to be the foundation of their craft (Deutsch, 1985, Rogers, 1992). Unfortunately, personal distress is common among psychologists. A study by Guy, Poelstra, and Stark (1989) reveals that 74.3% of psychologists reported feeling personal distress during the previous three years. In other surveys, over 90% of psychotherapists reported emotional problems directly related to their professional therapeutic role (Guy, 1987, Guy & Liaboe, 1986). As a result of this distress, the therapist's disposition is altered and the quality of services rendered may be jeopardized.

Beyond the impact on therapy, the negative effects of personal distress on therapists' personal lives are sufficiently compelling as to be of direct concern. A small body of literature documents the strains, wounds, and impairments incurred by therapists as a function of the helping role. In fact, some authors warn that the career of psychotherapist has inherent and serious hazards that are prominent throughout the career (Brady, Healy, Norcross, & Guy, 1995). The question of what ails the healer has revealed a plethora of major and minor symptoms associated with the practice of psychotherapy. Consequently, the study and care of the helping professional have become a research priority (Mahoney, 1991).

Among the sources of distress identified by therapists, doubts about the efficacy of therapy abound: Therapists wonder about their effectiveness in fully a quarter of the sessions they conduct (Orlinsky & Howard, 1977). Mahoney (1991), in an extensive review of the literature, also identified low self-esteem and doubts about efficacy of therapy as common sources of stress for psychotherapists.

The literature implicitly reveals that therapists' emotional well-being is judged as critical both for therapists personally and in their therapeutic pursuits. Unfortunately, therapists are often distressed. The subjective perception of lack of effectiveness in therapy is an important factor that contributes to this distress. This perceived lack of effectiveness is one factor that leads therapists to feel incompetent. Regardless of the accuracy of these judgments (the relationship to actual performance is contested) or the normalcy (some studies report that 70% of therapists report feeling inadequate in their role), therapists' feelings of incompetence are powerful. The therapists' internal judgment or doubts about their competence is the focus of this inquiry. When therapists internally challenge their beliefs about being good therapists a host of outcomes are possible.

Impact of Therapists' Self-Doubts.

The uncertainty about one's effectiveness as a therapist has substantial personal and professional repercussions for the therapists from their point of entry as students in the field of psychology and throughout their professional lives. Feelings of incompetence have been linked to the following: stress and burnout, sexual involvement with clients, depression, and alcoholism.

Stress and Burn Out

Although most therapists struggle with transient feelings of despair, between 2% and 6% of therapists' distress will lead to burnout (Farber, 1990). Burnout is a state in which human services professionals become possessed and eventually consumed by the demands of their role (Maslach, 1982). The typical symptoms associated with this experience are: feelings of physical and emotional depletion, increased irritability, anxiety, and the development of negative attitudes towards oneself, clients, and work in general (Farber, 1990).

Several studies have linked feelings of incompetence with stress and burn out. Farber & Heifetz (1982) conducted in depth interviews with 60 therapists. The single most stressful aspect of the therapists' work was identified as lack of therapeutic success by 73.7% of respondents. Their results revealed that self-perceived inadequacy was an important component of the burn out syndrome. Feelings of demoralization and disillusionment were frequently the result of the perception that therapists' efforts were inconsequential. Moreover, fully 55% of psychologists agreed that in order to prevent such feelings of disillusionment they have had to reassess the limitations of therapy and set "realistic" goals.

Factor analysis of data gathered via questionnaires sent to 264 therapists identified competency doubts as one of seven stress factors revealed by clinicians in yet another study on the stressful factors of the therapeutic role (Deutsch, 1984). Doubts about their effectiveness were also recognized as one of the three biggest sources of stress among therapists in a study by Daniels (1974).

It is clear that some of the hazards of our profession stem directly from the professional role and the incumbent expectations. Although most therapists expect the therapeutic work to be demanding, they also expect some "return" on their "investment". "Constant giving without the compensation of success apparently produces burnout" (Farber & Heifetz, 1982, p.98). It is important to note that the focus of the studies reported is on therapists' sense of success and on their internal self-evaluative processes. Doubts about their effectiveness and competency were self-generated and not a product of external performance evaluations or criteria.

What therapists expect from themselves is often as distressing as what they expect in terms of therapeutic results. Harbouring the illusion that they must always be perfect in therapy may lead therapists to collude in the process leading to their burnout. The misguided sense of self-as-guru (Mahoney, 1991), as paragon of virtue and psychological well-being in and out of therapy may lead therapists to overlook important personal and professional shortcomings that can eventually lead to their demise. The logical dichotomy between being super therapist and feeling incompetent may break down on an experiential level. Perhaps the two are more like close relatives than opposite ends of a continuum. This is certainly suggested by several studies.

Of the 13 irrational beliefs frequently endorsed by therapists in Deutch's study on sources of stress among therapists (1984), the most frequently declared were related to "doing impeccable work with all clients in all situations". They were: (a) I should always work at my peak level of enthusiasm and competence, (b) I should be able to handle any client emergency that arises, (c) I should be able to help every client, and (d) when a client does not progress, it is my fault. From a psychoanalytic perspective, the position of

being invincible is a defence mechanism against feelings of despair and powerlessness. If the therapist

> is supposed to help alleviate the client's distress, he or she may feel that it is imperative to deny his or her own psychological pains and aches and to make every effort to repress his or her identification with the client. A seemingly "helpful" way to deny one's similarity to the vulnerable and weak client is to become the client's opposite, a superman or superwoman, who has everything under control and feels nothing but strength (Strean, 1993, p.130).

The relationship between omnipotent and incompetent emotions may be narrow. Perhaps having unrealistically high expectations of oneself as a therapist makes one particularly vulnerable to experiencing feelings of incompetence. Therapists may also cling to these omnipotent fantasies as a defence against the feelings of incompetence. Other damaging outcomes result from therapists' misguided attempts to conquer feelings of inadequacy and incompetence.

Sexual Involvement With Clients

Wood, Kleine, Cross, Lammers, and Elliott (1985), set forth the thesis that some therapists may act on their sexual attraction to clients as an antidote to feelings of powerlessness within sessions. Although the magnitude of the problem is important, (9.4% of men and 2.5% of women have had sexual contact with their clients according to Pope, Keith-Spiegel & Tabachnick, 1986), very little is known about the dynamics that contribute to this ethical breach.

Depression and Alcoholism

Feelings of powerlessness and incompetence are difficult to admit and address in a profession endowed with curative powers. The 'god-like pretensions' bestowed upon professionals in our society bolsters the mechanism of denial. "It is often overlooked that those individuals who refuse to appear vulnerable, who cannot admit mistakes or acknowledge limitations or inconsistencies in their character or behaviour feel quite week but cannot face this fact" (Strean, 1993, p.130). Denial of stress contributes seriously to the problem of alcoholism within the profession of psychology, which is currently estimated at a conservative 6% (Thoreson, Nathan, Skorina, & Kilburg, 1982). The increased level of denial not only prevents distressed psychologists from seeking support when they feel incompetent or asking for help for their problems but also leads them to continue to practice while under the influence of alcohol.

Other authors have established that serious consequences result form the stresses of therapeutic work. Mahoney (1991) has identified a reduced resistance to disease and depression as potential hazards. Fully 58% of psychotherapists surveyed by Deutsch in 1985 reported having experienced serious depression while 2% disclosed a suicide attempt. What role feelings of incompetence play in these is unclear. The relationship may be indirect. For example, feelings of incompetence lead to distress, distress leads to alcoholism and depression.

Statement of the Problem

The important links that have been made between feelings of incompetence and the problems therapists develop justify a focused, direct, and in depth look at this subjective self doubting process. However, very little attention has been paid to how

therapists experience therapy; their subjective experience has virtually been ignored. Their feelings of incompetence remain neglected as a topic of formal study.

Therapist's Feelings in General

Psychologists have traditionally been characterized by adherence to the myth of their infinite power and invulnerability (Thoreson, Nathan, Skorina, Kilburg, 1982); the experience of difficult emotions by the psychotherapist has only recently become an acceptable subject of informal discussion. While most frequently divulged among colleagues or to a supervisor, some authors are quite candid about disclosing the extent of their struggles in therapy (Davis, Elliott, Davis, Binns, Francis, Kelman, & Schroder, 1987, Dryden, 1992, Yalom, 1989). For example, Yalom (1989), in discussing his involvement with a client describes how the therapist frequently wobbles, improvises, and gropes for direction. Similarly, therapists from different theoretical orientations are increasingly exposing the dilemmas they experience in the conduct of therapy (Brady, Healy, Norcross, & Guy, 1995, Kottler, 2002, McLeod, 1990, Dryden, 1985, Guy, 1987).

Despite the growing interest in this aspect of the therapeutic process, only a few investigators have proposed empirically grounded, theoretical explanations about the subjective experience of psychotherapists as they go about their tasks (Guy, 1987, Hill, Howard, & Orlinsky, 1970, Mearns, 1990). This is especially disconcerting in view of the accumulating evidence that clinical work exhorts a high cost on the personal and interpersonal functioning of the practitioner. In the words of Norcross (1990) "The silence is deafening" (p.46). Therapists have been the source of many theoretical formulations about process, yet reports about the direct inquiry into their feelings about

what occurs in the sessions have curiously been sparse (Howard, Orlinsky, Hill, 1969, McLeod, 1990). Why?

The scarcity of research in the area of therapists' experience of psychotherapy has been attributed to a resistance on the part of therapists to examine in public the experiential dimensions of their role (McLeod, 1990). Others (Orlinsky & Howard, 1977) postulate a prejudice against the study of the therapist's experience: it is not accepted as a legitimate subject for scientific inquiry. Two misleading biases lead researchers to judge therapists' experiences as idle curiosities or unwanted intrusions. The first is an image that abounds in the research literature of the therapist as an instrument of treatment and as such is not viewed to be participating as a person with subjective experience worth studying. The second bias implies that only the therapist's technical interventions matter because that is what affects the client's experience. The therapist is viewed as an agent and the client the object of treatment. In this view, the therapist's subjective experiences, although present, are irrelevant to the process. Orlinsky and Howard (1977) disclaim these widely held but often implicit biases. They argue that the fact that therapists are persons is inescapable and that they both act and experience during the therapeutic session. They contend that their actions are linked to their ongoing experience of therapy; "the experiences that condition his actions have an imminently practical relevance" (p. 567). They advocate systematic research on therapists' experiences, research that views therapists as personally implicated, reactive individuals. This stance then views therapists' experience and their attempts to cope with their emotions as critical variables in the process of therapy and hence in research that addresses psychotherapy process.

The exception to the general neglect of this topic area comes from the psychoanalytic school, which has focused on countertransference. According to the moderate definition of countertransference, all therapists' emotions are "counsellor reactions that originate from areas of unresolved conflict in the counsellor" (Rosenberger & Hayes, 2002, p.265). Countertransferential feelings are drawn from the therapist because the client is doing something that elicits those emotions; it is nothing more or nothing less than the therapist's transference reaction to his or her client (Brenner, 1985). Many studies have examined therapists' emotions during therapy from this standpoint. The contributions and limitations of this approach will be expanded on in the review of the literature.

Whenever studies of the difficulties of conducting therapy are reported, feelings of incompetence or similar constructs emerge among numerous factors that contribute to problems identified.

Therapists' Self Doubts

The research on the specific area of professional self-doubts and feelings of incompetence in therapists is rare. The fact that so few studies have attempted to explore specific elements of the hazards of psychotherapeutic practice for the clinician in depth has been identified as a weakness in the limited research that does exist on the general topic of the therapist's experience of psychotherapy (McLeod, 1990). The efforts deployed have concentrated on creating taxonomies and category systems as rough maps of the terrain. There is a call for research that elaborates on each or any of the components of these generic systems. However, few researchers to date have heeded the call.

Several studies have been conducted that explore constructs similar to feelings of incompetence. Within the school of social learning theories, for example, the attempt to understand the impact of low self-efficacy on therapists has spawned a new domain; counselling self-efficacy. Self-efficacy according to Bandura (1977) has been examined in relation to certain factors. Poidevant, Loesch, and Wittmer, (1991) explored the relationship between self-perceived levels of competency and vocational aspirations in counselling students. Johnson, Baker, Kapola, Kiselica, and Thompson (1989) assessed the impact of self-efficacy on counselling competence. Sipps, Sugden, and Faiver (1988) examined the relationship between self-efficacy and basic counselling skills. The results of these studies will be reported later.

Because they are behaviourally anchored and focussed on performance, these studies collectively do not address the internal dimensions of therapists' experience with self-doubts and feelings of incompetence. As such they are not well suited to investigate subjective phenomena. The contributions of this approach have nevertheless been meaningful and these attempts have given credence to the study of therapists' self-referent thought processes.

Beyond the focus on self-efficacy, systematic inquiries on therapists' self doubts as a sole construct or subset of the global subjective experience of being a therapist have yet to be elaborated. Very little has been documented about 'What it is like for a therapist to feel inadequate when doing therapy'. Several studies have approached the issue of insecurity and have correlated insecurity with lack of professional experience. Many of these studies have focussed exclusively on novice therapists or trainees. We continue to ignore how experienced and seasoned therapists feel, interpret, and behave in response to

their feelings of incompetence. Yet we know that these same therapists are experiencing stress, burn out, depression, and premature career terminations and that these are partially due to the feelings of incompetence.

Because the existing studies have not contributed to a profound understanding of feelings of incompetence in experienced therapists, there is a weakness in our ability to adequately explicate what the more general studies have identified as an important cluster of emotions having to do with a sense of professional incompetence.

Our inability to adequately describe this aspect of therapist experience leads to an inability to recognize its impact on our personal and professional lives, to mediate its effects, to create coping models, to teach prophylactic therapist self-care. We are neither preparing nor protecting ourselves or the new generation of therapists against this insidious, destructive, yet normative force of subjective negative self-appraisal. "It has become increasingly apparent that future refinements in the training of psychotherapists should include explicit recommendations regarding health behaviour and psychological self-care" (Mahoney, 1991, p.360). Critical aspects of this self-care are a systematic consistent approach to self-evaluation and skills to promote protection against the silent erosion of one's sense of professional competence over the entire career span.

Introduction to the Study

Based on the forgoing discussion, the notion that feelings of professional incompetence among seasoned therapists are at least common if not pervasive is assumed. This study aims to focus on this single element of therapist personal distress in depth. A tripartite rational indicates that a qualitative approach is warranted/justified: The domain is virtually unexplored, the nature of the material is subjective, and the level of

insight sought is 'deep' or 'thick' (Strauss & Corbin, 1998).That is, we are seeking information that is detailed, nuanced, and vivid. A series of semi-structured interviews was conducted and later analyzed and scrutinized for knowledge contributing properties. As our understanding and exploration of this sensitive area is meagre, the more lofty goals are to open the field, to initiate exchange, to set a precedent for a new dialogue, to generate themes, to challenge myths about the profession, and to humanize the role of the therapist. A discovery-oriented philosophy allows the researcher to remain susceptible to serendipity while purposefully striving to elicit a structure, to mount a substantive theory from the emerging information.

Purpose of the Study

The construct of feelings of incompetence or thematically related constructs (i.e., competency doubts, feelings of inadequacy, ineffectiveness) are repeatedly identified among a group of factors that contribute to therapist stress, distress, and impairment. The purpose of this study is to elaborate on and enrich these results by probing deeply into the area of therapists' subjective experience of incompetence. The aim is to achieve a meaningful understanding of the nature and impact of such internal struggles with the issue of one's effectiveness in the therapeutic role. The population of interest is the experienced clinician.

Research Questions

Feelings of incompetence are an inevitable aspect of psychotherapists' internal world. Theories, multiple factor studies, and therapists themselves acknowledge its importance. Despite the scattered yet compelling knowledge about feelings of incompetence, several important questions remain:

2- Phenomenological

How are feelings of incompetence defined and experienced by seasoned clinicians?

What are the factors that influence feelings of incompetence?

How do experienced therapists deconstruct the moment of feeling incompetent into more basic elements?

How are these elements related to each other?

What is the relationship between feeling incompetent and the therapists' actions?

How do therapists themselves understand and interpret their feelings of incompetence?

2- Developmental

What is the evolution of the feeling of incompetence for clinicians across different levels of training and experience?

These are the questions that will be central in this study. The emerging theory will demonstrate the components of the construct feelings of incompetence and will elaborate the relationship among these components. Thick descriptions will illustrate what impact this experiential dimension has on therapists and their imminent actions.

Original Contribution to Science

The study of therapists' experience of therapy is underdeveloped. This study aimed to enhance our understanding of the causes, antecedents, consequences, and correlates of a targeted subset of therapist emotions. A focussed, systematic, phenomenological approach to the experience of feeling incompetent by experienced therapists was undertaken. A dynamic, pan-theoretical, multiple component theory summarises the detailed and novel information gathered on this topic. It is among the

most complete, empirically grounded theories to date on the topic of feelings of incompetence.

Significance of the Study

There remains in the profession of psychology a reluctance to openly acknowledge even among ourselves our vulnerabilities and limitations. Witness the countless workshop/conference hosts who display "successful" cases and miraculous personality transformations. The profession as a whole is reluctant to recognize the special burdens inherent in our work (Brady & al., 1995, Kaslow, 1984). Candid descriptions of the actual conditions and stresses of the psychotherapeutic role are fundamental to help address, prevent, or minimize the demoralization that unavoidably occurs when therapists are unprepared for the disappointments and self-doubts that they will inevitably face. A realistic appraisal of the impact of psychotherapeutic work on the helper must be built into the structure of the profession (Farber & Heifetz, 1982). "To thrive in this role it is necessary to be cognizant of and prepared for the pitfalls inherent in a counselling practice"(Brady et al., 1995, p.1). Graduate training programs, supervision, conferences, and seminars are arenas that could serve for the dissemination of the true nature of the therapeutic endeavour, the potential failures as well as successes, the stressful and dysfunctional aspects, as well as the rewards.

Ostensibly this process begins with knowledge; knowledge about different levels of experiencing by the therapist, and knowledge about the inner world of the therapist as he goes about the task of being helper, healer, and fellow human. This project begins the formidable task of gaining an in depth, magnified, first person perspective of a particular subset of such experiencing, namely the feeling of inadequacy in one's role as therapist.

An elaboration on components of meaning, consequences, and correlates will serve as a springboard towards the following long-term goals: a) to correct the discrepancy between therapists' needs and supervision, b) to design and institutionalize a preventative training-module against possible damage caused by feeling incompetent, c) to encourage prophylactic use by individual therapists, and d) to introduce a more realistic, humble portrait of the role of therapist.

Hence the study's ultimate aim and contribution is to the field of applied psychology and bridges the areas of prevention and therapist self-care. It also contributes to the area of psychotherapy process research by examining the role of therapists' self-doubts on therapists' decisions, imminent actions, and emotional attachment to clients.

A review of the literature immediately follows this chapter. It summarises this emergent field while justifying the methodological choices of the present study. These are then detailed in the subsequent chapter. The findings comprise the body of the fourth chapter. They are described in detail and integrated in a theoretical proposition. The final chapter, the discussion, briefly synthesises the information gathered and reviews the gains made in light of previous research and ideas.

Chapter 2

REVIEW OF THE LITERATURE

In this chapter, the accumulated knowledge on the nature, development, correlates, and consequences of feelings of incompetence will be reviewed. First, a summary of how therapist experiences and difficulties in general have traditionally been examined will be discussed. Next, the identification of self-doubt as an important element in therapists' experience of psychotherapy will be demonstrated. In other words, the discussion will move from the general to the specific. Theories that relate to experiences that are similar to feelings of incompetence (F.O.I.), low self-efficacy and insecurity, will be reviewed and research based on these theories critiqued. Factors that contribute to F.O.I. will be suggested. The effects of such self-doubts on therapists, on clients, and on the therapeutic relationship will be examined. Finally, a brief review of the methodological approaches to the study of the construct feelings of incompetence, their strengths, and shortcomings, will be presented.

The theoretical and empirical literature in clinical and counselling psychology will be reviewed to gain an understanding of how the subjective feelings of incompetence have been perceived and studied. The discussion will encompass the therapists' experience of therapy in general and their subjective self-appraisal in particular. For the purposes of review the following terms will be considered equivalent and will be used interchangeably: feelings of incompetence, professional uncertainty, felt incompetence, self doubts, self perceived inadequacy, and ineffectiveness. Use of these terms will convey the following meaning: the therapists' belief in their ability, judgment, and/or

effectiveness in their role as therapists is temporarily diminished, reduced, or challenged internally.

Because the literature base that focuses on feelings of inadequacy is limited, parallel literature and related concepts such as mastery and confidence will be included in the review. When the term self-efficacy is used, it can correctly be assumed that the author is describing theory or research that emanates from Bandura's (1977) self-efficacy model. The tangential concepts of anxiety, dilemmas, and fear of failure will be examined to ascertain whether they can contribute meaningfully to our understanding of this area. The terms therapist, counsellor, psychologist, counsellor trainee, and practitioner will faithfully reflect the nomenclature used by the respective authors reviewed.

Research on Therapists' Experience of Therapy in General

Global approaches have identified F.O.I. as a factor of import and concern within the broader area of therapist personal stress/distress. The following studies demonstrate that while there are a number of difficulties that are identified as critical by therapists, there is a fairly consistent agreement across studies that feelings of incompetence are among the most distressing.

By far the most extensive research that has been conducted in the general area of therapists' feelings about therapy is by Howard, Orlinsky, and Hill (1969) and Orlinsky, Howard, and Hill (1975). A questionnaire entitled, "The Therapy Session Questionnaire", was developed to investigate the feelings of both therapists and clients after each session in which they participated. The participants were asked to rate on a three-point Likert scale a series of 152 statements that described therapists' perception of client and of self. The results were factor analyzed and one of the factors that emerged for therapists was

named "sense of failure". It was characterized by such items as disappointment, inadequacy, frustration, apprehension, and anger (Howard, Orlinsky, & Hill, 1969).

Another study by the same authors, revealed a similar factor called "sense of mutual failure", which reflected the therapists' sense of personal efficacy (Hill, Howard, & Orlinsky, 1970). This dimension was described as the therapists' experience of a self-critical sense of failure and involved feelings of disappointment, inadequacy, frustration, apprehension, and a desire to urinate. This category of therapist feeling was thought to contribute to one of four major experiences of therapy by therapists, namely, personal distress.

Several other factor-analytic studies of therapists' difficulties and stresses point to the importance of self-doubts. Farber & Heifetz, (1981) investigated, through the use of rating scales, the satisfactions and stresses of psychotherapeutic work for 60 clinicians. Of the three derived stress factors, the second factor labelled 'therapeutic relationship' indicates a similar notion: "giving so much, receiving so little and through it all remaining vulnerable to doubts that one's efforts are effective" (Farber & Heifetz, 1981,p.624). The study was replicated by Hellman, Morrison, and Abramowitz (1986). They asked 227 licensed psychologists to rate on a Likert scale the extent to which 37 different situations were experienced as stressful. An analysis of the responses to this Therapeutic Stresses Rating scale revealed that therapists' stresses loaded on five factors. The third factor was labelled professional doubt and subsumed the following items:" a) doubts about the efficacy of therapy, b) difficulty in evaluating my therapeutic contribution, c) frustrations with insufficient therapeutic success, d) slow and erratic pace of my work, and e) silently critiquing my therapeutic technique while conducting

therapy" (Hellman & al., 1986, p.201). Deutsch (1984) also sought to clarify the stress inherent in client sessions and in the professional role. Of the seven factors that emerged from his analysis of 264 questionnaires, one was also labelled competency doubts. This factor subsumed items such as: "I should be able to help every client" and "when a client does not progress, it is my fault" (Deutsch, 1984, p. 837).

These studies begin to decipher the elements involved in the construct of professional self-doubt. Issues of attribution and responsibility, internal dialogues, and therapists' expectations are put forth.

The rating scale approach used in the preceding studies has several advantages. It yields data that are relatively easily managed and analyzed statistically. The factorial approach is rigorous. However, rating scales are not very sensitive and offer a limited view of the therapists' internal meanderings. Factors are proposed but only briefly described and these descriptions could be enriched by adding contextual texture.

Other research achieves more descriptive detail. For example, Davis et al. (1987), in their quest to elaborate taxonomy of therapist difficulties, gathered a series of 125 examples of difficult moments from seven experienced therapists. The group of therapists then elaborated a consensual set of experiential categories from the initial item pool. Nine categories of difficulties emerged, one of which was labelled T- Incompetent and defined as:

> The therapist questions or negatively evaluates his or her skills/performance/adequacy as a therapist. The therapist's expressed concern is not with the consequences of this deficiency for the patient but with his or her own narcissistic injury. The therapist's confidence in self is

undermined (Davis, Elliott, Davis, Binns, Francis, Kelman, & Schröder, 1987, p.118).

This category scheme remains rooted to the therapists' perspective and moves beyond the surface of the experience. However, this study was preliminary and missing a larger theoretical scheme to explain the categories and their properties.

The aforementioned studies demonstrate that when the therapists' experience of therapy is examined globally, feelings of incompetence or doubts about competence consistently emerge as a subset of the bigger picture. These studies collectively set the stage for future research. The fact that feelings of incompetence and similar constructs emerge across studies despite the different methodologies, orientations, and aims suggests that feelings of incompetence merit further investigation. It is a valid topic for this inquiry process.

Theory and Theory-Driven Research on Feelings of Incompetence

Three main approaches account for the theoretical understanding of feelings of incompetence and self-doubts: psychoanalysis, self-efficacy theory, and developmental models. These models and their contributions are summarized below with the aim of outlining the need for an alternative conceptual framework and methodological approach for the study. Subsequently, research that examines parallel concepts is reported.

Psychoanalytic Theories and Countertransference.

According to psychoanalytic principles, it is not all at unusual for a therapist to feel baffled "if they are at all honest with themselves" (Strean, 1993, p.130). These moments create uncertainty and feelings of vulnerability for the therapist.

> Inasmuch as therapists feel baffled much of the time, confused and uncertain most of the time, and very clear about what is happening in the therapeutic process only a small portion of the time, they have to mobilize their defences to cope with this ever-present state of acute discomfort (Strean, 1993, p.130).

When therapists experience confusion and uncertainty in themselves as a result of the complexity of the material presented by clients or because they identify with the client, a likely defensive response is to have fantasies of grandiosity and omnipotence. Therapists ardently attempt to ward off their insecurities and ineptness by maintaining the position of the doctor who knows it all. In doing so the client is often inadvertently kept in a position of dependence and inferiority. The power imbalance can be perpetuated by many therapeutic strategies such as: labelling, obstruction of the client's attempts to be critical by interpreting such communications as resistance, and encouraging the client's love transference. These reactions and others are considered to be counterresistant manoeuvres: They are the therapists' way of resisting involvement with clients or subject matter likely to cause upsets for the therapists. The theory does not elaborate on therapists' F.O.I. during therapy beyond their attribution to countertransference and counterresistance. The moderate definition of countertransference focuses exclusively on therapists' unresolved conflicts. It is probable that other mechanisms are involved.

While the literature in this field is varied and the contributions are rich and clinically meaningful, the contributions stem from writings which, historically, were mostly impressionistic and anecdotal (Hellman, Morrison, & Abramowitz, 1986). Indeed, a major shortcoming of psychoanalytic writings is that they have been largely conjectural until recently. Traditionally, scientific rigor has neither been an aspiration nor a

convention of the psychoanalytic school of thought. However, recent years have witnessed increasing methodological sophistication and a newfound commitment to systematic and respected forms of inquiry (Rosenberger & Hayes, 2002). In a review of the literature on countertransference that has been published since 1979, Rosenberger and Hayes(2002) reported that most of this research used analogue methodology. While the improvement in the level of confidence with which causal relationships can be inferred is significant, the external validity of this body of research remains questionable. It is not clear whether the findings can be generalized to settings outside of the laboratory. To remedy this problem with external validity, the authors proposed that "interviews, observational studies, and field experiments are all needed to deepen current understanding of CT" (Rosenburger & Hayes, 2002, p.269). Thus although this approach offers the most in-depth and insightful analysis, the constructs and hypotheses could be strengthened by additional empirical material to support them, particularly data that emanate from practice settings. The present study aims to complement this body of knowledge by exploring alternative explanations for feelings of incompetence (in addition to countertransference) and inadequacy and by making explicit links between real-life data and theoretical propositions.

In the last ten years, psychoanalytic theories and their constructs have begun to be explored by standard research approaches. Other theories, such as self-efficacy theory, have proponents who have been profoundly committed to accumulating a sound empirical base since the theories inception.

Self-Efficacy Theory

Bandura (1977) issued the broad theoretical statement that self-efficacy, defined as the conviction that one can successfully execute behaviour to bring about a desired outcome, operates in all learning situations. A second major concept, outcome expectancy, was postulated. It was defined as the person's estimation that a given behaviour will lead to the desired outcome. Together these two constructs, self-efficacy and outcome expectation, form the basis of self-efficacy theory.

This social learning theory is based on the concept of mastery and relies on the idea that cognitive-mediation factors influence a variety of behaviours; whether coping behaviours will be initiated, how much effort will be expanded on a task, and how long it will be sustained in the face of challenging obstacles (Bandura, 1977). Put simply, the theory rests on the assumption that all behavioural and psychological change occurs through the modification of an individual's sense of personal mastery or efficacy and these cognitive change events are induced and altered particularly by experiences arising from effective performance. Bandura (1977) theorizes that preoccupation with personal inadequacies have a debilitating effect on performance. Enhancing self-efficacy will reverse that effect and generalize to other situations; hence the notion of reciprocal determinism.

Four major background and experiential sources contribute to the development of self-efficacy. In order of influence they are: performance accomplishments (clear success or failure experiences), vicarious or observational learning (modeling or imitation), verbal persuasion or encouragement, and emotional arousal (negatively experienced emotional arousal gives the person negative information in regards to their performance

capabilities). These are the main antecedents of self-efficacy and are also the avenues by which self-efficacy can be altered. Although originally conceived as a framework to explicate change processes in clients, Bandura's formulations logically extend to therapists and as such have been central in the few studies that address this factor (Johnson, Baker, Kapola, Kiselica, & Thompson, 1989, Sipps, Sugden, & Faiver, 1988).

Bandura's theory has generated a large amount of research. Generally, self-efficacy has been found to predict differences in the degree to which people choose, persist, and succeed in performing targeted behaviours across behavioural domains. The theory is very much based on observable skill and extrinsic motivational factors as well as external sources of feedback, not much attention is paid to intrinsic factors and individual differences.

Like all social learning theories, self-efficacy theory has also been criticized for being reductionistic. The positive results in the literature could be attributed to the strong bias in cognitive and behavioural literature towards analogue studies, mild cases, and highly reactive criteria (Shapiro & Shapiro, 1982). De facto, much of the research on self-efficacy originally examined highly circumscribed target problems and performance criteria (Lent, Brown, & Larkin, 1984). The theory has also been applied towards understanding highly complex performance areas, such as counselling.

The Application of Self-Efficacy to Counselling; Counselling Self-Efficacy

Self-efficacy theory has been applied to the domain of counselling and used as a framework to understand counselling related behaviours, attitudes, and choices. Defined as "a generative capability in which component cognitive, social, and behavioural skills must be organized into integrated courses of action to serve innumerable purposes"

(Larson & Daniels, 1998, p.179), the concept relies on the basic premises described in the general self-efficacy theory. Counselling self-efficacy (CSE) is about counsellors' beliefs in their capacity to effectively perform the tasks involved in counselling clients in the near future. CSE beliefs are also related to choice of counsellor response, effort expenditure, persistence in the face of obstacles, and risk-taking behaviours. The cognitive mediation factor rests on the four sources previously reviewed; performance accomplishments, vicarious experiences, verbal persuasion, and emotional arousal. These are the premises upon which the counselling self-efficacy research is based.

Guided by Bandura's model and definition, Johnson et al (1989) studied the relationship between counselling self-efficacy and counselling competence in pre-practicum training. The results indicated that efficacy increased with training but its relationship to performance of skills was weak. In other words, no strong link emerged between the belief in ones capacity to perform well and good/better performance. This study, which is widely cited, established the therapist's self-efficacy as a critical variable to study. Details of the study can be found in the section on the relationship between self-efficacy and performance.

Poidevant, Loesch, and Wittmer (1991) are another group of researchers that used self-efficacy as a variable of study. They assessed its impact on graduate students' professed preferences for different types of professional activities. Significant positive relationships were found between self-efficacy and preferences for the following professional activities: a) research, b) supervision and training, c) administration, d) consultation, e) writing and editing, and f) teaching and training. No relationship was found between preference for counselling and self-efficacy.

Jointly these studies highlight the following points; there seems to be no strong relationship between performing well and feeling efficacious, or between feeling efficacious and preferences for counselling activities .The present study was designed to target the following question: If therapists' feelings of incompetence are not bound to their performance, what causes them to feel this way? The studies reviewed also focus exclusively on counsellor trainees and novices, which motivates the present study's objective to understand the experience of feeling incompetent in accomplished therapists.

Although Self-Efficacy theory's major tenets have been supported by studies that test them, the theory does not seem able to account for therapists' feelings of self-efficacy. In other words, therapists' prior successes do not linearly affect their feelings of self-efficacy for conducting therapy. The weakness of the link between performance accomplishments and self-efficacy retains our attention because it suggests that the self-evaluation/doubting process of interest is multifaceted and perhaps too complex to be broached by a more generic type of theory. Perhaps some critical elements that affect the construct of counselling self-efficacy, and by extension counsellors' feelings of incompetence, are beyond what can be apprehended with a model anchored in behavioural indices of emotional experiences. It substantiates our contention that therapists' feelings of incompetence have many components at different levels of depth and will best be understood by an approach that validates these and incorporates them into its elaborations. It justifies the need to do this study using a qualitative, grounded approach.

Developmental Models

Developmental models of supervision have identified professional self-confidence as an important element in the evolution of counsellors from novice to expert. Despite their different theoretical underpinnings, most models are similar to one another (Halloway, 1987) and describe development as a series of discrete stages of which only one of the components is change in self-assurance in one's role as therapist. These models are linear in nature, assuming that therapists begin with high levels of insecurity and that with experience, they become increasingly self-confident. Generally, therapists in stage one are viewed as highly anxious and lacking in self-confidence (Loganbill, Hardy, & Delworth, 1981). The fear of failure is prominent (Grater, 1985) and all failures that occur in work with clients are attributed to self (Skovolt & Ronnestad, 1992). Therapists are uncomfortable in their role and are afraid of being found out. This preoccupation subtracts from the interest devoted to clients (Auerback & Johnson, 1977). Stage two is characterized as one of ambivalence, where therapists vacillate between overconfidence and a feeling of being overwhelmed. As a result, motivation fluctuates (Stoltenburg, 1981). In stage three, therapists begin to establish a sense of themselves as therapists and feel more in control. There is an increase in their level of professional self-confidence (Stoltenberg, 1981). Finally, in stage four, therapists are secure and have appropriate levels of self-confidence. Part of this security is based on an acceptance of ambiguity; therapists have become familiar with moments of uncertainty (Stoltenberg, 1981). Other authors have suggested that the stage of reconciliation, where the therapists' perception of their limitations is accepted and integrated, is not inevitably achieved with experience.

Contrary to the way most developmental theorists in the area of counsellor development have described the evolution of self-confidence through the stages, Blum and Rosenburg (1968) have postulated a curvilinear relationship between level of training and self-confidence. They theorize that beginning students have particularly high levels of self-confidence because of their reliance on common sense interventions and their underestimation of the difficulty of the therapeutic interaction. This is followed by disillusionment in the second year when the abortive attempts to use common sense lead to self-conscious behaviour. With the experience gained in the third year, counsellors' self-efficacy expectations increase. The fourth year trainees, having been exposed to many mastery experiences (Bandura, 1977) have the greatest level of self-efficacy. It is assumed that from that point onwards, the feelings of mastery naturally continue to increase. There is no further elaboration as to the evolution of the family of emotions related to self-doubts beyond these initial years.

The primary weakness with developmental models is that little empirical support has been generated to support them. Developmental models have also been criticized for their exclusive focus on the early phases of professional growth. "With the possible exception of Skovolt and Ronnestad (1995), the existing literature gives only a sketchy account of professional development in the later years" (Orlinsky et al., 1999, p.204). These models then routinely equate feelings of inadequacy/incompetence with lack of experience and neglect to inform about the nature and impact of longstanding struggles with professional self-doubts. The empirical literature has reflected this tendency to focus on early career phases as most studies have been conducted with trainees and therapists in their immediate post graduate years (Skovholt, Ronnestad, & Jennings, 1997). Which

begs the question: Do more seasoned therapists experience feelings of insecurity in their role as therapist? What is the nature of and impact of this experience? How do these questions about one's adequacy affect the experienced therapist and the therapy?

Other Causal Explanations for Feelings of Incompetence

Experience

The role of clinical experience in feelings of incompetence is ambiguous. While many believe that feelings of mastery undoubtedly develop as one gains experience as a therapist (Auerback & Johnson, 1977, Skovolt & Ronnestad, 1992, Stoltenburg, 1981). some question the assumption of a linear progression from early feelings of uncertainty to secure confidence in one's abilities. Anthony's (1967) longitudinal study revealed that therapists who were more experienced expressed feelings of decreased security in their role after four years of practice. Despite their experience level (mean years = 6.4), the therapists in Orlinsky and Howard's(1977) exploration of the therapist's experience of psychotherapy reported feeling inadequate on a quarter of the occasions observed. Mearns (1990) reports that two of the most seasoned therapists in his study with over 20 years of experience and recognized as the leading therapists in Britain disclosed sometimes doubting their ability as counsellors and the urge to sometimes "pack(ing) it all in and return(ing) to business of burying myself (sic) in administration"(Mearns, 1990, p.91).

A study by Orlinsky, Ambühl, Botermans, Davis, Ronnestad, Willutzki, Ciepra, and Davis (1999) attempted to demystify the relationship between experience and insecurity. They accessed data that resulted from a survey (Development of Psychotherapist Common Core Questionnaire) of 3,900 psychotherapists at all career

stages in several countries available through the Society for Psychotherapy Research (Orlinsky et al., 1999). A scale labelled Perceived Therapeutic Mastery was factor analytically derived from practitioner ratings on the following items: (a) How much mastery do you have of the techniques and strategies involved in practicing therapy?, (b) How well do you understand what happens moment by moment during therapy sessions?, (c) How much precision, subtlety, and finesse have you attained in your therapeutic work?, and (d) How capable do you feel to guide the development of other psychotherapists? The results indicated that for the group as a whole and for every experience level subgroup, perceived therapeutic mastery was positively correlated to the therapists' years in practice ($p < .0001$). The author's analysis indicated that 28% of the variance in perceived therapeutic mastery was predicted by practice. Of particular interest for our present purposes was the result that reports of low mastery declined across the 10 experience-level cohorts from 83.2% (reported by those with 0 to 1.33 years of experience) to 69.2% (1.33 to 3.15 years), 52.3% (3.15 to 5 years), 39.8% (5 to 7.25 years), 35.2% (7.25 to 10 years), 17.5% (10 to 12 years), 14.8% (12 to 15 years), 16.6% (15 to 18 years), 15.8% (18 to 23 years), and to 7.6% for the most experienced therapists (23 to 52 years). The authors concluded that "it seems plausible to interpret the observed relationship between years in practice and perceived therapeutic mastery as a reflection of a genuine developmental trend" (p.211).

Despite this sweeping conclusion, several issues merit concern. The most flagrant is the question of what accounts for the remaining 72% of variance in perceived therapeutic mastery not accounted for by experience.

Secondly, although the authors underscore the magnitude of the feeling of low mastery ("only 7.6% for the most experienced therapists"), it is disconcerting to learn that 7.6% of clinicians with 23 to 52 years of experience judge themselves to have low mastery and that the percentage of therapists experiencing low self mastery dips below 35% only after 10 years of experience. In other words, although the trend across experience cohorts is a decline in feelings of low mastery, an important percentage of therapists continue to have doubts well beyond their rookie years. This suggests that F.O.I. are a relentless dimension of therapists' experience, internal events that continue to plague many therapists despite the accumulation of years of experience.

Finally, because the design used is cross-sectional rather than longitudinal, it is possible by the authors' own admission that some of the effects could be attributed to selective attrition, that is the therapists experiencing less mastery may have 'packed it all in' (see Mearns (1990) above). In sum, the study suggests that although feelings of low mastery decline over the years they remain important for a large number of experienced therapists.

The relationship between feeling incompetent and experience needs further elaboration. While Orlinsky et al. (1999) offer a compelling, researched account of the correlation between experience and felt therapeutic mastery, an important percentage of therapists continue to feel incompetent until well into their careers. While experience certainly plays some role in F.O.I., we need to know how it operates and what else is involved in this experience.

Not all results are as unequivocal as Orlinsky et al's (1999). The counselling self-efficacy literature reports an inconsistent relationship between experience and counselling

self-efficacy. Larson and Daniels (1998) offered a plausible explanation: "after gaining some experience and/or supervision the relation of counsellor self-efficacy to experience appears minimum" (p.195). Perhaps the short-sighted focus on the early years of experience in theory and most research has produced spurious inflation of the correlation between feelings of mastery and experience. This relationship may no longer hold true after the first years. A review of the counselling self-efficacy literature by Larson and Daniels (1998) summarized the 32 studies conducted under this umbrella since 1983. Of the 32 studies (many of them unpublished) at least three quarters focussed on counsellor trainees and on overt performances. They collectively failed to address self-efficacy issues with more experienced clinicians. Part of the problem is that quantifying counsellor actions and defining them operationally is more difficult with experienced clinicians.

Theory and research that link feelings of incompetence to experience are problematic on different counts. There is some discrepancy between theory and research. Furthermore, there is a tendency in the literature to disqualify or minimize the importance and impact of feelings of incompetence on experienced clinicians by positing a negatively correlated relationship between feelings of incompetence and experience. However, since a significant number of clinicians continue to feel incompetent despite their years of experience, the question remains open for elaboration: What role does experience play in F.O.I.? What happens to seasoned therapists when they feel incompetent? What are the other factors, apart from experience, that influence feelings of incompetence?

Factors Beyond Experience

Several studies have attempted to make links between feelings of incompetence (or like constructs) and a number of variables. Bradley and Olson (1980) devised a structured questionnaire to assess the factors involved in what they termed felt therapeutic confidence. The definition of the elusive construct was based on the respondents' perceptions of a competent psychotherapist and whether or not they felt they represented that model. Seven contributing factors emerged that accounted for 41 percent of the variance in reported levels of competence. They were: a) total number of supervisors, b) age, c) total hours of supervision, d) year in program, e) prior mental health work, f) total hours of therapy related course work, and g) total hours of therapy conducted. An interesting finding of their study is that their sample attributed a very high degree of importance to the sense of professional competence. This exploration on feelings of competence generally reaffirms the link between several components of professional experience and competence. However, because of the limitations of the structured questionnaire approach, we still do not know about the nature of the relationship between experience and feelings of incompetence.

Feeling Failure

When we look further afield, other research reports on experiences that resemble feelings of incompetence. Mearns, (1990) conducted an in depth probe of counsellors' experience of failure as a unitary construct. The definition of the experience of failure was left open for the 75 participants to decipher and this task became part of the process of inquiry. The unstructured questionnaire was comprised of three questions: (a) In what circumstances do you experience failure as a counsellor/ therapist?, (b) What is the

experience of failure actually like for you?, Describe it in whatever ways are meaningful to you, and (c) How do you usually respond to the experience of failure? What do you do? His qualitative approach yielded a wealth of information pertaining to the types of client-counsellor relationships (i.e., problems of involvement), client behaviours (i.e., the dumping client) and therapists' frailties (i.e., not being good enough, impotence). Particularly significant is his discovery of the pervasiveness of this experience (sixty one of the sixty two returns acknowledged the existence of self perceived failure) and the intellectual and emotional struggles therapists engage in to conquer this experience. Mearns' study resembles the present research in that it uses a qualitative approach and looks at a construct related to feelings of incompetence. It contributes in the following way : it reasserts the importance of the feeling of incompetence as an important component of therapists' experience, making a strong link between doubting one's effectiveness and experiencing failure. The study endorsed a qualitative approach to the study of therapists' emotions about therapy and demonstrated the level of meaning attained by this form of inquiry. This study closely parallels my project yet differs in important methodological and conceptual respects, the most obvious being the subtle yet critical distinction between 'feelings of failure' and 'feelings of incompetence'.

The feeling of failure includes elements within and beyond the therapists' volition such as premature termination by clients while feelings of incompetence pertain to evaluations of oneself; one's role, understanding, decisions, and actions. Feelings of incompetence are one among numerous components of feeling failure. The following study will elaborate on the specific area of F.O.I. and will reach beyond the level of description and data synthesis reported in Mearns' study towards the goal of building a

theory. Attempts to ascertain whether there is something particular about a therapist who experiences feelings of incompetence or insecurities are reflected in other studies.

Therapists' Personal Characteristics

Attempts to link specific therapist characteristics with their difficulties have generally proven inconclusive. For example, Guy, Poelstra, & Stark (1989) concluded from their study that there is no such thing as an identifiable, distress prone therapist. In other words, they were unable to isolate characteristics that were unique to practitioners or their particular work situation that would account for the variability in the level of personal distress experienced.

Reports from the self-efficacy literature on the relationship between self-efficacy and personality are contradictory. While Johnson, Baker, Kapola, Kiselica, and Thompson (1989), after repeated measurements, concluded that efficacy functions more as a trait than as a state characteristic among graduate students, a literature review of this domain fails to corroborate this finding. Larson & Daniels (1998) reviewed 14 studies that addressed the link between counsellor characteristics and self-efficacy. Only a minimal relationship at best was found between counsellor self-efficacy and counsellor personality, aptitude, achievement, and social desirability.

Freudenberger's (1990) conclusions were diametrically opposed. He reported a list of personality characteristics typical of the impaired:

> They tend to be highly competitive, are rigid, have high expectations of themselves, have excessive concerns for details, may be passive-aggressive individuals, are narcissistic, or dependent people. They may feel basic insecurities, have a tendency to be depressive, are vulnerable to stress, and may

> have highly ambivalent attitudes about their work. They may be perfectionnistic, guilt ridden, idealists, have overly full schedules, and cannot say, "No!" comfortably (p.33).

This exhaustive list was based on his experience treating 50-75 impaired therapists but the exact method of data collection was not reported.

Other authors believe that counsellors' tendency to be intropunitive (Lietaer & Neirinck, 1986) leads them to magnify shortcomings and generally to intensify negative self-evaluations, yet few empirical studies confirm this tendency.

Attempts to pair personality characteristics with therapists who experience distress and self-doubts is compelling yet anecdotal. The issue remains ambiguous at this time. The indeterminate nature of this relationship further evokes and fuels this inquiry.

Client Factors that Contribute to F.O.I.

Certain defence mechanisms clients use may contribute to the therapist's sense of inefficacy. Therapists often feel powerless when dealing with clients who use an arrogant interpersonal style to defend against a damaged self-concept (Loganbill, Hardy, & Delworth, 1981). Howard, Orlinsky, and Hill (1969) reported that erotic transference resistance in patients (defined as "blocking and embarrassing sexual arousal with accepting therapist", p.89) impaired the felt effectiveness of therapists.

Summary of Factors that Contribute to Feelings of Incompetence.

Theory and research on therapist self-doubt is scattered throughout the literature and allusions to its' prominence abound. Most of the research aims to construct categories or identify themes at the broader level of the therapists' experience of therapy. These efforts could be enhanced by a study that focuses exclusively on feelings of

incompetence. The factor analytic approach has shed some light on factors related to the construct but this method fails to capture the richness of the therapists' encounter with moments of feeling inadequate. Self-efficacy theory has provided the background for much of this research but the operational definitions and measurement strategies have limited the depth of the understanding gained. Attempts to determine the causes and correlates of feelings of incompetence and related experiences have resulted in confusing results: It is altogether unclear what causes feelings of incompetence to arise in therapists. Therapists' countertransference and counterresistance are well documented yet this body of knowledge is weakened by an unripe empirical base. Certain client factors appear important.

The developmental literature and research on the relationship between experience and incompetence while still inconclusive nevertheless supports the contention that with increased experience therapists encounters with feelings of incompetence and insecurity decrease. Generally, authors are content to note the decline in number of therapists reporting this negative feeling and overlook the large percentage of experienced clinicians who continue to express feelings of insecurity, incompetence, and the like. By interviewing therapists with 10 years of experience and more, this study seeks to clarify this oversight. The goal is to expand our understanding of feelings of inadequacy beyond the initial years of the therapists' career and thus to add subtlety, to outline context, and to expand on the simple equation that is repeatedly put forth between gains in experience and decreases in feelings of incompetence.

Our need to gain insight into the subjective world of experienced therapists is not properly addressed by a body of literature that has focussed mainly on overt performances

and on novices. We need to find out more about the antecedents, causes, and correlates of this feeling; what are the circumstances that pull for this internal response. The present study addresses this directly. A serious, profound, focused, and empirically grounded approach to the internal experiential realm of therapists' F.O.I. is undertaken.

While we are unsure as to the causes and correlates of feelings of incompetence, its importance is underlined by the impact and consequences F.O.I. and related emotions have on the therapist and on the conduct of therapy.

Effects of Feelings of Incompetence

The impact of therapists' self evaluation goes beyond their own psyche and has potential ramifications on their performance, the process of therapy, the therapeutic relationship, and the client's experience of therapy.

Relationship Between Feelings of Incompetence and Performance

In the counselling self-efficacy literature, many authors have hypothesized that low self-efficacy negatively influences performance (Bandura, 1977, Wicklund & Brown, 1987). Others have postulated that increases in self-efficacy will improve performance (Lent, Brown, & Larkin, 1984). Although this has been demonstrated to be true for therapeutic recreators at the undergraduate level (Munson, Zoerink, & Stadulis, 1986) and for numerous client behaviours (Johnson et al., 1989), the relationship does not seem to be as clear or consistent for the performance of counselling skills.

In their pioneer study, Johnson, Baker, Kapola, Kiselica, & Thompson (1989) studied the relationship between self-efficacy and competence in prepracticum counselling students. The study was the first to examine the relationship between efficacy and performance in the "real life" context of a graduate class (Johnson et al., 1989). 50

master's degree level students were given the Counsellor Self-Efficacy Scale at different points during their prepracticum training. The scale requires the student to rate the level and strength of their competency on 26 micro counselling skills. The level of self-efficacy reflects the number of skills the student reports being capable of performing while the strength reflects their level of confidence in their ability to perform the behaviour. Students' self-ratings on their levels and strength of efficacy for the 26 skills were not related to scores obtained from ratings of their taped performance during counselling role plays. The authors found that efficacy and performance were unrelated after training in basic skills and intermediate skills.

Self-efficacy has also been found to be unrelated to the prediction of counselling skill ability (Ridgway & Sharpley, 1990). When trainees' self-efficacy ratings were tested as a measure for the prediction of counsellor trainee effectiveness; they were unable to effectively predict outcome. Self-efficacy was seen to be a poor predictor of counselling effectiveness that was assessed through measures of counsellor skill, behaviour, and client satisfaction. This study also failed to support the prevailing belief in the relationship between self-efficacy and performance. There are inconsistencies between theoretical predictions and empirical results.

Another important weakness in the self-efficacy literature is the narrow focus on students and novices. A review of the counselling self-efficacy literature by Larson and Daniels (1998) concluded that the studies of counsellor performance have focussed almost exclusively on beginning level skills and on trainees. Consequently, the relationship between self-efficacy and performance issues for seasoned therapist is undetermined.

These authors also posited a paradoxical finding: counsellor trainees whose self-efficacy ratings were higher than their objective performance (as rated by a supervisor) fared better. Of import to us is the conclusion that in fact, for most therapists, the discrepancy between self-efficacy and performance went in the opposite direction. Most counsellors' level of self-efficacy was lower than that which could have been predicted by their actual performance; counsellors underestimated themselves.

Correspondingly, Poidevant, Loesch, and Wittmer (1991) have noted that many highly effective counsellors seem to seriously underestimate their capabilities and to feel like "impostors". Originally coined by Clance and O'Toole (1987), the impostor phenomenon, afflicts many very capable students in quality training programs who continue to perceive themselves as incompetent and fear being exposed by their peers. The notion that feelings of incompetence and incompetent performance are related is contested by this explanatory scheme that argues that feelings of inadequacy of the most disturbing kinds arise despite very effective performances.

Bandura (1976) in a related inquiry on the relationship between anxiety, insight, and competence, reported no relationship between the therapist's self-ratings of anxiety and psychotherapeutic competence. The lack of relationship between feeling incompetent and being incompetent is somewhat counterintuitive. Among theorists who most strongly endorse the performance base of self judgments, Bandura, (1977) posits that discrepancies between performance and efficacy expectations are likely to occur when the tasks are highly ambiguous as can logically be argued for the task of conducting therapy. This may explain the discrepancy between theoretical predictions (high self-efficacy equals better performance) and research results.

The inconsistency between theoretical predictions and empirical findings on the nature of the relationship between feelings of incompetence and incompetent behaviour is mysterious. Perhaps it is due to the myriad of definitions of constructs that are thematically related yet that stem from such divergent theoretical roots as to make an amalgamation of results impossible at this time. This reflects the immaturity of this field of research as well as the general trend in psychotherapy process research to perpetually 'reinvent the wheel', that is to fail to build on established notions. Mahoney (1991) poignantly and succinctly summarized the concerns for the quality of mental health services by voicing the following concern: "But how are we to know when a psychotherapist's form or intensity of personal distress is likely to interfere with responsible and effective functioning as a helping professional?" (p.351). He concluded, like we do, that at this point the research is inconclusive and that at this juncture we "simply do not know" (p.351). A direct inquiry into the impact of therapists' feelings of incompetence on the therapeutic work may fill this gap.

Effects of Therapists' Feelings of Incompetence on Clients

Beyond the general relationship established between therapist confidence and positive outcome measures in the literature that explores common factors, little is known about the relationship between therapists' emotions and clients' experience of therapy. The impact of therapists' specific insecurities on clients and on therapeutic outcome is an area that remains obscure. Several indices warn that this area is worthy of further exploration.

A review of the empirical literature by Orlinsky and Howard (1986) showed how therapist engagement, credibility and confidence, congruence, and empathy were

positively related to client outcomes. This relationship was consistent across theoretical orientations of the practitioner. Surely feelings of incompetence must enter into our accounting of these factors in therapeutic situations.

In fact, Orlinsky, Howard, and Hill (1975), in their extensive study of the therapeutic experience for both therapist and client have explored how the therapists' negative feelings about their effectiveness could directly affect clients. They concluded that when the therapist feels a sense of failure, the client perceives the therapist as feeling displeased, rejecting, and as behaving in an aloof manner.

Effects of Feelings of Incompetence on Therapists

Burn out is the most commonly cited and most researched negative outcome of prolonged exposure to negative self-evaluations. A burned out individual is "someone in a state of fatigue or frustration brought about by devotion to a cause, way of life, or relationship that failed to produce the expected rewards" (Freudenberger, 1990, p.171). Kestnbaum (1984) made the relationship between feelings of incompetence and burnout clear when he announced that unrealistic expectations therapists may harbour about client growth and progress during therapy will lead to lowered morale and eventually to burn out. The critical aspect was the dissonance between the expectations and the perceived result. Because "many therapists simply do not know when they are doing well" (Kestnbaum, 1984, p.375), the author concluded that therapists created their own burn out by calling into doubt skills, judgments, and competence when they failed, perhaps erroneously, to perceive growth and therapeutic movement. In other words, the therapists' self-doubts could produce burn out.

Beyond the distressing feelings occasioned by the self-doubts, other problems result from this negative self-evaluation. Self-efficacy is thought to affect how much effort will be expanded on a task, how long people will persist in the face of obstacles, and even whether coping behaviours will be initiated (Bandura, 1977). According to the self-enhancement theory, people who expect to receive feedback that will reveal low ability will engage in little information seeking because presumably they are not interested in confronting their weaknesses (Brown, 1990). Taken together, self-efficacy theory and self-enhancement theory would predict that counsellors with low self-efficacy would not persist toward improvement nor would they be enthusiastic about seeking feedback. Presumably, this would affect both the effectiveness of their ongoing training and their subsequent capacity to practice therapy.

Furthermore, the feelings of incompetence and related emotions have insidiously contributed to the development of serious personal and professional problems: depression, alcoholism (Thoreson, Nathan, Skorina, & Kilburg, 1982), burnout (Farber, & Heifetz, 1982), suicide (Deutsch, 1985), and sexual misconduct (Bouhoutsos, Holroyd, Lerman, Forer, and Greenburg, 1983).

The literature on the impact of the hazards of therapy for the therapist has focused almost exclusively on burn out. However, burn out is a process that unfolds along with repeated exposure to insidious stressors. Other more incremental outcomes, equally important but less dramatic, are probable. It is important to document the full range of impacts of feelings of incompetence on the therapist in order to know , aside from burn out, what some of the other consequences of feelings of incompetence are. The issue of adaptive outcomes where opportunities for the therapist to benefit from self-doubts is

curiously lacking from the spectrum of outcomes researched. Feelings of incompetence: Are they ever beneficial?

Effects of Therapists' Feelings of Incompetence on the Therapeutic Relationship

When therapists experience a sense of inefficacy in the treatment process, they report behaving in a manner characterized as impersonal, critical, inactive, restrained, and insistent (Orlinsky, Howard, & Hill, 1975). The feeling of failure is accompanied by a somewhat passive-aggressive style of relating.

Therapists in training actively defend against feelings of powerlessness and inadequacy through denial. They commonly attempt to rid themselves of these feelings entirely and when this fails, they may avoid further interactions with the client altogether. Premature termination or referral is often the result (Loganbill, Hardy, & Delworth, 1981, Strean, 1993). It would be interesting to know whether F.O.I. affect seasoned therapist likewise. It is well documented that doubts regarding competence can hinder termination regardless of therapists' level of experience (Brady, Guy, Poelstra, & Brown, 1996, Lietaer & Neirinck, 1986). This hindrance may take the opposite form of letting the length of treatment get out of hand when therapists needlessly prolong therapy to counter their feelings of helplessness (Brady et al., 1996, Strean, 1993). Feelings of helplessness and self-doubts call forth the therapists defence mechanisms such as the tendency to reassure, to give advice, and to make premature interpretations (Strean, 1993).

Farber and Heifetz (1982), who identified the perception that "one's efforts were inconsequential" as a common denominator among those suffering from burnout, described several possible impacts on therapy: the therapist becomes cynical toward the

clients, blame them for their difficulties, label them in derogatory terms, increase the usage of technical jargon, and refer to clients in diagnostic terms.

Anxiety causes a corollary impediment to effective therapy. Situations that are anxiety provoking for the client are often anxiety provoking for the therapist as well (Bandura, 1977). Therefore, just when the therapists' non-anxious and accepting responses would be needed, they often respond in ways to avoid the anxiety producing situations. Bandura (1977) reported the following: interruption in the form of questions that serve to divert the discussion, premature interpretation that blocks the patients expressions, paraphrasing the patients' statements without essential clarification, unnecessary reassurance, and unwitting disapproval.

These research results demonstrated that the therapists' encounters with feelings of self-doubt, both in particular instances and more globally, can negatively influence the client, the therapist, the therapeutic relationship, and eventually the overall management of clinical cases.

Research results often present only a restricted portrayal of the impact of therapists' subjective experience of therapy on the therapeutic relationship by focusing almost exclusively on the objective evaluation of therapist behaviours: "...in this work 'experiencing' is taken to be a variable which can be rated by external judges or observers listening to tape recorded therapy segments: there is no attempt to ask either the therapist (or client) what the experience is like for them" (McLeod, 1990 p.79). Hence, it is difficult to know how therapists' feelings of inadequacy interfere or enhance their practice of therapy beyond what has been reported by observing basic skills..

Although studies fail to consistently conclude that there is a direct link between feelings of incompetence and global incompetence, the experience of incompetence by the therapist nevertheless has been shown to promote less than optimal therapeutic behaviours that may have harmful consequences in the short and long term for both therapist and client. Yet direct inquiries into this relationship remain sparse. "One of the most neglected dimensions in the study of the therapeutic process is how the clinician's personal dynamics can impede therapeutic progress" (Strean, 1993, p. ix).

More needs to be known about the link between therapist emotion and their imminent actions and between feeling incompetent and the therapists' in session decision-making process. The understanding of this dynamic will be enriched by examining the internal dialogue and decision making processes that therapists engage in when they are feeling inadequate and incompetent. The interview process will include such queries. The insider's perspective gained by interviewing will fill the gaps left in our understanding of the topic by methods typically used in the study of therapists' feelings.

A Review of Research Strategies

Systematic investigation of the therapist's experience in therapy has yielded knowledge that is compelling yet wanting refinement. The results are tentative and needing further detail. Beyond the reluctance to view the therapist's experience as a valid topic for scientific inquiry, the lack of agreement as to basic definitions, the plethora of approaches and methods of investigation, and the failure to amalgamate previous conclusions have limited our understanding of this area. This relative state of puzzlement is aggravated when it comes to understanding feelings of incompetence as a singular

aspect of the therapists' overall experience. The literature contains mostly references to themes but efforts to examine particular aspects in depth have been few.

Methods Used to Research Therapists' Feelings in General.

Several research techniques have been used to collect information from therapists. The most popular tool for these investigations has been the rating scale. The process is one where therapists are asked to rate the occurrence of specific experiences during therapy on a three or five point scale. The data are then subjected to a factor analysis that reveals patterns and themes. Orlinsky and Howard's (1977) therapy session report and its subsequent analysis are an example of this approach. The major disadvantage of this method is that it yields a rough, generalized image of what the therapist is experiencing (McLeod, 1990). Depth and richness are somewhat compromised for the sake of expedient data analysis.

Other methods that have been used are more sensitive to the intricacies inherent in the formulation and exploration of therapist difficulties. For example, Davis et al. (1987) used a peer group to generate and then discuss a pool of difficulties they had experienced. The taxonomy, however, was not used in further empirical studies. Several author-editors have presented amalgamations of therapist narratives regarding difficulties and stresses (Dryden,1992, Kottler, 2002). These have provided more profound and contextual knowledge of the subjective realm of therapists' lives. The understanding gained could be enhanced by more highly structured attempts to extricate patterns and to formulate theory.

Methods Used to Investigate Feelings of Incompetence or Low Self-Efficacy.

By far the most common method of gaining information on the therapist's feeling of incompetence is through the use of questionnaires. These are of three types. The first and most frequently used variety is behaviourally anchored. Therapists are asked to report their degree of self-efficacy (or lack thereof) in executing specific therapeutic tasks and interventions (Johnson, Baker, Kopala, Kiselica, & Thompson, 1989, Sipps, Sugden, & Faiver, 1988, Poidevant, Loesch, & Wittmer, 1991). The response format is customarily Likert type scales. This approach has borne an array of results on a range of isolated self-efficacy-behaviour combinations. The experiential realm of the therapist is not addressed.

A second type of questionnaire assesses feelings of incompetence as divorced from their behavioural manifestations. The questions are of a more global nature and are aimed at getting a general idea of the issue. For example, Bradley and Olsen (1980) asked their respondents to rate on a Likert scale their response to the following question: "In terms of what you consider to be a competent therapist, rate your present competence as a psychotherapist" (p.931). The ensuing information only begins to offer an understanding of self perceived incompetence: the task of defining the term is left up to the therapist. The approach is informative but could yield more meaningful data if supplemented by further queries into meaning, experience, causes, and consequents.

A third approach is to try to gain indirect access into this subjective state by operationally defining the construct. The resulting definition can be removed from its original meaning. Witness the development of the Self-Efficacy Test by Ridgway and Sharpley (1990). This test consisted of the two following items: 1) "Tick the box that best represents the grade you expect to receive for your counselling skills examination"

(p.168) and 2) "Put a cross on the line below at any point from 0 to 100 that best indicates your degree of confidence in your choice of grade" (p.168). It is uncertain to what extent the information gained from such an approach can contribute to a meaningful understanding of self-efficacy.

Any framework used to examine self-evaluative processes needs to reflect the complexity of the construct as well its multiple determinants. The qualitative research method of in depth interviewing would lend itself well to the type of exploration necessary to gain a meaningful, coherent, and holistic understanding of self-perceived incompetence. To date, no such systematic and deep process has been undertaken. This thesis will attempt to rectify this shortcoming in the existing research (McLeod, 1990).

Summary of Literature Review

For all the talking we psychologists do about authenticity and transparency, we as a profession are generally reluctant to examine our weaknesses and self-doubts. The literature on therapists' feelings about therapy and on feelings of incompetence reflects this discomfort.

Theoretically, three major approaches have attempted to explain how and why experiences that are similar to feelings of incompetence happen. The most concerted efforts to understand such phenomena have been undertaken by the psychoanalytic school. Typically, the clients' experiences of helplessness and hopelessness may trigger the therapists' feelings of incompetence through the process of identification. From this perspective the therapist defends against this anxiety. In order to have a more accurate portrayal of F.O.I. the construct needs to be expanded and more empirical support needs to be gathered .

Based on Bandura's (1977) self-efficacy models, counselling self-efficacy theory postulates a direct link between performance and self-evaluation. Therapists will feel good about themselves mainly when they have accumulated experiences of successes during therapy. Rather than achieving an overall positive self-evaluation, self-efficacy will be felt for each of the micro skills that collectively make up a therapist's repertoire. Major shortcomings of this theoretical approach are the impossibility of breaking down a complex task such as counselling into a series of micro skills; an approach that would be necessary in order to remain faithful to the theories' basic tenets. Also, the theory as it stands (and research deriving from it) is heavily anchored on behavioural indices or cognitive appraisals of task behaviour. It does not take into account a host of other factors that have proven to have many times more impact on the therapeutic outcome than the skills/technique dimension such as the relationship, counsellor intuition, and therapist characteristics. In other words, the theory's assumption that if therapists feel they are capable of performing a skill than they will feel confident in bringing about desired change in a patient is incomplete. No therapist alive today would expect therapeutic success merely by performing a series of well selected and executed tasks. Furthermore, the research based on this model disconfirms its major tenets: the empirical support for a self-efficacy-performance link is weak at best.

Developmental models have expanded on the issue of insecurity but mostly within the context of professional immaturity and have failed to account for therapists' longstanding struggles with issues of inefficacy. The empirical literature has focussed mostly on the early years of counsellor development and those that have looked beyond

have suggested that many seasoned therapists continue to battle with feelings of inadequacy despite the mounting years of experience.

Several studies make tentative links between causative factors and feelings of incompetence but they are preliminary and do not adequately address the question of what factors promote feelings of inadequacy in seasoned therapists.

The empirical literature contains reports of several concerted attempts to examine therapist difficulties and stresses. Collectively and unequivocally, they identify F.O.I. as a concern. Further attempts to study this phenomenon specifically have been inconclusive. Although many studies and their focus are thematically related- low self-efficacy, inadequacy, therapists' sense of failure, therapists' difficulties, therapists' stress, the subtle and not so subtle differences in their definitions and semantic properties have made it difficult to accumulate knowledge and allow the field to grow. Finally, the research methods employed, mostly analogue studies, factor analytic studies, and anecdotal accounts have yielded incomplete data. While the anecdotal studies maintain the integrity of the therapists' experience, they do not specify patterns or relationships among instances and constructs. Factor analytical studies, on the other hand, do present schemas and possess scientific rigor but the techniques may overlook some critical and introspective facets that are only accessible through the participant's voice.

The present project aims to fill these gaps by applying a systematic, thorough method of analysis to an experiential component of therapists' existence in that role. Systematically evolving a theory from the subjects' perspective of their feelings of incompetence will provide both a rich, descriptive aspect as well as a rigorous and scientific understanding.

Chapter 3

METHODOLOGY

Ontology, Epistemology, and Paradigm

The choice of a methodology or "how the would be knower goes about finding out whatever he or she believes can be known" (Denzin and Lincoln, 1994, p.108) is guided by ones' ontological and epistemological stance: that is one's belief about the nature of reality and the nature of the relationship between the would be knower and that reality. A constructivist paradigm highlights the experiential dimension of knowledge, the notion that reality is inseparable from the knower. In other words, reality reflects not something that exists 'out there', apart from observers, to be apprehended by them but rather is a reflection of observers' interactions with the moment. The path to knowledge is through the understanding and interpretation of subjective meanings assigned to events by participants, including the observer, in the inquiry process. This constructivist paradigm is adopted for the study. The basic set of beliefs that guide the inquiry process reflect this tradition: an abiding concern for the lived experience or the emic perspective, a valuation of the active role human beings play in the construction of reality and knowledge, and a relentless striving for meaning and understanding.

Many approaches subside under the eclectic umbrella of constructivism. The procedures proposed by Glaser and Strauss' grounded theory methodology (1967) guided the discovery process as a generic approach. Other authors and their ideas supplemented these basic principles: Guba and Lincoln (1994), Strauss and Corbin (1998), and Rubin and Rubin, (1995).

Grounded Theory Methodology

Grounded theory is a general methodology used to develop theory that is 'grounded' in the data, that is theory which emerges from the information that is systematically gathered and analyzed. The 'constant comparative method' (Strauss & Corbin, 1998) of fitting theory to data and checking data to enhance theory, is a core feature of this methodological process. It ensures that the aim of building theory is achieved by a series of well-devised procedures that will both faithfully reflect core concepts introduced by participants and organize our understanding of these constructs into higher order relational dimensions.

Justification

Grounded theory is appropriate for this study because it is anchored in a philosophy of discovery. The method of data analysis, although highly organized and structured, relies partially on induction, a process whereby the observer looks to the data to draw out the concepts and their interrelationships that will be the building blocks of the theory. These emerging theories are then tested against data for confirmation and adjusted as need be. It is ideally suited for this situation in that the accumulated knowledge we have about our topic is scant and the nature of the construct under study is highly abstract and subjective (Rubin & Rubin, 1995).

Approaching such a loosely defined and experiential construct as feeling of incompetence necessitates an approach that will gain access into a subjective process and allow the observer to apprehend and interpret the meaning of this experience for the participant. Grounded theory engages us in a deep/thick descriptive process and allows us to move beyond description into the domain of theory building offering both profound

understanding and an organized framework of related concepts by which to interact with the phenomena. In summary, we strive for both profound understanding and conceptual structure.

The Ultimate Goal: Substantive Theory

Under the grounded theory rubric, several levels of theory building are possible. Formal theories are those that explain phenomena across a range of disciplinary concerns and settings (Strauss & Corbin, 1998). They are not domain or milieu specific. Substantive theories are more pointed. They are restricted to specific populations, times, and circumscribed settings or milieu. The present goal is to elaborate a substantive theory that will evolve from the study of a particular population, in this case experienced psychologists /psychological counsellors, as they function in their therapeutic role. Empirically derived constructs, their properties, and the relationships between these constructs will be postulated as they apply to this group.

These constructs represent interpretations; they are a blending together of themes taken to a higher level of abstraction and organization. These concepts and themes originate in and are extracted from the raw data through the processes of open and axial coding which will be explained shortly.

Data Collection

Instrumentation

Structured Questionnaire

A structured questionnaire was used to gather basic demographic data about the therapists who were interviewed (see appendix A for a copy of the structured

questionnaire). These questionnaires were mailed to the participants several weeks before the scheduled interviews and were returned to the researcher at the time of the interview.

Semi-Structured Interview.

The semi-structured interview reflected the main questions this study aimed to explore (see appendix B for an outline of the guiding questions).These questions aimed to clarify areas of weakness in our understanding of F.O.I. identified in the literature review: the need for a more profound, detailed, and contextualized understanding of F.O.I., the need to understand the causes, consequences, and correlates of the experience of F.O.I. and finally the need to delve further into the relationship between F.O.I. and experience. To recapitulate, the types of questions were:

1-Phenomenological Questions.

How do experienced therapists define and experience feelings of incompetence?

What are the factors that influence feelings of incompetence?

How do seasoned therapists deconstruct the moment of feeling incompetent into more basic elements?

How are these elements related to each other?

What is the relationship between F.O.I. and the therapists' actions?

How do therapists' themselves understand/interpret feelings of incompetence?

2-Developmental Questions.

What is the evolution of the feeling of incompetence for clinicians across different levels of training and experience?

What is the experience of incompetence like for seasoned therapists?

The semi structured interview protocol was developed to provide the interviewer with a number of possible questions to ask to address issues that were considered to be central in this study. The questions had a dual nature: descriptive questions and experiential questions. The first type were questions that asked the therapist to describe feelings of incompetence and their components, while the second type of question had the participant provide examples of lived moments of feelings of incompetence. These questions were devised on the basis of suppositions derived from prior experience as a therapist, in consultation with other therapists, and from the information gathered in the review of the literature.

In order to be true to the basic nature of semi-structured interviews, neither the exact wording nor the order of the questions was predetermined (Gorden, 1992). Rather the interview protocol served as a guide and a reminder of the basic uniformity of information sought while the respondent's answers fuelled the follow-up questions and probes. The principal themes of inquiry were description and identification of the cognitive, emotional, and behavioural manifestations of the feeling of incompetence, causation, consequents, and evolution over time and experience levels.

The focus of the data collection evolved through the process of data analysis when it became clear that certain patterns were emerging from the data that needed further elaboration and clarification. For example, after the third interview it became obvious that there were different levels and intensities of feelings of incompetence, quantitatively and qualitatively different experiences of this emotion. The subsequent interviews incorporated the notion of range, depth, and movement up and down a scale of intensity

of feeling of incompetence. The issue of process became more central and in need of elaboration and questions reflected this aim.

Interviews

Eight participants were interviewed once. The interviews lasted from 45 to 90 minutes and were recorded on audiocassettes and subsequently transcribed verbatim. This resulted in approximately 274 pages of typed text.

Time Frame

The interviews were conducted over a period of a year (September, 2000- August 2001). The timing of the interviews coincided with participant availability and the requirements of the analytical process. The first two interviews were immediately transcribed and coded (September and November, 2000). Subsequent interview protocol modifications were based partially on these initial results. An initial set of themes was extracted and specific questions aimed at their clarification were incorporated in the protocol. The next group of three interviews was conducted from February to July, 2001. These interviews were also coded by the open and axial coding methods. Themes that were previously discovered were repeated and new themes and relationships between them emerged. The interviews were then all recoded afresh and a structure mounted to represent the knowledge thus far gained. Again, the interview protocol was updated to incorporate questions that would clarify the emerging patterns. The last three interviews were conducted in August, 2001. They mainly served to confirm, deepen, and qualify the properties of the categories previously elaborated.

Interview Settings

Four of the interviews were conducted in the greater Montréal region. One of the interviews was conducted in Ottawa and three interviews were conducted in Edmundston, N.B. The geographical location reflected the home base of the participant. A variety of settings resulted from the participant's requests and space availability; participant's home (2), participant's private office (2), and work location (1) and researcher's office (3).

Participants

Criteria for Involvement in the Study

A basic set of criteria for the selection of participants reflected the ideology of the study. They were:

1- A Minimum of 10 Years of Clinical Experience

The therapist had to have accumulated ten years of direct counselling/therapeutic involvement with clients/patients. Ten years was the cut off point for a therapist to be considered experienced.

2- Presently Practicing Psychotherapy

The therapist had to be actively engaged in practice at the time of the study. The focus of the study was on ongoing struggles and a practicing therapist would offer a contemporary/present day view into the experience as opposed to a possibly diluted, retrospective analysis of an experience removed in time.

3- Minimum Educational Requirement

The basic educational requirement was considered to be a master's degree in either clinical or counselling psychology. These reflected the minimal entry requirements

to gain licensure for the 'Ordre des Psychologues du Québec' at the time of the study. This criterion was established to offer some uniformity to the sample base.

Sampling

These criteria guided the selection of participants in criterion based sampling (Goetz & Lecompte, 1982). Participants are selected for their ability to inform and offer insight into the phenomena of interest. These criteria were established and then instances of these profiles were sought.

Recruitment

Most of the participants (7) were friends or acquaintances. They were approached through a telephone conversation and asked to volunteer because they possessed the attributes sought and they were introspective and communicative. In other words, they were selected for professional and personal qualities that would offer the most in depth possibility to learn about the phenomena of feelings of incompetence. All participants readily agreed to do so. The strategy of network selection (Merriam, 1988), whereby participants are referred by prior participants, was employed to identify three other participants. The expressed interest to participate in the study was high, no one refused the invitation. An explanatory handout and a consent form (see Appendix C) followed up the initial telephone call. These were mailed to the participant within the week of their acceptance and returned to the researcher at the time of the interview.

Theoretical Saturation

Participants continued to be interviewed and these interviews transcribed until a state of theoretical saturation was reached. Categories are said to be saturated when " a) no new or relevant data seem to emerge regarding a category, b) the category is well

developed in terms of its properties and dimensions demonstrating variation, and c) the relationships among categories are well established and validated" (Strauss & Corbin, 1998, p.212). When it was evident that the last two interviews merely confirmed what the initial six interviews had provided in terms of themes and structure, no further data was generated for analysis. The categories were considered to be saturated after eight completed interviews were thoroughly analyzed.

Attrition

Of the eleven interviews conducted, three could not be used for the analysis and were set aside. The first participant's level of postgraduate clinical experience did not meet the ten-year cut off point. Technical difficulties contaminated the data for participants number three and seven; the tapes were unintelligible and had to be set aside.

Participants' Demographic Data

The eight subjects whose interviews qualified for analysis had the following characteristics:

Sex

Two were males and six were females.

Age

Four of the participants were in the 30-40-age range, three were in the 40- 50-age range and one was in the 50-60-age range.

Years of Experience

Years of postgraduate (post master's) clinical experience ranged from 10 to 29 years with an average of 14.25 years. Three of the participants reported extensive pre Master's

clinical experience in the related fields of psychiatric nursing and paraprofessional counselling. These were not calculated in the mean.

Title and Profession

The therapists interviewed operated under a variety of titles: counsellor (2) clinical psychologist (3), counselling psychologist (1), therapist (1), and resident in psychology (1). These titles were self ascribed and did not reflect consistent differences in education or type of employment. Most of the participants (5) were in private practice either full or part time. Others were employed by non-profit community organization (1), provincial government (3), university and high school counselling centres (2).

Theoretical Approach

A variety of theories were proposed as the participants' guiding framework as revealed on the structured questionnaire: Cognitive (3), Rogerian/ humanistic(2) Narrative (1), Eclectic (1), Behavioural (1). Participants' stated second choices for theoretical affiliation were: Cognitive (2), Behavioural/Rational Emotive Behavioural (2), Solution Focused (1), Client-Centred (1), Systemic (1), Reality (1).

Use of Participants' Interview Material

Because of the highly sensitive nature of the information disclosed during the interviews special precautions were adopted. The possibility, however remote, that a therapist and the clients they discussed in their vignettes could be identified was a particular concern. All demographic and descriptive information about therapists was minimised and kept at a group level. In order to protect the participants' privacy, pseudonyms were used and any information that would make them susceptible to

identification was omitted or deliberately made vague. This protocol was followed throughout the manuscript.

Data Analysis

Basic Unit of Analysis

The units of analysis were identified based on the following criteria proposed by Lincoln and Guba (1985): "a) The unit should be heuristic, that is, both relevant to the study and stimulate the reader to think beyond the particular segment, and b) it should be the smallest piece of information that can be interpreted in the absence of any information beyond a broad understanding of the context of the study (cited in Merriam, 1988, p.132)." The length of the units varied from a single sentence to a paragraph. When multiple utterances related to the same theme, they were coded as such. Conversely several units contained more than one idea, and were coded under different category labels.

Open Coding

The most basic exercise in the process of open coding is to label or name an idea, event, incident, or act. This exercise generally elicits a number of elementary labels that can be synthesized along common elements into categories. When the basic units of analysis share common properties or evoke similar meanings they were grouped and an abstract label was applied. In order to generate a healthy number of themes and get an initial system of categories, all units of analysis in the first three interviews were subjected to this process. That is, they were given a label representing a conceptual interpretation. (See Appendix D for themes). These labels were originally written in the margins of the typed transcripts. Eventually, the cut and paste method was applied: All

segments pertaining to a theme were extracted (copy function) from the initial interview transcripts and pasted into a document that collected instances of that theme. The first three interviews were coded twice on separate transcripts to verify the reliability of the coding. The selection of themes for interview segments was highly consistent despite the one week lapse (approximate) between the first and second codings.

This list of generated themes was then organized into basic categories when they shared common elements that allowed for their grouping under a label with a higher level of abstraction. (See Appendix E). The subsequent interviews were coded using this scheme. As the coding continued, some new categories were generated, others eliminated, and still others relocated within the scheme under different labels. They served as basis from which to engage in the next level of analysis, axial coding.

Axial Coding

The three initial and five successive interviews were analysed using the initial categories. These categories were refined, expanded, and organized into major categories and sub categories. Throughout this process questions were addressed to the data to identify the properties and dimensions of a category. Comparing instances of occurrences of these phenomena allowed for the specification of the conditions that gave rise to a category, the context in which it appeared and the correlated actions.

Selective Coding

Selective coding is a process whereby a core category is selected and all other categories' relationships to it are outlined (Strauss & Corbin, 1998). The categories and their interrelationship were arranged on an integrative diagram and a central dimension

was identified around which the other categories were integrated to form an explanatory scheme.

Enhancing Methodological Rigor

The canons of scientific rigor are distinctively different when evaluating the merits of a qualitative study than those used to evaluate a quantitative study. The traditional emphasis on reliability, validity, and objectivity that characterize positivist research paradigms are replaced by criteria such as trustworthiness, credibility, and authenticity (Denzin & Lincoln, 1994). These standards reflect the relativist ontology or multiple realities of the constructivist paradigm, and support the naturalistic set of methodological procedures that go with it. Credibility, transferability, dependability, and conformability are subsumed under the notion of trustworthiness (Denzin, 1994). They address such questions as: How truthfully do the interpretations of the author reflect the participants' multiple constructions of reality? Could these theoretical explanations of the phenomena be 'discovered' again? Do these results apply to anyone else?

When the results of a study hold internal coherence and reflect a high level of correspondence to what the participants' have experienced, the study is rendered more valid by its' authenticity or 'vraisemblance' (Fontana and Frey, 1994). The choice of methodology contributes to the study's trustworthiness and authenticity while the design of the study has several built in features that promote these canons of scientific accuracy.

The set of procedures that comprise the grounded theory model promote trustworthiness and authenticity. Because a set of clearly defined steps for collecting and analyzing data is outlined, the project is protected from idiosyncratic and whimsical approaches to the data. The constant comparative method of analysis ensures that themes

that are not truly reflective of the lived experience shared by participant will be modified and rendered accurate. The groundedness of each concept and category forces the theory to remain close to its' empirical roots. Similarly the testing for negative cases or for instances which disconfirm emergent propositions enhances the study's rigor.

During the interview sessions a constant verification of the interviewer's understanding was assured through the techniques of active listening and paraphrasing. The participants were accorded the ongoing opportunity to correct, enrich, and add subtlety to the inductive process thereby supporting the conformability of the findings.

Changes incorporated in the semi-structured interview both within and across interviews allowed for the incorporation and in vivo testing of emerging categories, relationships, and insights. The respondent's were invited to comment on the versimilitude of the evolving understanding of the phenomena by the transparent nature of the process of interpretation that happened often simultaneously with the interview process.

Validity was further enhanced by taping the interviews. The analysis of transcribed interviews guards the process from retrospective distortion of the data or selective memory. The inclusion of numerous and extensive transcriptions in the findings allowed the text to "bear witness to its' own authority"(Lincoln& Denzin, 1994). It allowed the reader to verify whether the interpretations and themes were faithful to the individuals and contexts they were supposed to represent. The process of interviewing until theoretical saturation was reached also bolstered validity. Because each succeeding interview confirmed and enhanced prior themes and categories, the conceptual framework gained credibility and sophistication.

Chapter 4

FINDINGS

The findings of this study were derived from an analysis of the eight transcribed interviews. Participants' perspectives were gathered, synthesized, and organized into a substantive theory. In order to arrive at this thematic level of organization, segments of the interview were extracted according to theme and were taken to the next level of abstraction. These categories were then labelled and organized in relation to each other.

This chapter summarizes this substantive theory by examining each of the categories discretely and then by presenting how these categories function in relation to one another. First an in depth description of the phenomena from the participants' perspective will be presented. This exploration includes definitional properties of feelings of incompetence as well as their emotional components. Next, the main categories resulting from the analysis will be presented and described thoroughly.

The analysis yielded four higher-order categories; depth and nature, sources, mediating factors, and consequences organized around the central category of depth. The notions of depth and nature were universal and rested on the assumption that there are a multiplicity of feelings of incompetence that are related to different types of self-doubts. The self-doubts and feelings of incompetence that are related are best represented on a continuum. The self-doubts were organized hierarchically in six levels of progressively troubling questions about therapists' judgments about their competence. Three major categories of experiences of feelings of incompetence (F.O.I.) represent the continuum of intensity: inadequacy, insecurity, and incompetence proper. The levels of

self-doubt and the related categories of experiences of F.O.I. will be presented descriptively and schematically.

The second major category to emerge and here described was source of F.O.I. Therapists described a variety of experiences that initiated their feelings of incompetence. These F.O.I. producing elements are grouped and presented under four major causative factors: permissible factors, professional factors, process issues, and personal factors. The factors had the potential to elicit different depths of F.O.I. The actualizing of that potential depended on mediating factors which is the third major category of the findings section.

Mediating factors were elements described by therapists as having an impact on how they experienced F.O.I. on a moment-by-moment basis. These factors were called mediators because they influence the dynamic phenomenological process by acting as catalysts, protagonists, or antagonists. The mediating factors described were cognitive management of feelings of incompetence, therapist level of experience, the role and stance adopted by the therapist, and different forms of pressure felt by the therapist.

The last major category was consequences, the results of the feeling of incompetence. This section is presented in terms of the impact on the therapists' imminent actions, the impact on the therapists' feelings about the client, the impact on the client and on the therapeutic relationship, and the long-term impact on the therapists. A special category emerged and terminates this section: the positive outcomes of feelings of incompetence.

These four major categories are presented discretely and in detail. The fine analysis yielded subcategories, multiple elements that together made up the major

categories. These elements or subcategories, their dimensions, and properties are presented and described thoroughly. When sections of the interview illustrate the category or elements of a category they are incorporated and displayed.

This section concludes with an integration of the findings where the relationship between core categories will be explained. This delineation of the relationship between categories and their mutual influence on each other represents the hypotheses that together make up the substantive theory.

Definition of Feelings of Incompetence

Although responses to the request to define the concept of feelings of incompetence were highly original and personal, all therapists readily admitted to such feelings when asked if such an experience was familiar. Therapists heartily recognized this aspect of their experience with responses such as "with absolute certainty" and "Oh God! Yes!". Follow up comments indicated that participants welcomed the opportunity to talk about them and experienced a mixture of relief and mild apprehension with the topic of the study. The initial query that yielded these responses was left vague with the terms feeling inadequate and feeling of incompetence offered but not explicitly defined for the participants. The task of defining feelings of incompetence was left to the participants and several general descriptions ensued: Katherine concisely describes the experience as "the moment of 'Oh, my God!' ". Cameron elaborated on the emotional and cognitive elements in more detail as follows:

> Participant: I don't know anything about the issue and so there he is, and there I am and I have to do it, and I have *no idea what to do next* (Participant's emphasis). That's the other time.

Interviewer So, from your perspective, like this feeling comes up...How do you experience that? Can you describe that feeling for me?

Pause 8 seconds

Participant Sometimes it's hum...(pause) a feeling that something is eluding me. It's like I'm trying to catch a butterfly, and I just can't quite grab it. I'm not really anxious; I'm just frustrated by my own ineptness. I feel like a bull in a china shop and I just want to grab that. If I could just get my mind, you know, like I'm just grabbing at something that I can't get. I know it's there. I know I can grasp it but I just can't get it *right now*, and it's frustrating...

The participants introduced notions of confusion, discomfort, and urgency that accompany descriptions of feelings of incompetence (F.O.I.).

Emotional responses to the request for a definition were colourful and often sharp. Table 1 summarizes the initial spontaneous emotional responses shared.

Although therapists generally began to offer insights and give vivid examples of F.O.I. as if it was a unidimensional construct, further exploration led them to discover and reveal important distinctions in the types of F.O.I. they experienced. These distinctions inevitably led the participants to declare that the feeling of incompetence is not a monolithic construct but rather feelings of incompetence exist on a spectrum. A scale of related emotions organized according to depth and labelled fairly consistently by participants more keenly represented the full range of experiences with

Table 1

Therapists' Emotional Responses to Feelings of Incompetence

Emotion	Number of Therapists
Anger/aggravation/frustration	6
Cheated/manipulated/exploited, i.e. "like they're sucking you dry"	4
Challenged/threatened	4
Dread	4
Insecurity/stress/anxiety	3
Hate/dislike for client	3
Disbelief/confusion	3
Drained/depleted, i.e. "nothing left to give"	2
Discouraged/ disappointed	2
Distraction/ boredom	2
Therapist feels clumsy	1

F.O.I.. These levels of self-reprobation were qualitatively distinct, that is differed in instrumental ways. Cameron, the very first participant interviewed began to clarify this by stating the following at the end of the interview:

> Participant: I think even the best of anything has moments of feeling incompetent. There's always someone better than you, there's always someone worst than you, so therefore, you can always have feelings of, *I would not say incompetence but of inadequacy* (my emphasis). I think

that's probably even more accurate of how I feel in session and sometimes out of session as well. Is not necessarily incompetent but inadequate.

Interviewer: What do you see as the difference between feeling inadequate and incompetent?

Participant: Inadequate is that, you're not at the optimum level of that client's needs, they need so much and you're just shy of it. Incompetent is you're not even able to touch. You have no clue!

Interviewer: You're not on the scale! (Laughs).

Participant: You're not on the scale or on the track. Laughs.

Seven out of eight therapists interviewed confirmed that F.O.I. exist on a spectrum rather than a dichotomy. They were described as a cluster of related emotions ranging from less to more intense.

Depth and Intensity

The participants that were interviewed subsequently elaborated on the distinctions between the different levels of potency in their F.O.I. and offered insight into the types of self-doubts and fears that brought them up and down a scale of intensity. This scale of intensity is described progressively along six levels of depth of experience labelled one through six. Susan, who has 25 years of experience, and then Katherine, who has 10, provided examples of the concepts of depth and intensity:

Participant: Yeah. You've made an important distinction. You see the first one a sense of inadequacy because of the lack of knowledge or particular skill that might be missing there, I don't have a problem with that because I don't expect myself to know everything but I certainly feel

when it's in front of me a responsibility to get informed or to get better informed. I never fake it with people, I am very honest and say " I am not an expert in this area bla bla let me see what I can do or let me look or... I can't think of having done that but I know that I would do it if I was in that situation. But you're right. There's a much different feeling between that which I am comfortable with and the other thing, which I just experienced with this lady, which is a sense of just not being there, just not being able to assist.

Katherine pursued a similar thought:

Participant: It's not concerning techniques, because techniques are techniques. At a deeper level, a client has to bond and if I question my ability to do that, I question myself as a person.

. While most therapists could relate to the extremes on the continuum(levels 1 and 6) and spoke directly of the nature of these different forms of F.O.I., the middle range F.O.I., that is levels 3, 4, and 5, described further, were mostly derived through examples rather than being reported directly by participants.

The most experienced therapist, Mary, who has 29 years of experience as a psychologist, categorically renounced feeling the most severe forms of incompetence and declared that she would not tolerate F.O.I.:

Participant: Yes, I think that I would leave that kind of job. If this were to happen very often, I wouldn't stay in that field, that kind of a job. No. For myself, I wouldn't, I wouldn't bear to feel incompetent maybe more

than a few times during a year or so. No, I wouldn't stay in something that makes me feel incompetent like you said two or three times a week.

Interviewer: Because?

Participant: Because I would feel that it's not my place and I feel that I am there to help people and if I am destroying myself in trying to help people, it's not my place anymore.

Although therapists used different labels to set out their ideas, the pattern was consistent and summarized below. It was possible to discern three major types of F.O.I (labelled stages) representing six levels of self-doubt. Each of these levels of self-doubt was organized around one major type of preoccupation. See Table 2

First Stage–Inadequacy

The feeling of inadequacy was said to result from two types of self-doubt judged by the participants to be at the shallower end of the spectrum in terms of the severity of the anguish they produced.

Level 1- Preoccupation-Being Correct

The first level of self-doubt represented a series of either self-oriented questions or preoccupations with being correct or making the right therapeutic choices on a moment by moment basis as illustrated by the following anecdote by Ella who works as a counsellor for an educational institution and runs a successful private practice:

Participant: Now, I don't know what happened to that girl or her boyfriend. Clearly the collusion with her was not useful. Could it have stopped if I had convinced her individually? I don't know. Like there was all this: "Was I right? Was I not right?"

Table 2

Depth and Nature of Therapists' Self-Doubts

↓ Depth	Nature of Preoccupation
First stage-Inadequacy	
Level 1-	Preoccupation-Being correct (8/8) Am I doing the right thing? What is the best thing to do here? Am I on the right track? What went wrong? Did I miss something?
Level 2-	Preoccupation-Being effective (7/8) Am I able to help the client? Can I do what needs to be done? Am I addressing the needs of the client? Did it work?
Second stage-Insecurity	
Level 3-	Preoccupation-Being Confident (6/8) Am I a good therapist? Somebody could do better than me. Is this within my area of competence?
Level 4-	Preoccupation-Faith in Process (3/8) Does psychotherapy work? How much impact can one actually have?
Third Stage- Incompetence Proper	
Level 5-	Preoccupation-Contribution-Attribution (5/8) Am I doing any good? Am I doing any harm? Am I responsible for success? Am I responsible for failure? Am I producing change?
Level 6-	Preoccupation-Identity (7/8) Do I have what it takes? What is wrong with me? I have no right being in this field. Is it about my shortcomings?

Note: In the table the levels are organized in a hierarchy that moves towards greater levels of intensity. The table also highlights each level's major preoccupation and displays examples of the types of self-doubts

that represent them. These questions are paraphrased from the participants' responses. The ratio of participants endorsing each level of self-doubt is in parenthesis.

Ella continued to share her feelings about the moment of self-doubt:

> And I sat with that for a while because there was a lot of blood and disarray and upset (laughs) and I was angry at the police. I mean, I was angry at a lot of things, OK (laughs).

All therapists shared their experiences with this form of self-examination that resulted from a variety of encounters, some dramatic, others more commonplace. Questions such as: "Am I doing the right thing? Am I on the right track? Did I miss something?" represented this doubting at the most elementary level.

Level 2- Preoccupation- Being Effective

The next level of self-doubt (level 2) also produced feelings of inadequacy and had as its' central concern the issue of being effective. Susan, who has twenty-five years of experience in the mental health field, described the process of wondering about effectiveness in the following way:

> Participant: What's this going to bring? Who are they? Who are they going to be? Am I going to be able to do what I need to do in here? What if I can't? What if they don't like me? Basic stuff... Not as strong... the liking part isn't because I think my experience in psychiatry showed me that I'm a generally warm person and people generally get attached to me and like me and all of that. So, I don't think that was a big issue. I think it was more that, even though they might like me initially, *am I going to be able to come through for them* (my emphasis)?

Other participants' internal questions echoed this theme: Can I do what needs to be done? Am I able to help the client? Did my intervention work? Ella shares the following:

> Participant: That's right. (Laughs). But at some level with this client: "OK. Is it me? Am I not engaging this client in the way she needs to be engaged? Am I incompetent with this client?" I mean, I tried to be empathic, I tried to be confrontational, I tried it all. I even started reading an article; I did it all, all right? (Laughs). It wasn't moving this client!

These two types of self-doubting/preoccupations (being correct and being effective) led the participants to feel inadequate. Inadequacy was seen as a mild form of incompetence and was quite common among participants. Ralph, who has accumulated ten years of front line experience, stated it in the following way:

> Participant: Every exchange might provoke some sense of "Am I doing the right thing? Am I listening well?" I mean this is always going on, right?

Second Stage-Insecurity

Level 3-Preoccupation-Being Confident

Being confident was the main theme of the third level of self-doubt. Two main concerns that defined this level were: Am I a good therapist? And is this issue with this client within my area of competence? The insecurity stemmed from questioning that was broader than the previous levels and reached beyond wondering about the concrete exchange with the client to wondering about one's role as a psychotherapist. Mary shared the internal dialogue she has had at those moments.

> Participant ... I just tell myself: "OK, you have been working for so long with these kinds of people and nothing bad happened to them so it means that you are not that bad and don't be so hard on yourself". But for a little while though, I feel maybe I am not the right person to do that kind of job at this particular moment.

A common element within this level was the feeling that someone else could probably be more effective or useful as a therapist. This sentiment was expressed in a variety of ways by the participants; fears of being replaced, frequently considering referring, and outright statements of comparison such as Susan's below:

> Participant: You know, maybe it's from ...like right from the first thing that I said to you; that sense of always feeling that there is always more that I should know or could know and that push to always be better at everything. Never never feeling that I have reached that very comfortable place of saying: " You know what? I'm really ... Out of the ten psychologists I know, I put myself in the top three". You know, it's always. I'm always sort of feeling that I'm working towards something.

Level 4- Preoccupation- Faith in Process

Coupled with faith in oneself in the psychotherapeutic role was faith in the process of psychotherapy. This type of doubting constituted the fourth level and also created insecurity in the participants. This was a process where the therapist wondered whether psychotherapy in general works with questions such as: Is the service of any value? Although less common in my sample (three of the eight participants

spontaneously disclosed this type of self-doubt), it was no less poignant for the implication it had on the therapist as exemplified by Cameron's disclosure:

> Participant: Screw that. Laughs. I just beat myself. No, I can't be that bad because I probably would have quit years ago but it's more... much more... especially when I have a client and I have no idea where I'm going with this client, and I have no idea, you know, I understand why the client is there, but I don't get a) that I can possibly help this person, b) that anybody could help this person hum... And you know, it's weird because I go through this thing in my head, you know, part of the reason people come to see a therapist is because talking helps. And just talking helps, and that's... they could talk to a plant and it would help and yet that is the first thing I forget,
>
> Interviewer: O.K.
>
> Participant: and that's, you know, if I can remember that, then I feel much less incompetent, because I know that at least, that's a big part of the therapeutic process.

And again exemplified by Cameron in the following disclosure:

> Participant: Absolutely, and that brings me to question the whole are we doing any good, you know, do we ... it's not the question "Do we provide service?" but "Is the service of any value?" You know or are people going to get better because people are going to get better and are people going to commit suicide because people are going to commit suicide? And we're just sort of the spectators... and that's still something I struggle with.

Does psychotherapy work? Doubting the usefulness of psychotherapy placed the therapists in a position of insecurity with regards to their role as helpers.

Third Stage- Incompetence Proper

As we move along the scale into levels five and levels six of self-doubting we attain deeper levels of emotions and struggles with anxiety and anguish. Levels one and two included self-doubting questions directed primarily at skills and knowledge. Levels three and four were related to the therapists' role whereas the next two levels have to do with questions that reach to the core of the person; the self. What is the quality of my contribution to the client's change process and how is success or failure attributed?

Level 5- Preoccupation- Contribution and Attribution

The first theme brought forward therapists' struggles to assess how helpful they are being, to gather some feedback and knowledge about the quality of their impact on a client. Therefore a measure of one's contribution is sought yet there is a reluctance to take full responsibility for the changes. This balance was seen as precarious as therapists generally valued being helpful and wanted to contribute but wanted to avoid shouldering the entire burden of moving the client along the healing process. Witness this juggling act in these two contrasting statements from Cameron:

> Participant: I don't want to believe, you know, that a big part of me doesn't want to believe that I'm just going along for the ride ...that it completely has nothing to do with me. I'm just sitting there like a plant would. I actually want to believe that I do have an impact on someone, in a

positive way, hopefully, and that they feel better because they've been here. You know, that's what I want to believe in. Do I always believe it?

Later on in the interview she pursued this thought:

Interviewer: But there is a struggle about attributing success, like, it's not clear when there is success, how you divvy it up?

Participant: Yeah, if I have any part in it at all even.

Interviewer: It's a question or you say no?

Participant: It's a question. Sometimes I feel like you know, I actually played a part in this person's growth and development and sometimes not. But I think that might have to do with my not wanting to feel like I had a part in that young man's death. I want to distance myself a little bit from the success or failure of a client, just in case there is another case of a client committing suicide. I don't want to feel that I played that big a part in their success or failure.

Interviewer: Because if you take credit for the success, then …

Participant: I'd have to take credit for the failure.

Interviewer: …you'd have to take credit for the failure.

Participant: yeah.

These two juxtaposed statements illustrate the complexity of satisfying the therapists' need for contributing to client growth while remaining separate from the attribution of success and failure. Therapists explicitly disclosed the centrality of this issue and how it is intimately linked with feelings of incompetence. Under this rubric fall different challenges that are inherent in the profession of psychotherapy insofar as

evaluating one's impact, how one defines success, what the client's and therapist's expectations are, and the ambiguity of the results. A precarious situation was created by the unlikely contradiction of being attracted to a field of work because of ones' natural inclination to help, of incorporating and making central to ones' definition of self the notion of being a helper/healer and then finding oneself with very few cues or indices to validate or reinforce one's effort in that direction. Cameron expounded on the notions of ambiguity and attribution:

> Participant: Along with probably just the nature of the work. The lack of concreteness of it. You know, we are not making gadgets or even sewing a patient up. You know therefore that if you have sewed up and you see blood coming out that it's inadequately sewed. The patient dies, he died, you know. *We don't know* (Participant's emphasis). Most of the time we are not dealing with life and death situations, we are dealing with minor injuries. We don't know if we helped or not or how much we helped and ...
>
> Interviewer: How much we helped now and how much of it we did ...
>
> Participant: How much of it they did or a combination thereof. Where does this client go from here on?

Level 6- Preoccupation- Identity

The most profound and disturbing level of self- doubt contained self-challenges that were more personalized. This level of self-analysis, level six, targets the therapists' sense of identity and internal coherence. Ones' basic qualities as a human being were brought up for evaluation as the therapist wondered whether they have what it takes to be

a good therapist. The following excerpt shows Katherine's experience with this 'what is wrong with me?' flavoured self-targeted question.

Interviewer: How would that questioning sound, if somebody was able to hear that, how would that sound?

Participant: Euh... Euh...(Pause 5 seconds) It would be more ...euh... What's missing? What am I unable to give in order to give a good service? It's not concerning techniques, because techniques are techniques. At a deeper level, a client has to bond and if I question my ability to do that, I question myself as a person. Am I able to connect? My level of empathy, am I adequate with that? If not, why?" and....euh... things like that, more...

Interviewer: more of going to the core of your person.

Participant: Yeah!

The major themes were character defects and shortcomings. This type of self-doubt at times led the therapist to reconsider their value and worth beyond the circumscribed therapists' role. Therapists began to question their qualities and capacities. Examples provided by therapists ranged from re-evaluating their intelligence, their capacity to be empathic, their ability to bond with people, their inner level of warmth. Bob's exploration of this more profound self-doubting process clarified these links between feeling incompetent as a therapist and feeling incompetent as a person.

Participant: Well, let me start with one extreme. I first felt that when I was beginning as a counsellor in the education system. I strongly doubted that I was mentally capable of handling a career in counselling. I knew that my heart was in the right place, but I wasn't sure that I had the mental

capacity or the mental energy to be a counsellor and it was almost like the feeling of being naked downtown, in a very populated area where everyone gets to see who you really are, like being exposed as a fraud. That's how I felt, that would be one extreme for me. And I like that continuum metaphor, because at one extreme, I think I've made reference to this, I wouldn't want, I couldn't have and this must never happen, that someone better than me comes along at X and replaces me. It's not only my professional confidence and image in X (city) as being... working in the best X in the city and stuff. (...) but all the things that are tied in to that. Whenever I've doubted myself in other areas, I've always been able to tell myself "*Well you know Bob, you're doing something that's consistent to your values. You're helping people, you're a nice guy, you work very hard and you're being rewarded by being given this job. This is who you are". So, when I base so much of who I am on what I do as a counsellor, those feelings of incompetence sometimes, if they gnaw at that foundation, it could be, everything could fall apart* (my emphasis). I'm saying that it's somehow set up that way, that if I would fail as a counsellor at X, it would take a long time to recuperate from that. And, I don't feel this feeling if I'm not being good with a client. But let's say I'm having a terrible week, and hum, in a week I'll see 20 to 30 clients and I'm being ineffective with most of them. I might ponder that if I haven't chosen the right profession, that maybe I'm getting older or I can't hack it anymore. Those little scary thoughts that come into mind, that makes me want to, at first, hide those

feelings or hide that realisation from everyone else and do something that would fix it and then be a better person for it..... *That's the one extreme that rocks the foundation of who I am as a person* (my emphasis). That's very scary for me ...

Most participants provided examples or elaborations on this theme where the depth of the anguish was related to whether the self doubting question remained at the periphery of the self, like wondering about techniques or whether the self questioning targeted core elements of the self. In the latter case the threats were perceived as more menacing and the nature of the wounds more narcissistic.

One probable explanation was suggested by the preponderance of statements made by therapists that indicated how central their role/function as a psychologist/counsellor was to their sense of internal coherence. Seven therapists spontaneously declared (as the therapist cited above- see bold) a very deep investment and attachment to this aspect of their self-definition and predicted not only professional but also personal chaos were that aspect of the self to be contaminated. Those therapists that experienced prolonged and debilitating experiences with this level of feelings of incompetence did report extensive damage that went beyond professional aspects and encompassed the personal life of the therapist. Cameron provided an example that is further elaborated in the section dealing with the impact of feelings of incompetence on the therapist.

Participant: and, that whole ramification of that whole experience left me feeling about, I don't know, two and a half inches tall and completely incompetent.

Interviewer: In which areas?

Participant: In *all* (Participant's emphasis) areas.

Interviewer: O.K.

Participant: In business, in a hmm,

Interviewer: Therapy?

Participant: Therapy in..., you name it. *It was akin to self-destruction* (my emphasis).

Interviewer: O.K. so, there's one situation where the feeling of incompetence became major, became central.

Participant Central. Absolutely. Absolutely. To probably the destruction, or the, the, I don't think the clients got benefit from me or the process because of that, the internal conflicts that were going on.

Therapists related both how damaging to the self these experiences were and how arduously they defended against the anxiety this type of self-questioning or criticism could cause. Having experienced a number of self-debilitating doubts in the recent or distant past, most therapists had elaborated mechanisms by which to avoid exposure to situations that would elicit this feeling in its most extreme, intolerable form.

In the following example, Susan elaborated on the critical nature of feeling competent professionally in her global self-evaluation and how she has organized her work world to minimize threats to her work esteem by limiting the number of clients and being selective about the population she serves.

Participant: I think I feel less incompetent in my ...if you want to talk about incompetence in the rest of my life, we will be here for four days you know, because having so many children and just all the pressures from out

there. That's different. I think this is sort of ...in many ways this is my oasis now. Seriously this is now. So, when you ask me that question, it's hard for me because I really... I love being here 95% of the time. I really love being here. I feel good about what I do here. It's rare that I feel incompetent and it's rare that I feel anxious about what I'm doing here. To be very honest, it's rare now. Now I don't work... I don't see forty people a week. That's to keep in context. I see between...I average about 15 hours. I don't exceed twenty-five. I go through periods of twenty hours a week. And I can keep things relatively balanced. I prefer not to do over twenty hours. I don't think I have had more than twenty-five hours maximum come my way anyways, in terms of my private practice here.

Interviewer: That's still a lot.

Participant: Yeah, it's a handful. Definitely. Even at 15, that's still two good solid days in here. And with working through it and understanding and readings, making notes and that type of thing...

Interviewer: Court reports...

Participant: And if I have to do any of that on top of it, for sure. But I really have very few feelings of incompetence here. It's well defined here as far as ...*I've created it so that it's well defined* (my emphasis). I don't take people that are not people that I think I can work with. I see a lot of short-term people. I see people for employee assistance programs. I have from five to seven hours to do my thing. And I do it. I can be very solution oriented and I can be all of those things and I have developed that in

> twenty-five years. I've worked in acute care settings, psychiatric settings where you have to be very fast at formulating impressions and plans so I'm OK here. But, you know, incompetence in terms of raising teenage daughters, knowing how to help them all the time, having them look at me and say "you should know, you're the psychologist" in a very angry tone and me kind of "Oh! My god!" um...never feeling that I'm available enough to them or my husband. I'm not the greatest cook and I'm this and I'm that. Tons of incompetence outside my office but here I think I value this. I don't want to see incompetence here! I don't want to feel incompetent! I really don't. If I am incompetent, I would be the last to know, at this point in my life, *which is scary too. If I truly am incompetent here, then I don't know it. I don't want to see it* (my emphasis). I don't want to feel incompetent here but to be really as honest as I can be, I don't think I am incompetent here and I think it's rare that I feel incompetent. But I am not immune to feeling incompetent. I know what it's all about.

Summary of the Depth Category

Feelings of incompetence are best defined on a spectrum from mild through moderate to deep or profound. As we move along this scale we see how the nature of the self-doubts associated with level of depth of the uncertainty represent elements that move from peripheral to the self, towards issues that are more central to self. As the core is progressively approached, the anguish intensifies and the anxiety becomes less circumscribed and more pervasive, diffused, and destructive or dangerous. Seven of the eight therapists reported being vulnerable to different forms of feeling incompetent, from

the mildest to the deepest. The frequency of therapists spontaneously reporting middle range feelings of incompetence was somewhat lower. These moderate levels of F.O.I. were subtler than the F.O.I. that lay at either extreme of the continuum and were often expressed in the context of examples rather than defined. Four therapists stated that the deeper levels had become a rare and unusual experience.

The degree and kind of incompetence felt by the therapist varied according to a host of causes, correlates, precursors, and catalysts. These will be reviewed presently under the headings of sources and mediating factors according to whether the emotion was seen as originating from the factor or whether the factor was seen tempering the potency of the source, respectively.

Sources

As we examine the sources of these feelings or what happens that causes these emotions to arise, it becomes evident that the elements that give rise to these feelings are qualitatively different and links can be made between the source of the feeling and its depth. On a very general level, mild feelings of incompetence were usually brought on by issues that were normative, situational, and momentary while deeper struggles resulted from ongoing, repetitive assaults on one's sense of competence as a therapist and person. The sources or factors that caused therapists to feel incompetent varied within that range. The first two categories are labelled permissible factors, and professional factors. They were perceived as relatively non-threatening and minimally threatening for the therapists' sense of competence. Permissible factors were factors that under certain conditions therapists allowed as inevitable and even at times positive. Professional factors were factors related to the know-how of conducting therapy and business.

Process and personal issues were more potent causes of feelings of incompetence; they elicited deeper levels of emotion and produced repercussions that were more messy and complicated to resolve. The process issues were issues that arose in the dynamic exchange between client and therapist. The most damaging causative category of F.O.I. was personal factors. These were factors that reached the therapists personhood by touching sensitive areas, wounds, or psychodynamic issues and personal values. They stimulated deeper levels of therapist emotion, at times reaching the therapists' core and identity.

There is a qualitative distinction between emotions stimulated by thoughts such as "I am not sure I know enough about pedophiles or anorexics" and other thoughts such as "Maybe the client is unable to connect with me because of a personal incapacity I have to engage people". In the first instance, a corrective path of action is often obvious and subsumed in the statement of the problem or doubt. The issue is much more concrete and does not permeate the therapists' entire being or raison d'être.

Permissible/Conditionally Positive Factors

The mildest and most inoffensive factors that contributed to feelings of inadequacy are labelled permissible or conditionally positive factors. Under this heading were global arguments aimed at normalizing and removing the stigma from feelings of inadequacy and doubt. They represented thoughts on human fallibility, ambiguity as part of the profession of psychotherapy, and the ever-learning nature of human beings. All therapists in the sample allowed for the occasional lapse into less than optimal functioning. Echoes of being "only human" and the impossibility of being "all things to all people" were common when discussing F.O.I. on a global level.

The general consensus was that even the best therapists were allowed room for unavoidable error and for ongoing development. Although therapists frequently alluded to the fact that they were always and forever in a learning process, and that being uncertain was 'part of the game' on an abstract level, several did not allow themselves that measure of fallibility when discussing concrete cases. This was exemplified by Susan's harsh judgments of herself despite an intellectual or rational attempt to pardon what she perceived as her inaccessibility to a client upon returning to work following a death in the family:

> Participant: I expect that from anybody. I think any reasonable person should feel, if they're really challenging themselves and not being safe all the time, then they're always going to get in situations where they're going to feel inadequate and it's part of growth. It's just part of growing. And yes, so I do... I put that...
>
> Interviewer: It's normal.
>
> Participant: That's normal.
>
> Interviewer: Comes with the territory?
>
> Participant: If you don't do anything about it then it's not normal but I mean to have the feeling all of a sudden that you're not quite whatever but then to ignore it and to not follow up and whatever that's not good but to have it initially is OK.
>
> Interviewer: The other end is that's it's not OK and it's not acceptable.
>
> Participant: To be incompetent?

Interviewer: When you're talking about the more profound experience of it, like this case with this lady. That's not... You can't let yourself off the hook there.

Participant: OK that's interesting. You know what I think I would have let myself off the hook twenty-five years ago when I first started. I shouldn't be doing it at this point. Oh, that sounds really harsh hey?

Interviewer: Yes. It does (laughs).

Participant: No, I think I should know better by now. I really should. You know, it's been a long time. I mean, it's been a long time to be working in this field. Now, I've never lost an X (family member) before. I mean, God forbid, I hope it's many many years from now. I still have an X left and I hope I'm more prepared to sort of cope differently but oh... no. I don't know how to explain that. You know, logically, in my head, like so many people say to me, in my head it works, but in my heart it just doesn't cut the mustard. There's just something about the whole thing that just says to me: "No, it wasn't OK. You should have been smarter than that. You should have been more aware of the kinds of consequences that would have had and you should have.. yeah you should have just managed it better." That's harsh.

Others, although not as openly severe, imposed certain conditional clauses to their statement of acceptance of feelings of incompetence. Conditions varied, but revolved around the issue of responsibility. Six therapists stated that they accepted, in themselves and others, a certain amount of trepidation, hesitation, and outright feelings of

incompetence if the person experiencing this had insight, took some proactive steps to address the root causes of it, and remained firmly invested in the process of evolving from the awareness of feelings of incompetence. Respect was extended towards therapists who admitted feelings of incompetence and subsequently used them as an opportunity to learn. Therapists demanded that action follow insight into ones' perceived shortcomings. Indeed, a certain amount of disdain accompanied the description of those for whom awareness had not yet arrived or who squarely refused to be propelled into affirmative action by that awareness. The following conversation with Donna, who is in private practice full time and has twenty five years in the mental health field, gave us a glimpse of this;

> Participant: Well, I was director at family services at one point and we had this new employee *avec un Bacc. en services sociales*(bachelor's degree in social sciences) and he knew everything. I was very very scared of that guy .I didn't trust him because you can't know... You don't know anything! He was new and he could do everything and he was *so good at everything* (participant's emphasis) and he would never come for help and he would never ask questions hum... He was too confident and he scared me a lot. So, I've always respected that it's normal to feel inadequate and at some point you don't hide that. If you hide it that's what it does, people don't have any confidence in you.
>
> Interviewer: So the big thing for you and this has come up before is not whether you have feelings of incompetence or not because you will have

them . It's rather what happens with them or what the therapist does with that , that you see as critical.

Participant: Yes, and not to hide it or feel ashamed of that. It's normal. Do something about it. Don't hide it.

Yet another participant, Ella, raised the issue of responsibility and saw it as the critical element that distinguished acceptable from unacceptable incompetence. This therapist went beyond that and saw issues of responsibility as the main propeller that moved one from the inadequate end of the continuum toward the incompetent end, an end she found wholly unacceptable for both herself and others. She tied in responsibility, action, ethics, and acceptability in her attempts to distinguish between inadequacy and incompetence in the following dialogue.

Participant: I assume that if you sat with inadequacy long enough then you would be incompetent but for me personally, I have little patience for people who are incompetent but for people who have a sense of inadequacy, I think it's a courageous position. You can say I am inadequate and I am going to do something about it.

Interviewer: You see it as possible to respect somebody who admits inadequacy but it's not possible to respect incompetence because the person has decided...

Participant: Deliberately is not using it as a motivating factor, is using it as an excuse or whatever

Interviewer: Allowing it to happen?

Participant: Allowing it to happen. Either it shows a total lack of introspection, a total lack of commitment, or it shows something about the person.

Interviewer: Some defect?

Participant: yeah... Maybe (Laughs). Yes, but there's that unethical part in there too. But inadequacy is very similar to that Adlerian sense of inferiority for me. An Adlerian thought, of course, is that we all have that sense of inferiority and how we use it ... and a healthy way is to use it to grow. You want to overcome your sense of inferiority. Well, that's what I've done with inadequacy.

Interviewer: OK, so, it's ... as far you're concerned probably a normal aspect of being a therapist or... ?

Participant: Being a human being.

Interviewer: Being a human being in any role?

Participant: In any role ... It's when you feel " Gee, I really don't know. I didn't handle that well that you're going to do something about it! If you're responsible, but if you botch that and you botch this and then you're incompetent if you don't do...

Interviewer: So, for you the distinction is responsibility. If you're inadequate and responsible you won't be incompetent but if you're inadequate and irresponsible then you will eventually..

Participant: Be incompetent.

Interviewer: roll right on over to the other end of your continuum.

Participant: Crash right into it! That's right. That's right. You're putting the right words on it (LAUGHS).

This segment suggests, and echoes of this are spread throughout the interviews, that therapists can accept, even promote feelings of inadequacy to a certain extent and at times conditionally when they can attribute this sense to normal aspects of being humans in an ongoing growth process who will utilize the moment to motivate learning. This permission is nevertheless limited and doesn't apply to more extreme forms of feelings of incompetence. As we proceed into different sources and depths, it is gradually withdrawn and replaced by self-accusatory/blaming ideas and more stringent and inflexible self-judgment criteria.

The complexity of judging as acceptable or unacceptable different levels of feelings of incompetence was brought forth by contradictory responses to a devil's advocate question posed during the interview process: Some people would say that if you are feeling incompetent then you probably are incompetent. How would you respond if you were challenged like that? Ralph, who is the coordinator of a crisis unit for a non-profit agency and has ten years of counselling experience, responded:

Participant: I would say if you are not acknowledging that this is part of our business, our work, then you are probably taking the stance that it's always the client's fault. If you are in absolute competence, if you are in absolute competence, then there is some aspect of your personality that (laughs) doesn't fit well with this business. You have to be very egocentric and have no sense of humanity or humility and you have your faults and your weaknesses. You bring all kinds of things to the therapy and you

have to be open to looking at it, all of that. That is not incompetence. That is....

Interviewer: Being human.

Participant: Yeah. *No, I would strongly disagree* (with the devil's advocate question). I think acknowledging our feelings of incompetence, in the end makes us a lot more competent. We actually talk about that quite a bit in training.

Ralph vehemently denied that therapists' subjective feelings of incompetence indicate real incompetence.

Bob's endorsement of this idea (below) stands in bold contrast.

Participant: I kind of agree with that (the devil's advocate question). It can be misinterpreted though. If you're feeling competent you probably are well that's not a blanket statement that indicates that you are competent in everything. But, I agree with that, because those feelings are there for a really good purpose, not to make you feel like shit or you know, to be mean to people afterwards, but they're there to tell you that you need to do a better job here. And, I don't have nothing against that at all. *I completely agree with it* (my emphasis). Sometimes, you've got to do a better job. Either you're not paying attention or you're not working hard enough, you need supervision or you need to consult with somebody.

Interviewer: So, you see it as a flag?

Participant I see it as a flag, yeah.

These seemingly contradictory statements bring forward several critical issues in terms of the normalization of feelings of incompetence not the least of which is the relationship between feeling incompetent and being incompetent. Directly and indirectly there seemed to be the dual propositions that these feelings were both normal and on a certain level acceptable insofar as they were not left to fester unattended but rather used to spur growth, and motivate learning. This conclusion was best reflected in Ella's comment below:

> Participant: I think just to reiterate that sense of inadequacy as being very useful and that it's a very responsible therapist who will acknowledge it and run with it in a learning, growing way. A sense of incompetency (sic), if you sit with that and refuse to address it, I think you should get out of the business.

In other words, there seemed to be general agreement among participants that feelings of incompetence were normal in the sense of being frequent and widespread but that they carried a crucial message. From the therapists' perspective, it was the management or non-management of that message that transformed self-perceived inadequacy into actual overt incompetence.

Professional Issues

The second category or group of factors that caused feelings of incompetence was summarized by the theme professional issues and included the following: insufficient knowledge, lack of training, lack of related experience, and administrative tasks.

These were factors that were related to the acquired capacity to understand clients and their specific presentation and to the possession of the necessary repertoire of skills to intervene therapeutically.

Knowledge, Training, and Experience

The most commonly acknowledged and easily broached causative factor was lack of knowledge. All participants admitted their ignorance on circumscribed problem areas or with specific therapeutic populations and clearly attributed many of their feelings of incompetence to these. Therapists openly divulged their lack of theoretical knowledge, insufficient training, and/or lack of experience in dealing with specific issues such agoraphobia, anorexia/bulimia, borderline personality disorders, and others. Ella elaborated:

> Participant: Yeah and probably another thing is if there is a client bringing an issue to bear that I have yet to encounter. Now, after twelve years you probably have seen most... there's variations on a theme, basically (laughs). How else can I say it? But one just happened to me last week! Where I was presented with somebody, where the X Institute was the referral source and so I get to see a pedophile; an active pedophile who is just now warned and who has this very peculiar fetish. Now, I read the literature, I have seen people after treatment but not ...So this was a challenge and it was one where I had been forewarned. Now, had this client just come to me and started presenting, I think I would have rolled with it. But because I was warned that he was difficult and resistant and this whole other kafuffle, I thought " Oh my God! I haven't had this much experience

with pedophilia or fetish and this particular...It was a very unique fetish. I haven't had that much experience so I was filled with this sense of inadequacy or a certain pause before meeting him.

Therapists also referred to this category on a more general level when asked how they and their feelings of incompetence have evolved over the years as Donna succinctly summarized below:

Interviewer: O.K. So, now. Last series of questions is about developmental issues. Have you felt that you've worked on these feelings of incompetence as the years have progressed?

Participant: Absolutely.

Interviewer: How have you changed?

Participant: Knowledge, information, training, experience. Maybe, always having acknowledged it.

Clearly, therapists equated feelings of incompetence with knowledge and training deficits.

Administration

Other professional issues that were ascribed causative status for feelings of incompetence were related to the corollary duties of administrating a caseload or a private practice business. Issues such as file upkeep, scheduling appointments, handling money issues, and taxation practices created some feelings of inadequacy. Several participants deplored the exigencies of their professional licensing bodies in terms of paperwork and were thrown in a virtual state of panic upon being informed that they had been chosen for the auditing process where their files would be reviewed and their practice evaluated.

Incompetence feelings related to professional issues engendered levels of self-doubt that were more intense than those elicited by the permissible category yet nevertheless were relatively mild. As previously mentioned, correctives for this self-perceived flaw were more obvious and the participants spontaneously peppered their description of this source with remedial propositions. Knowledge, skills, training, and experience were seen as something that one either had or had not acquired. The potential for ongoing acquisition of these attributes as well as the stipulation to actively seek to change this condition of ignorance moderated the severity of the judgment therapists levelled against these types of limitations. Therapists felt that they exercised a comfortable amount of control over their intellectual and experiential shortcomings. Other factors that contributed to feelings of incompetence were neither as self-contained nor as directly amenable to the therapists' volition. As such, factors that were related to the therapeutic process had a more intense and long lasting impact.

Process Issues

Process issues were conditions or situations that arose from direct contact with clients and occurred in the dynamic therapeutic exchange with them. These issues that were capable of eliciting a moderate level intensity of feelings of incompetence were grounded in the proceedings of therapy. They were collapsed into the following categories: process-outcome discrepancy, relationship and relational issues, thought-action incompatibility.

Process-Outcome Discrepancy

Many of the examples that stimulated feelings of incompetence in the sample of therapists depicted situations where the result of an intervention or of a series of

interventions was not one that the therapist expected or would have predicted based on the process. In many instances the therapists were quite satisfied with the nature of their work until subsequent feedback forced them to re-evaluate the quality of their therapeutic decisions and gestures. Six therapists made the link between such instances and feelings of incompetence. Katherine offered a case example:

> Participant: If I have a client ... Hum... who is very critical of my services. Hum.... like I remember a client that, at the end of an interview, I had seen her the first time *Vendredi Saint*, Good Friday ... the last client. She had called, she needed an appointment quickly and Hum ... kind of an emergency. She was going through a separation and it was quite special the relationship she had had, a bit traumatic even. So she comes to the office, she is in such a panic and overwhelmed that I... The interview lasted an hour and a half. So, I supported her and she had been through... It was a first time experience of homosexuality and the other person hadn't been honest with her and ...hum... It was such a mix-up. She was traumatised by some things that had happened. So I kind of debriefed her and normalised her feelings and tried to give her tools to deal with the situation until I see her again and to take care of herself. So I thought I had done a pretty good job.
>
> Interviewer You were happy with it.
>
> Participant But I felt that something was...she... I wasn't able to make closure and when I really tried harder to make a closure after an hour and a half ...she... and I told her how much the session was... she stands up and

> she looks at me and she says... I don't remember the exact message. It was in French she said: was that all that I could do for her? And ...hum... It had not helped her a bit and she goes on and on... and I was like "Oh, my God!". I felt so powerless, very powerless and angry a bit, like I was saying:" What's happening here?" I did my usual thing. The anger came more after.

In other instances a client's ultimate fate forced the therapists to struggle with the cognitive dissonance produced by the competing emotions of having performed well as therapists yet bearing witness to pain and tragedy despite their best efforts and intentions. Cameron shared a situation where this discrepancy between process and outcomes was dramatic.

> Participant: Like I did all the right things and that I'm really (laugh) I'm so glad I did all the right things, I guess because of that it's really bolstered my feelings of self confidence and yet it's very saddening that you might do the right things and clients will still go out and kill themselves.

These vivid examples and others like them make a definite link between moments where therapists cannot find fault with their therapeutic decisions yet feel incompetent because the results are poor.

Relationship and Relational Issues

All therapists in the sample correlated feeling of incompetence with relational factors.

Closeness and engagement.

The building and maintenance of a strong relationship was viewed as the sine qua non of feeling competent as eloquently displayed by Susan in the following disclosure:

> Participant: I think for that first week I was back, I needed to stay very umm very detached so, I think with her she really needed me not to be detached and I was. So, giving her handouts on communication and schemas and questionnaires and stuff where normally, I am quite engaged at not only the cognitive level but at the emotional level. I think that's why I'm successful is because I don't stay very clean, you know, on the other side. I am often very intuitive and I'm very expressive and I don't have any. I don't have barriers that hold me back from doing that but with her I closed up.

This statement clearly underlined the importance of the relational aspect for the therapist's sense of competence and the impact that the absence of a strong relationship had in the opposite direction. The poor quality of the relationship was attributed both to therapist influences and to client characteristics as Susan continued to explore her feelings about a client:

> Participant: Qualitatively just different and I think it's because I had these very strong feelings around her coming that I didn't have for a very long time.
>
> Interviewer: How did those feelings get triggered off?
>
> Participant: She was very um she was very cold. She was very cold and negative, very black and white, very little empathy, I think, when she was

talking about people. I think she was probably just as shut down, emotionally maybe, as I was at that point. Yeah, probably.

Interviewer: So, she was a bit of a reflection.

Participant: Yes. Probably, yeah...She really required a lot of... First of all, she really required a relationship with me, you know, because she had no relationships with other people. So, the fact that I shut down on her almost immediately I think had a lot to do with my feelings about her not coming back.

Therapists talked about feeling incompetent when unable to develop a positive relationship because of distant clients, mistrustful clients, and generally resistant clients. Therapists' also examined their own contribution to lack of stability within a therapeutic relationship including the dynamic reciprocity between client characteristics such as criticalness and their own counter resistance or distancing manoeuvres. Susan shared her musings on the interconnectedness between a client's contribution to this process and her own reluctance to invest.

Participant: So, maybe in a very similar kind of way, now that I am talking about it I am making the connection between the two and maybe that's why when we are talking about incompetence, this particular kind of client is very negative and critical somehow triggers off in me an early warning system that somehow they won't be safe. The other fellow that I was talking about who was alcoholic was also very negative but it was in a kind of wounded way, you know so my sense was that the type of relationship I can offer him by being nurturing in a way and setting it up

so he can have a trusting relationship for the first time in a long time that would be helpful. These other two, I didn't feel... there wasn't the warmth there perhaps.

A strong therapeutic relationship at times functioned as a safeguard against feelings of incompetence stirred from other sources. Therapists could withstand a certain amount of self-doubt and negative feedback without undue discouragement if the positive aspects of a relationship were preserved. When taking responsibility for the poor quality of the therapeutic relationship therapists experienced mostly guilt. The issue of responsibility generated a fair number of situations where therapists had felt incompetent.

Responsibility and boundary.

The issue of responsibility for change, progress, and movement was pervasive as a motif across interviews and generated a large number of vivid examples. All therapists reported a variety of ongoing struggles with decisions about responsibility and concomitant attempts to establish boundaries to outline this division of therapeutic labour. Witness Ralph's description of how he experienced moments when boundaries got blurred.

Participant: If I get that feeling, that question comes; "What's that related to? What's going on? How come I am, you know... What part of the conversation with this client might have led to me taking this feeling on? Was it when they were telling me about the fact that they were worst and still shitty and I was feeling, for a moment, I took a moment of responsibility for that?" Rather than saying: "Well, that must be really

hard for you, that you are working so hard to improve things and it stills feels so shitty". Throwing it back.

Interviewer: OK. In the moment where your boundary was less clear...

Participant: I let a little bit of it in and then I whoop heard that icky feeling of saying "Oh Ralph ..."

Interviewer: "Close that door!"

Participant: "You didn't help this person, you shit!"

Therapists readily acknowledged that when boundaries were clearly set and onus for change lay with the client, the feelings of incompetence were significantly attenuated. This attribution of responsibility and the process of deciding what belongs to the client and what belongs to the therapist was principally an internal exercise and the setting of a boundary the result of an introspective process. It appeared that this internal clarification was more important than the interpersonal element. The therapists' efforts to set, to recognize, and to respond to violations of responsibility boundaries were primarily private.

Although all therapists elaborated on this critical dimension and all but one saw a relationship between taking on too much responsibility and feeling incompetent, there was considerable variability in the judgments about the extent of responsibility that was indeed acceptable/tolerable.

Several therapists allotted the full responsibility to the client. Ralph described this in the following excerpt.

Participant: Whereas ten years ago it might have been " Christ, this kid is not getting better, I feel incompetent ". It's not like that anymore.

Interviewer: You've seen an evolution?

Participant: "This kid's not getting better. I wonder what **she** wants to do about it?" No sweat. Go home and never think about her again.

Others shared the responsibility and defined their role as instrumental. They expected the client to contribute mostly in a motivational manner. For example, Mary defined her responsibility:

Participant: That's it. I feel that my responsibilities are to give them some tools to take care of themselves and if they don't then I am not responsible for that part. I am responsible to give them the right tools, what I think are the right tools to help themselves, and if they don't, like we say, usually, it's their problem, it's not mine anymore.

Ella concurred with the following statement:

Participant: It's a joint responsibility. I will be helpful. I know I am not the only variable in this person's life. There are a lot of things happening outside of the office. I am just one of many tools that this person has if they choose to. That's how I see it. That's a whole different dynamic to that one.

As previously mentioned, in response to the interviewer's invitation to elaborate on the relationship between responsibility boundaries and feelings of incompetence, one therapist, Donna, saw no link between these processes.

Interviewer: Does that impact on your feelings of incompetence, when you are able to allow the client to take some of the tasks on. Is it... Hum..

Participant: No, *je ne vois pas*, there is no ... feel more. like, I feel it was something I had to learn to do and it's good.

Interviewer: So that you feel less inadequate with the client, when you set the boundary?

Participant: Not less inadequate, less tired. I didn't see it as inadequate. It's just.... *Je ne sais pas comment expliquer ça.*

Interviewer: You have learned to do that with time as you evolved from an inexperienced to an experienced therapist. You learned to set clearer boundaries in terms of who is responsible for change and who works.

Participant: But I still feel a great deal of responsibility and it's all right with me. I like that.

This therapist saw no real advantage in terms of feeling less inadequate in setting up clear limits, internal or external around responsibility issues. She reported usually working much harder than her clients and felt comfortable in the role of carrying the burden for progress and improvement. In the following disclosure we see a slight movement towards holding the client responsible. The therapist, however, simultaneously reiterated the centrality of her role as the instigator of change.

Participant: I worked harder than the clients. Oh yeah!

Interviewer: I see. So, that has changed now.

Participant: Yeah, now, I let them work a little bit. I still work hard.

Interviewer: Yeah. Can you talk about that? Like the responsibility shift is a boundary issue there?

Participant: I took some courses in hypnosis and that's where I got the" let the client work a little bit here". And I realized that I worked too hard and that helped a lot. It helped that I didn't feel so responsible. But I have

that. It's a responsibility. I need to be able to help these persons and if I can't, I better find somebody who can. But something has to change here for them and something has to happen and they come to me because they've eliminated their resources, you know.

The links made between limiting ones' responsibility and some form of improved comfort in session is tentative at best and disclaimed by a reappropriation of the global responsibility for the clients' ultimate welfare. This vague and apprehensive treatment of the topic of responsibility contradicted what the other therapists very clearly stated; the more responsibility you take for client growth processes the more vulnerable you are to feelings of incompetence. Perhaps Donna is still in the process of discovering this equation.

Communication obstacles.

Four therapists elaborated on specific obstacles to the development of a relationship, issues that made the establishment of a sense of connection, mutual understanding, and collaboration more difficult and at times impossible. Differences that contributed to these relational stumbling blocks were cultural, language based, religious, and gender based. One participant mentioned degree of pathology as a factor that made establishing communication more tenuous and strained. When the therapists struggled to communicate with their clients, the feelings of incompetence were triggered.

Projection.

Another aspect of the relationship that therapists reported as influencing their feelings of incompetence was what can be termed projection. The consensus among

participants was that emotions experienced by the client were at times introjected and reflected in the therapists' emotional and often self-deprecating experiences.

All therapists spontaneously referred to situations whereby they inadvertently assumed their clients' experiences of helplessness, hopelessness, immobilization, defeat, confusion, anxiety, and even dread. Ralph eloquently summarised this process:

> Participant: Right. And this belief that you, most of the time, we inherit some aspect of our client's own feelings about things. So, I tend to see how I feel about things as a clue to how the client might feel about things but something that is unspoken, like resonance in some European models of practice. Like you are resounding some feelings that the client has. So, if you are feeling... not looking forward to a session it might be also that the client is coming but they're not there. If you are feeling hopeless about your client's situation, maybe there is some of that with them and if you talk about that you might start to, to be in the right place to work.

Clients' despairing emotions led therapists to doubt themselves and to feel incompetent.

Projective identification.

A corollary experience, similar to what is known as projective identification in analytical terminology was described by three therapists whereby the client unconsciously pulled for a certain kind of response from the therapist. In other words, there was an unspoken invitation for the therapist to be a certain way. Therapists entered into an unspoken collusion with clients' dysfunctional interpersonal dynamics and inadvertently abdicated their normal role. Therapists then failed to intervene in their habitual style and

eventually felt incompetent because of it. This process was exemplified in the following conversation with Ralph:

Participant: Hum. *And I would shy from my better judgement sometimes in the room* (my emphasis).

Interviewer; How would that work?

Participant; Yeah, I am lacking a bit of, you know, they're so practised in getting people to back down and I play their game of (wavering gestures).

Interviewer: Maybe I'll see you next week (laughs).

Participant: Laughs... You sound like a great guy.

Thought-action incompatibility.

The concept of projective identification was offered as one explanation of situations where therapists' actions were incompatible with their knowledge, their understanding of the problem, or the interventions needed to help the client. Several therapists mentioned this inconsistency as the source of their feelings of incompetence. Ralph talks about this below:

Participant: I feel I am at the level where if I feel incompetent, it's because I am not doing something I know (banging on table) and want to do but somehow I get scared.

Therapists' also mentioned personal history, fear, and their own personality dynamics as obstacles that at times prevented them from doing what they thought ought to be done.

In fact therapists described a panoply of personal factors that not only prevented them from acting on their therapeutic judgment but that also at times directly stimulated feelings of incompetence per se.

Personal Factors

Personal factors, the last major category regrouping sources of feelings of incompetence was more difficult for participants to discuss and affected them at a more profound level than the previous categories. Subsumed within this category were the following themes: wounds/historical wounds, personal vulnerabilities, psychodynamic issues, personal values, and state and trait issues.

During the interviews the therapists both discussed and displayed how perturbed and deeply affected they became when feelings of incompetence reached far into their personalities and their personal experiences. Some interviews had to be stopped to allow the therapists to cry and then regain their composure to continue. Several times the offer was extended to discontinue the interview but the participants flatly refused. Incompetence triggered by the reliving in session of wounds/historical wounds was the most painful experience of feelings of incompetence for many participants.

Wounds/Historical Wounds

Clients at times presented personality constellations, problem areas that out rightly disarmed the therapists. When the clients' style of relating or issues paralleled either recent or distant painful experiences of the therapists', the latter reported "loosing all their ways". Donna shared an example of such a moment where her client's presenting problem echoed ongoing personal issues of hers.

Interviewer: How did that touch your feelings of incompetence? What was going on inside at the level of feeling inadequate when he said that " I don't feel any different. Nothing has really changed".

Participant: What I am thinking it's weird, hey that case, I didn't want to take and at first I followed my instincts. My friend, she's a psychologist, she referred the case and she said:" This is... he has fear of attachment, of intimacy. With his girlfriends, if it's a year he gets close, he runs and stuff like that". She says " You've had cases like that " and I said " Yes, in my personal life a lot!" (Laughs). "With men, yeah, no problem"...and she said:" Are you comfortable?" And I said:" I don't know if I am comfortable with that". You know, this is what I am living now in my life, fear of intimacy and I'm tired of that. So this guy comes and he tells me "I don't know if this is working and nanana and if you're... Grrrrrr!.(participant growls).

Many therapists reported being conscious of the dangers of counselling clients whose issues were "too close for comfort" and despite their attempts to protect both themselves and the clients from what Donna called "subjectivity and projection", it happened that therapists were caught unaware. Susan, who has accumulated 25 years in the mental health field, offered this example:

Participant: What drives it for me is not managing the emotional, the strong emotional reaction that I may have to a particular client or in response to a client or even something that is going on within me that... like this woman wasn't so terrifying, this last woman. It's just that I wasn't

in a space for her. I wasn't even prepared for her. I knew it. *I knew it after the fact. I didn't know it at the time* (my emphasis).

Susan's retrospective analysis allowed her to recognize how her personal vulnerabilities had prevented her from being fully present for a client with whom she eventually felt estranged and incompetent. This awareness was not immediately available to her during the counselling process. At times the therapists' internal turmoil superceded client or client –therapist dynamics in terms of generating feelings of incompetence.

Personal Vulnerabilities

Therapists' personal struggles and life events that were independent of the client and client issues could prevent therapists from functioning at their optimal level. Katherine provided the following example:

Participant: ....I was in a period of my life where I had been through hell...

Interviewer: Personally?

Participant: Personally, hell. *Really*, hell. (Participant's emphasis).

Interviewer: Were you vulnerable?

Participant: Very. And I just begun to work again and ...hum... the situation was, it was an old client, that I hadn't seen because I was on maternity leave but I had started again, but ...hum.... I was functioning at a minimum level,

Three therapists spoke both of functioning sub optimally and of being increasingly self-critical and prone to feelings of incompetence after experiencing the death of loved ones, divorce and separation, and personally traumatic experiences.

Typically, they expressed an increased sense of vulnerability during these times and an increase in self-protective mechanisms that handicapped their therapy. Therapists' spoke of changes in their way of relating, limiting their investment in the therapy, of withholding, and of becoming more directive and technique dependent. While the actual impact on the client's progress remains unclear, therapists at these times felt incompetent because the modification of usual ways of practice was not based on therapeutic issues but on narcissistic ones.

Psychodynamic Issues

Beyond personal struggles that were related to life events, therapists reported other challenges posed by their own growth, evolution, and strivings towards self-understanding. Certain participants made links between familial relationships (family of origin) and feelings of inadequacy, insecurity, or incompetence. Psychodynamic principles seemed to lie at the heart of these allusions.

Katherine offered the following self-analysis:

> Participant: Hum, personally...for me, I'm at the stage, concerning the feeling of incompetence... I'm in a stage where I'm dealing with some past issues that I think are making me vulnerable to certain situations. Like, I had a mom who was very critical, *exigeante*(demanding) and critical. So what does it do, when I get exterior feedback? I think it's the reason why I had to work at it, because from the beginning and it's not only with clients, it's elsewhere. So that's why I say that I need to grow, *dans ce sens là*, because it puts me in too vulnerable a situation. But I see some positive out of it, because it puts me, well anything, it's like that in our work and for

> me, it's special and normal because in our work we deal with interpersonal relationships, but in any work the feeling can be there. So, maybe that's why I take it as normal, because I'm telling myself, because of my upbringing wherever I would be, whatever I would be doing, I would question myself and always want to do a better job or better quality. That part is normal, but that part that is in excess, I have to say stop.

Katherine's own psychological evolution and understanding of her past had created vulnerabilities that made feeling incompetent more likely. She was prone to being excessively critical perhaps because she had internalized that tendency.

Personal Values

Two of the therapists in the sample spoke of situations where a particular value or belief prevented them from operating in their usual way. While Donna refused to see bereaved parents because she truly believed such situations to be hopeless and herself useless in these cases, Ella continued to service the clientele in question and wondered whether her value laden interventions were beneficial.

Ella explored this issue in detail:

> Participant: Probably the only time I am quite directive is … and this is… I was thinking about this the other day. When it comes to children, that is probably where I do everything differently than what I just said. (Laughs). I am talking about parents of children and guardians of children and not children themselves. I take that responsibility so seriously that I insist that the guardians understand the commitment to children. And if they're not there and they don't want to hear it cause it's not where they're

at and everything, I don't care. That is my agenda. And that is the only thing… or maybe animals too or put children and animals together for this purpose. But aside from that, really it's children. For minors, you're responsible for minors, I don't care how much they want to find themselves and do other things. You have a commitment and I just keep hitting that back home even if they don't want to hear it

Interviewer: So, this is when you're agenda…

Participant: This is my agenda.

Interviewer: Takes precedence over the client's desires.

Participant: And I don't know how therapeutic that is. And I have some self-doubt about that but it is something I can't negotiate… I could negotiate, I guess, but I chose not to. We don't have enough advocates for children, especially in the therapeutic milieu. Hum… It's all "Hey! What about yourself and what about your needs and getting them met" and we forget. We forget about the children and there's nobody advocating for them or rarely. And I take that. Even if it's not on the agenda, it has to be said.

Interviewer: It's tied to a value and your value is child protection.

Participant: Yeah.

Interviewer: That comes above self-evolution and self-development and all that other nice stuff. Too bad.

Participant: That's right. And I think I may have lost some clients and I certainly have certainly not met the needs of the client and that's my only… It doesn't fit my …

Interviewer: Philosophy...

Participant: Philosophy...but I can't let it go and I think it's because I have worked with so many damaged children. I think that's probably where it comes from. And we live in a society that keeps forgetting to remind people of their responsibility and I want to... might find it dubious but it's something I really believe and it's something that has to be said. Because they're not getting it from anywhere else, people don't even factor it in very often. Or (they say):"As long as my needs are met, my children will be happy". What crock is that? You know, really? And I've said that ...something that therapists are not supposed to say but really. Where do they get that? (Laughs). The North American system drives me bananas and that's where I loose it all.

State and Trait

State.

Four therapists shared that mundane factors such as being tired, hungry, and seeing the last client on a full day also could cause them to feel incompetent. The state of the therapists' immediate physical and mental well-being influenced the subjective judgment of their competence. Therapists' and their feelings of incompetence during sessions could also be contaminated by feelings of incompetence stimulated in other work or life areas. Marital conflict, criticisms from ones' children, confrontation with business

business partners, and accusations levelled at one from other building tenants were examples offered by therapists. The main argument here was that when one enters into the session with unfinished business and feelings of incompetence one is susceptible to re-experiencing them with the client. Susceptibility to feelings of incompetence was also attributed to one's personality by most therapists.

Trait.

Five therapists alluded to a personal tendency to be critical, self-doubtful, or feeling 'not good enough' in many areas of their life and viewed therapeutic moments of self-doubt as an extension of this general way of being. The last interview segment presented by Katherine gives us a glimpse of her attempt to ferret out the positive and destructive aspects of self-criticism at a more general level (see p.115). While some described this personality trait as a burden, others reframed it in terms of striving and seeking to surpass oneself. Susan elaborated on this:

> Participant: OK. It's interesting that when you started to say that, the thought that came to my mind is that I'm a personality type that I think that constantly struggles with feelings of not incompetence but always that I could be doing better. A kind of overachiever that feels that what I am doing is not yet at the level that I am completely satisfied with and so, if we are talking just about my work, it's a reflection I think of my complete personality in terms of always feeling that I have to keep just pushing myself and moving ahead that way. .
>
> Interviewer: So, it's familiar to you in a profound sense. You define yourself with that striving.

Participant: Yeah, I don't think it's particular to my work as a professional. It goes right across all the different areas of my life; as a mother, as a wife, as a daughter, as a whatever. There is always that sense.

The tendency to question one's competence was viewed as one aspect of a more overriding aspect of the personality, which can be seen as negative or, as in this case, growth enhancing. The therapist's self-judgment can either fuel a healthy ambition to continuously evolve as a therapist or conversely be used as a weapon in a process of meaningless self-flagellation. This will probably depend on other factors.

Summary of Personal Factors Category

To recapitulate, in terms of personal factors that cause feelings of incompetence, therapists made links between feeling incompetent and sensitive topics and vulnerabilities, personal moments of upheaval, and psychodynamic issues. Therapists also felt incompetent when personal values influenced their therapy, when characteristic self-critical tendencies manifested, and finally when prone to self-doubts by states such as fatigue or illness.

Summary of the Section on Sources of F.O.I.

In summary, the major sources of feelings of incompetence in ascending order of profoundness were permissible factors, professional factors, process issues, and personal factors. Generally, the latter had the power to elicit more disturbing feelings of incompetence for which immediate remedial actions were not obvious. The feelings of incompetence generated by process and personal issues were also less contained and session bound. The feelings of incompetence as a result tended to permeate and affect the therapists' general sense of well being beyond the therapeutic hour. The relationship

between depth of emotion (incompetence) and source was not always direct. Other factors obviously served as catalysts, precursors, and general mediators tempering the relationship between the sources as described above and the intensity of the feelings of incompetence.

Mediating Factors

Therapists provided a host of mediating factors that interceded in the process of evaluating oneself as incompetent following the introduction of one of the sources described above. The mediating factors can propel the therapists' feeling back and forth along the depth gradient. They either intensified what was described as usually a milder type of feeling of incompetence associated with a less profound source or conversely abated what could usually elicit intense levels of feelings of incompetence. The sources then can be viewed as potentials and the mediating factors as engines that allowed the potential to be fully realized or tempered.

Two elements that had a significant impact were the cognitive management of feelings of incompetence and the therapists' level of experience. Other mediators were: the amount of pressure/stress, both internal and external, experienced by the therapist, and the role and stance adopted by the therapist.

Cognitive Management of Feelings of Incompetence

The eventual depth of feeling provoked by a potential source of incompetence feelings was often mediated by the therapists' thoughts, their internal dialogue. Some of these internal meanderings dulled/blunted the feelings and others aggravated the self-depreciation tendency. When F.O.I. threatened to arise, therapist generally engaged in cognitive manoeuvres to address these feelings. Participants shared these by verbalizing their internal dialogues and exposing their private thinking strategies. These strategies

were grouped into the following categories: cognitive containment, attribution exercises, self-control techniques, and cognitive mismanagement.

Cognitive Containment

The most common exercise engaged in by therapists when doubts about their competence began was cognitive containment. All therapists actively sought to limit the extent and breadth of the feeling through one of the following techniques: self-soothing, modeling, prayer, and normalizing the experience for self.

Self-soothing.

Self-soothing was one popular method of keeping feelings of incompetence relatively circumscribed. Five therapists engaged in positive self-talk to promote their inner sense of calm and peace.

Cameron shared her internal coaching:

> Participant: "Just keep going. You'll figure it out. You're not stupid". You know, all of those good words that I need to hear! (Laughs).

Modeling.

Therapists often called forth the words of a model or mentor to defuse a growing feeling of anxiety and fear. Cameron explained:

> Participant To my self, most of the time... Hum, (chuckles). I usually say to myself the same thing. I quote Lettie Cox in my head. (Laughs). I say to my self: "Clients are forgiving. Hum, and one moment or one session doesn't make or break a therapeutic alliance nor your ability to help".

Therapists whose feelings of incompetence were triggered also used models as bases of comparison and as templates against which to evaluate themselves, their performance, and their expectations as demonstrated by Ella below:

> Participant: Yeah. And in session with someone who spoke this absurd Serbian tongue and he didn't speak Serbian in any way and they had this forty-five minute session where neither understood what the other one was saying. The client, afterwards, and this was the first time he had met Mossack (sic) and the client afterwards was interviewed and spoke of how helpful this session had been.
>
> Interviewer: OK
>
> Participant: Now, I take comfort from that! (Laughs). When I'm feeling inadequate, OK? (Laughs). That perhaps (hard laughter)... just having a relationship, just feeling heard even, maybe not even understood but being heard, might be enough for some people. So, I hang on to that! (Mutual laughter).
>
> Interviewer: So, this is like a soothing move.
>
> Participant: Yeah, it's self-soothing, a little self-masturbatory thing there! (Mutual laughter) But that's kind of what I'm thinking though.

Prayer.

Another form of cognitive containment frequently encountered among therapists was prayer. Five of the eight participants spontaneously revealed their exchanges with a higher being as a favoured mechanism to keep their mounting anxiety about "not

knowing what to do" manageable. The following example shows how Katherine incorporated God in her attempts to both contain and self-sooth.

> Participant Hum... It's like for me, I am talking to my self in a way, like I'm saying to myself, if I become anxious, I'm saying to myself: "Calm down! Because, if I am not calmed down, I don't have any solutions that come to mind and I know that if I'm calmed down and ...hum... Sometimes, well I'm very spiritual, and sometimes I even say, "Oh, my God, inspire me! Show me the way!!!" Or, like:" I know my job, I know what to do but ...hum... Guide me!!!" So it kind of gives me some kind of connection, some kind of inner peace that makes me more present to the moment.

Normalizing.

Another form of internal dialogue perceived by therapists as effective in maintaining their balance was one where the essential message was a normalizing one. These messages carried the tacit permission for the therapist to have "moments of not knowing". In other words, therapists often reminded themselves, when the initial feeling of incompetence was generated, that they were mortal, fallible, and not ultimately endowed with magic curative powers. This type of cognitive containment was useful as an antidote to feelings of incompetence brought on by an exaggerated sense of responsibility for the client (see sources- process issues) or an inflated sense of one's power in the affairs of the client. Five of the therapists interviewed used this method when feelings of incompetence threatened to move towards the more intense and overwhelming extreme.

Re-Attribution

This "letting of oneself off the hook" was closely related to issues of attribution, the second form of cognitive management of F.O.I. Therapists both directly and through examples demonstrated how a critical mediator of all sources of incompetence revolved around issues of attribution. Also seen as a source of F.O.I. (described under that section), attribution also served as a mediator when therapists actively, during a session made important internal shifts away from accepting themselves as causative and curative agents in the client's mental health. This internal response and boundary recognition alleviated the therapists' budding sense of incompetence and could be termed reattribution.

Self-Control Messages

Another cognitive intervention performed by the participants was to give themselves directives in an attempt to regain what one participant called a "sense of control". Concerns about ones' performance and effectiveness at times overshadowed therapeutic considerations and therapists struggled to maintain the therapeutic concerns a priority. The self-directives varied but the main theme was a command to focus: focus on the here and now, focus on the client, focus on the issues, focus on the contract, the needs, and the goals. All of these self-directed messages can be seen as efforts to move the therapists' energy away from self-preoccupation back into the interpersonal arena. Cognitive containment, attribution boundaries, and self-directives were three positive internal mechanisms therapists engaged in to counter the feelings of incompetence as they arose and to harness them, keep them from bleeding into all aspects of the therapeutic encounter. Other cognitive self-interventions were not productive. They exaggerated, exacerbated, or prolonged the negative self-appraisal process.

Cognitive Mismanagement of Feelings of Incompetence

In response to the internal challenges to their professional integrity some informants revealed practices that they knew to be damaging both to themselves, to the client, and to the therapy. The participants' experiences fit under the following headings: distancing from the emotions, labelling the client, blaming the client, rumination/dwelling, and overkill/mind racing.

Distancing from the emotion.

An oft-quoted example of an inappropriate reaction centred on the theme of distancing from the emotion. Five therapists revisited scenarios where they had actively avoided feeling incompetent by refusing to acknowledge this feeling through denial, by diffusing responsibility for perceived inadequacies in treatment onto team members when working in a multidisciplinary setting, by giving up and withdrawing, and by silencing self-doubts without giving them due consideration.

Labelling.

Therapists at times made links between particular diagnostic labels and feelings of incompetence. A frequently referred to category was the 'borderline personality disorder'. This label both elicited feelings of incompetence for many therapists and also served as an explanation for feelings of incompetence. Ralph denounced the practice of labelling in the following example:

> Participant: And then your only way out at that time is... the way we used to deal with incompetence when we were strategic or more systemic and when we took the expert stance is to call the client resistant or name the

client's problem as being, you know...This is not changing. This is not getting better because ...

Interviewer: They have a personality disorder.

Participant: Yeah. His mother is narcissistic and his father is this and this kid is that. Try to fight the incompetence by blaming the client and then saving ourselves. I find with collaborative therapy, that all has changed.

Interviewer: So, there is no need...

Participant: There's no resistance, there's no labels.

The issue of labelling closely parallels the issue of blaming.

Blaming.

Two therapists cautioned against labelling and wondered if a certain element of blaming inadvertently entered into therapists' use of some professional terms.

Dwelling.

Three therapists were unable to disengage from the self-doubting process and their torment extended well beyond the therapeutic hour.

Bob offered the following:

Participant: And so, to answer your question, at the very worst they linger and they become preoccupations in my non-work life.

Interviewer: So, you take it home?

Participant: I take it home. And it's almost like a guilt feeling.

Cameron shared the following imagery to encapsulate the process of rumination:

Interviewer: It's something you take with you?

Participant: Yeah! Something I carry around. I always, hum; I often think of it as mental gymnastics or like a cow, you know, you're chewing on it.

Interviewer: (Laughs). OK.

Participant: That's my cud.

Interviewer: Rumination!

Participant: Rumination! (Her emphasis). I'll ruminate on it. And I usually get...I always have a client that I ruminate on.

Therapists engaged in a fair amount of self-justification alternating with self-depreciation in their internal battles with F.O.I. Neither finding good reasons for their decisions nor engaging in a retrospective reanalysis of what ought or ought not to have been done in a certain situation helped the therapist regain or keep their composure at times of doubt about their competence. In fact, therapists who dwelled and ruminated on their feelings of incompetence either during or post session tended to feel worst. In those cases the feelings of incompetence seemed to persevere at the expense of the therapists' sense of clarity.

Mind racing and overkill.

The following conversation with Cameron suggests this negative correlation between "overkill" and the therapist's sense of direction within a session.

Participant: Hum... and I find it distracting. That if I let it go and just let the client continue and ask what I think is dumb, stupid questions usually then it will (snaps fingers) hit me. It will strike me.

Interviewer: O.K.

Participant: Hum… but if I try to grab at it too much, it's like, you know, I keep going further and further away from what the client is actually saying to me then and there, so it's frustrating.

Interviewer O.K., so, the two aspects that you're focussing on is the elusiveness…

Participant Yeah!

Interviewer Of whatever is going on.

Participant: Exactly, that I just can't get it like either because I don't understand it or in case of like a client where I have no idea what I'm doing is that I'm chasing. Now what did I read in that book? It was this… and I'm going off in my own head…

This psychotherapist presented us with a moment of cognitive preservation that was not functioning for her in terms of mediating in the process of feeling incompetent. In her case, the preoccupation with being a good therapist turned into an insistent need to perform adequately now. As a result her mind began to race and she felt like her self-preoccupation prevented her from being truly present with the client. This in turn may have fed the feeling of incompetence creating a kind of reciprocally determined loop. More feelings of incompetence created more cognitive racing. Cognitive racing moved the therapist's focus away from the client creating a distance that the therapist then experienced as a further source of feelings of incompetence.

Cameron continue her exploration:

Participant: Yeah, sometimes. Well, like I said, it's mostly what I call "the noise". It's my own thought interference. That I scramble when I feel

incompetent. I scramble in my own thoughts. I think far too fast. Hmm, I reach for things that are way too... If I gave it just a couple of more minutes and keep the client talking I would be able to nail it but If I am feeling incompetent I try to grab for it before I am really sure what I am trying to say so, then I stumble in my words and in my thoughts and I am not clear. So, that makes me feel even more incompetent and so the vicious cycle continues. (Laughs)

Interviewer: You embark upon that spinning wheel!

Participant: Yeah. That's it! That spinning wheel! (Laughs). That's the one!

Three therapists described the distance created in the therapeutic relationship by self-preoccupation. Basically, they proposed that they could not be attuned to clients when internal processes preoccupied them. Ralph shared the following:

Participant: Hum. I start to get a great sense of frustration, I guess, a little bit of despair. I imagine a sense of confusion. I'm trying to go back (pause 3 seconds). My mind is working at a hundred miles an hour, trying to find a doorway that might, you know, I would imagine that in those times I am listening more to my brain than his.

Interviewer: Hum.

Participant: So, I am not so much in tune with what's going on with the guy in front of me that I'm in tune with what's going on within, inside me at the moment.

Interviewer: So, you are having like an internal dialogue?

Participant: A very powerful internal dialogue in those moments, I think and it seems to take over.

Although still operative in many therapists the tendency to dwell and persevere was generally described as representative of the earlier years of practice. Susan and Donna explained that they tended to do this 95% of the time in the beginning and now had managed to reduce this dwelling to 5% of the time.

Summary of the First Mediating Factor Labelled Cognitive Management

When therapists' sense of competency was challenged and their self-doubts generated, they reported engaging in a number of thought processes to quiet their angst. Several of these thought processes were adaptive. Efforts to contain the feelings cognitively, to reassess attribution boundaries, and self-directed messages to focus were employed and at times were successful in defusing the mounting fears about ones' adequacy as a therapist. Other cognitive methods clearly were not useful and produced mismanagement of feelings of incompetence.

Experience

Along with cognitive management, experience was identified as a powerful mediator of all sources of feelings of incompetence. Therapists generally described an evolution that was characterized by a gradual decrease in overall number of moments they felt incompetent. This decrease at times operated through the acquisition of knowledge and tools. Therapists benefited from having received different types of training via workshops and other post-university educational facilities.

In terms of the relationship between experience and process issues, the most significant link was between experience and responsibility boundaries. The therapists

described a gradual movement away from assuming complete control and tendency to take charge for clients well being and choices. At times shifting responsibility to the client was the result of training that explored this dynamic but often it was purely the therapists' own introspection that led to the erection of these self-preserving barriers. The therapists' ability to set boundaries internally and externally was directly related to years of experience by participants as they mused about their own growth and retrospectively recounted years of struggles with feelings of incompetence. It appears that for these therapists their own recognition of and respect for their limits far outweighed the actual communicating of the boundary to the client in terms of potency. When therapists achieved the capacity to relinquish the responsibility for the clients lives, their feelings of incompetence were less likely to be stimulated by the sources as outlined earlier. The F.O.I. that did appear were of shorter duration. Mary described her evolution in the following way:

> Participant: Like I said, maybe fifteen years ago, if a client got suicidal, I would say, "Oh my God! It's my fault, I didn't do what I had to do and I didn't help them enough, I didn't take care of them enough" and stuff. But I felt more like a baby sitter in that particular kind of situation but now I do everything by the law or by the book. Like if it's a child, I implicate the parents and the environment, the school and stuff and if it's an adult I give him or her the guidelines that could help. I have to make him or her safer, the safest that I could and that's about all I can do so even if one adult commits suicide, I don't feel that incompetency (sic) anymore and I don't question myself. Maybe for a few minutes I will ask myself, "Did I do

everything that I could?" And then I just revise in my mind what I did for this person and say "OK I did about everything I could and then....

Interviewer: So, the more global goals have changed. You are no longer there to save people from themselves.

Participant: That's it.

Experience also influenced how therapists evaluated themselves. The early tendency was to equate incompetence with the inadequacy of ones' technical choices and/or client progress. A gradual withdrawal from and divorcing of ones self-evaluation from client processes was the norm among therapists interviewed for this study. Therapists judged themselves on more abstract measures such as attributes, personality traits, and interpersonal qualities. This afforded some measure of protection against the ambiguous nature of some therapeutic results. Other factors that became staples of self-evaluation were creativity, authenticity, and intuition. Although therapists were consistent in their move away from basing their self-evaluations on client change, there seemed to be no agreed upon alternative. This will be explored in the discussion section as a possible avenue for further elaboration.

Generally, experience served as a buffer against feelings of incompetence stemming from the fallibility of humans (permissible) and for professional shortcomings. Informants had acquired enough confidence to be flexible about not knowing and had logically accumulated more training, knowledge, and general know how. However, experienced clinicians remained vulnerable to feelings of incompetence stemming from process issues and personal issues. In fact, the more experienced clinicians seemed to be

particularly inflexible and harsh in their self-criticisms and to be more intropunitive. Witness this example offered by Susan:

> Interviewer: And although it sounds like you're experiencing less and less, especially in the last five years, it can still hurt.
>
> Participant: It probably hurts more. It's more frightening and more intense now if I do. Like the feelings that I had to this lady were probably the most intense I've had around a client since the intensity of fear that I felt with this fellow, which was around three, four years ago. So, the feelings for her were intense. I just felt bad and I felt bad that I was happy that she wasn't coming back and then I felt bad because she really needs help and I may have screwed that up for her in terms of seeking help somewhere else. So, yeah, it's pretty intense.

Other reasons given by participants for experiencing more intense albeit less frequent feelings of incompetence related to their standards. It appears that as the years progressed therapists gave themselves less of a margin of error and become more rigid in their expectations of themselves. Susan explained:

> Participant: Which comes back to what I've said before is at this point in my career and the type of experience I've had both professionally and personally over the years, I should know better. It comes back to that. I should know better. (Chuckles). That's the incompetent part of that. That's how I am probably targeting that. To me, I should know better. I should be able to handle these feelings better, I should, I should, I should. I'm shoulding myself to death here.

Interviewer: Yet you have evolved in the sense that now certain kinds of inadequacies are permissible. Like, it's OK not to know about anorexia if you've never seen an anorexic client. You can get trained on that, you can read on that, you can consult on that. That's OK now but this other experience is not OK. You should know better in your mind.

Participant: Yeah, yeah

Vulnerability to feeling incompetent decreased over the years and six of the eight therapists revealed that they were both better equipped to prevent themselves from feeling incompetent, to quickly defuse the intensity of self-doubts, and to dismiss such emotions when they arose.

Ralph said:

Participant: "This kid's not getting better. I wonder what she wants to do about it?" No sweat. Go home and never think about her again.

However, therapists also admitted that when they were touched, the episodes were more painful and intense. Most therapists also spoke of special circumstances that would cause them to regress to an earlier level of functioning in terms of feeling incompetent and insecure. Ralph vividly made this point in the disclosure reproduced below:

Participant: Who is responsible and what is my job here? And maybe in part what happens when I am in front of a violent man, because I know the potential dangers and also with the high profiles, is I lose track of that. I get immobilized by taking all responsibility and I go back to where I was ten years ago, inheriting a mandate that... "You better do something here that will work! You're on the line!"

Contrast this example with Ralph's statement above offered earlier in the same interview. In the first instance, he described having reached a level of easily avoiding F.O.I. by placing the responsibility for change on the client yet also admitted areas of vulnerability and the possibility of loosing that capacity to quickly establish a boundary around attribution issues. Cameron cogently described regressing to earlier times

> Participant: The first client I saw after all this, I will never forget. I felt like it was my first ever client; the first time I sat as a counsellor.
>
> Interviewer: Starting over.
>
> Participant: Yeah, really, really starting over. I felt like a rookie, a complete beginner.
>
> Interviewer: Practicum. (Laughs).
>
> Participant: Yeah, practicum. (Laughs). I was terrified. I was *terrified* (her emphasis).
>
> Interviewer: What was going in your mind? What was so terrifying?
>
> Participant: That I was incompetent. I had no right to be sitting in that chair talking to someone. I had no ability (claps) whatsoever!

These examples illustrate that although therapists gradually moved from a position of perpetual self-doubt and insecurity described as the modus operandi for the first few years they were definitely not immune to feelings of incompetence. Experience renders feelings of self-doubt stemming from lack of knowledge, training, skills, or ambiguity of therapeutic situation less threatening for the therapist. Most therapists had fine-tuned their cognitive mediation techniques and were better able to deflate mounting F.O.I. Nevertheless, these informants remained vulnerable to feelings of incompetence

stemming from process and personal issues and were likely to be less forgiving of themselves if they perceived some transgression. The therapists interviewed all admitted at least one experience (and several therapists many)of profound feelings of incompetence in the six months that preceded the interview.

Experience had also allowed therapists to reconsider other aspects of their professional selves. For example, several therapists spoke of the decline in their feelings of incompetence as related to adjustments or modifications in role definition.

Role and Stance

The role and stance adopted by the therapist was the third mediating factor presented by the participants. Therapists invariably highlighted the importance of issues related to their helping role when discussing feelings of incompetence. Although all therapists addressed this issue there was no unanimous, unequivocal agreement about the best role definition. What was clear during the interviews was that the role adopted by the therapist and role related issues were a powerful mediator of F.O.I.

Some therapists had clearly seen an evolution from a more dysfunctional and vulnerable stance toward a way of being, of positioning oneself vis à vis the client that was both more fruitful and less inducing of feelings of incompetence. Others continued to struggle with contradictions and differential pulls along the following dichotomies: expert-dummy, being-doing, and peripheral influence-central influence in the client's life. Seven of the eight therapists declared a heavy investment in their role as therapist yet uncertainty remained as to the particularities of that role. Three therapists harboured private feelings of being an impostor while others referred to the role prescribed by their theoretical model.

Expert –Dummy Dichotomy

There seemed to be a lot of variability across interviews and even within interview protocols regarding the notion of expertise and the meaning and expectations that accompany that banner. Six therapists addressed this directly and several categorically rejected the label.

For example, Ralph said:

> Participant: Really, I can be really dumb.
>
> Interviewer: Ignorance works for you. (Laughs).
>
> Participant: (Chuckles). Beautifully! I have abandoned all these ideas of being an expert. I'd rather be a dummy.

Several therapists described having felt burdened by either a client or self-expectation that dictated that they ought to be all knowing. The role of expert sets one up for the inevitable disappointment of not meeting one's or another's standards. Ralph, cited above, described moving away from this in the following way:

> Participant: So, unavoidably I was always relating client progress to what I am doing and I think gradually, partly through a change in model, a change in thinking, moving away from the strategic/systemic models towards more collaborative/conversational models of therapy… Allowing clients to develop their solutions, maps, and being in a position of curiosity and not of power. Not sitting as an expert but as a non-expert. It allows for the freeing of responsibility for change, just being an investigator. "What could motivate you to change? You know, what could be the first step that you could take and how would you go about that?"

> And so, the whole conversation shifts over to having the client define how they're going to do that. What it would look like and what values they inherit from that and what message they would get from themselves, and all of that.

Other therapists equated the role of expert with feelings of insecurity, lack of confidence, and incompetence producing feelings of anxiety. Six therapists described this shift in stance away from being expert in evolutionary terms, that is they almost unavoidably adopted an all knowing posture as beginning therapists and eventually shifted to increasingly collaborative models. Ella explained it this way:

> Interviewer: So, you're more comfortable not zipping everything up or not closing things up as soon as it's presented.
>
> Participant: Which is... At the beginning, I thought it was part of our mandate and now I realize that it's not necessarily so.
>
> Interviewer: So, there's a definite shift in terms of your role. What was your role and what you define your role as being now. The role you gave yourself before was more producing of anxiety and incompetence?
>
> Participant: Yeah... because you had to be an expert and clients tend to create that so if you want to be what the client needs you to be then how do you play with that one?
>
> Interviewer: That's the trap.
>
> Participant: Yeah... that's it exactly. How do you get credibility? How do you get the client's confidence? How do you do that? The way I'm comfortable in doing that is by empowering the client by saying that it's a

collaborative thing. That I trust them to know what they need and want and I can give them a little bit of theoretical stuff and the two of us can make sense of it.

Interviewer: So, how did you move from point A where you felt you ought to have the answers and to cure and solve and save to this point here?

Participant: Is that just experience? Age? Time? This seems to be more effective and I think because it is more real. It's part of normalizing the experience where you are two human beings trying to make life a little easier. It's a whole different thing than the up and down or the uneven structure.

General overview of all transcripts pointed to the relationship between role definition and feelings of incompetence: The more participants were able to move away from seeing themselves as expert, and by extension uniquely responsible for client progress, the less vulnerable they were to feeling incompetent. The renouncing of the expert role was infrequently achieved in one decisional moment but rather a dynamic process; there seemed to be an ongoing internal negotiation process.

Therapists often declared a global non-expert persona yet within minutes exposed dilemmas related to the attribution of expertise. Witness Ralph, who declared himself a dummy above, shifting to the other extreme:

Participant: I mean through the years I have built a reputation as a good therapist, a specialist. If you have a difficult adolescent go see Ralph. So,

will these guys come out of this experience with the same feeling? This is a new layer (of F.O.I.).

Therapists experienced an ongoing vacillation and pulls towards both ends of this polarity and internal attempts to back away from insidious invitations to become the expert. Mary shared the following internal struggle to relinquish the expert role:

Participant: Because I am telling myself, they are sick, mentally sick and they are not in control and I am the one who should be in control for them and decide for them and maybe this is why this kind of insecurity occurs.

Interviewer: It fluctuates with the level of responsibility you ascribe to yourself.

Participant: Yeah...That's it yeah...

Interviewer: OK I see.

Participant: And then I say to myself; "You are not responsible, they are adults, they can take care of their lives" and stuff like that and so that feeling of insecurity disappears but maybe for a few hours during the session and afterwards, I feel inadequate.

Therapists who entertained a position of expert frequently challenged this position for themselves either in the following statement of the interview or shortly after. Several were very aware of being influenced by client and societal expectations and were able to dissect the experience and expose the dynamic interplay between internal and external allocations of power and vulnerability to feeling incompetent.

The following conversation shows Bob's musings of how attractive the expert role can be in terms of satisfying some underlying need of the therapist's and how he fights to remain faithful to his values of respect for client process and equality in the counselling relationship.

Participant: Yeah. I was telling you before about the syndrome of wanting to be an expert. So, that's part of it too, you know. You're the expert; you're the doctor, the magician that's going to magically cure this person. So, yeah, I've been given a lot of expectations and sometimes they contaminate my values as a counsellor and my approach as a counsellor. But, those aren't the only things that contaminate: the pace of the job and wanting to do things as efficiently or as expediently as possible. We'll get students, maybe this happens to you as a counsellor, but the student starts talking and in 15 or 20 words he's talking about... You've already come up with, not a diagnosis, but yeah, I guess a diagnosis of what he should do and the steps of how he should do it exactly and it's very tempting to say: "Look, let me save you a bit of time, just do this." And write a prescription or whatever (...). It's tempting sometimes.

Interviewer: Because of the constraints?

Participant: To drop the gun. Rather than being empathic, being more of a distributor of mental health.

Interviewer: Pills?

Participant: Yeah, exactly.

Interviewer: Prescribe and....

Participant: Prescribe. Here's your solution.

Interviewer: And it's sometimes tempting to give it all away when I bought into that role, that I'm there to cure and to fix.

Participant: And it's hard not to deviate from my own role sometimes.

Interviewer: Wonder why that is?

Participant: You get a lot of status.

Intellectually, therapists in our sample stated their position as non-experts, wanting an even distribution of power in their relationship with a client. Yet, indirectly, through the examples they provided and directly (as Bob above), they admitted that the call to take over and cure the client still exercised a measure of influence on their practice and on their F.O.I. The expert versus dummy dichotomy entailed other oppositional constructs or experiences. Other role related, incompetence producing internal struggles that followed from that were related to being versus doing and being central versus being peripheral in the clients life.

Being – Doing dichotomy

When therapists bought into the expert role they assumed the responsibility to have at their disposal knowledge and techniques that would induce them to perform some actions to single handedly rectify client life situations or problems. Therapists could get very attached to this aspect of their role as the dispenser of corrective/remedial experiences. Cameron explored this issue:

Participant: Just being there. That's it. And that's the whole point I find the hardest, cause I'm a doer. I like to do something with my clients. (Laughs). I like the song and dance. I like something the client can do, that

I can do, that we can do together, that we can achieve. Just being there is challenging.

Interviewer: Is challenging on this level (feeling competent)?

Participant: Absolutely.

Other therapists did not concur with this objectification of their role. Internally some therapists continuously reaffirmed the crucial impact of the 'being' end of this continuum by reminding themselves that techniques are secondary, that they are the tool, and that they are not valuable solely for their operational functions.

Central influence- peripheral influence

Closely related to the above struggles between expert vs. dummy and being vs. doing was the oft internal conflict between sensing one's role or impact as central to clients' quality of life (present and future) or judging one's implication to be of peripheral importance on a global level. Participants in the study alluded to this contradiction in a variety of examples or while exploring their philosophy of counselling.

Ella had clearly determined her role as peripheral.

Participant: I am not under any illusion that I'm the last chance for these individuals. Like, if it's not me then it will be somebody else but I have to be able to make that call pretty quickly before they're really involved.

Some participants spoke of cases where they clearly saw themselves as the client's last hope and last chance whereas others enumerated a number of possible influences on a clients' life and well being along with their own. The vulnerability to feeling incompetent fluctuated with the relative centrality therapists assigned to their role, their interventions,

and their relationship to the client. Within the same thematic domain was the relative assignment of power to oneself. Some therapists considered themselves to have a lot of influence on clients. Donna, for example stated:

> Participant: People, if they come with agoraphobia, I say: "My God! Hein! You're at the best place. What can I say? You chose the right one! Yes! I am going to help you with this. We'll do this, this and that. You've suffered too long. You should have come before.

Others felt more solid when sharing the responsibility with the client and refusing to allow clients to abdicate their responsibility for themselves and hence their power. Ella elaborated:

> Participant: I see it (therapeutic relationship) as being useful but I don't see it as being extremely powerful unless the person needs us to be. I mean decides to give us that onus but we don't have to buy it. I think by not buying it, it empowers the client even more which I think is one of the major goals in therapy.
>
> Interviewer: So, not only does it protect you from overwhelming incompetence and responsibility but in the end it empowers the client and propels him or her towards...
>
> Participant: Making their own choices.

In sum, the aspects of the therapists' role and stance having a impact on their vulnerability to feelings of incompetence were proposed as the following dichotomies to portray the ongoing struggles therapists engage in to establish and respect self-defining attributes. They were: expert vs. dummy, being vs. doing, and central influence vs.

peripheral influence. Where any particular therapist situated themselves along these ranges depended on several factors such as experience, client factors (for example dependent clients were viewed as stimulating more internal conflict in regards to sense of being powerful vs. powerless) and source of the feeling of incompetence. Therapists also referred on numerous occasions to roles they perceived to be prescribed by the theoretical orientations they honoured. Certain therapeutic and theoretical models determined the therapists' position along these continuums.

Roles Prescribed by Theoretical Models

Therapists described changes in their adherence to theoretical models that paralleled changes in their self-assigned attributes. The adoption of new models had direct impact on a therapists' vulnerability to feelings of incompetence. For example, when the new models alleviated the level of responsibility accorded to the therapist and established a more collaborative and equal relationship between therapist and client some therapists were relieved of many F.O.I.

While therapists chose models to reflect their evolving beliefs and changed their roles to reflect their theories' philosophical underpinnings, few achieved a consistent, coherent, and static internal representation of the true nature of these role characteristics. Rather, therapists' understanding of this aspect was in a continual state of flux and negotiation. Some therapists described themselves in a particular manner and followed up with case examples that witnessed them behaving in a completely different manner. At times the change in role and therapeutic model occurred after the feelings of incompetence began and could be seen as instrumental in helping the therapists contain

such emotions. Cameron who professed to be a cognitive therapist offered the following example:

> Participant: Exactly, that's it. So I try to really stick with the ... I go back to the Rogerian approach. I do not try to do anything. I'm just trying to be. I'm just trying to be supportive. I try to help them work through whatever they need to work through that week and because it's like anything else; the issues vary from a left to right and up and down and in and out and you know?

Adhering to a particular model afforded some therapists a sense of security, a decreasing vulnerability to feelings of incompetence through a variety of related mechanisms. A model gave therapists a sense of structure, direction, a circumscribed set of possible goals, and at times offered the means of reaching those goals. These guidelines all served to reduce ambiguity that felt threatening for therapists.

Cameron explored the relationship between her choice of theoretical orientation and her F.O.I.:

> Participant: And I'm confused but then if I go back to the original goals and go back to the original statement of understanding then we can move on and I think that's why I like Cognitive and that's why I like short term. These are really concrete and really clearly defined and you can move on from there. And they're not too grandeur! You know, "I want to feel better about my whole life". I don't like goals like that. "I don't know how to fix your life. I don't do it. I don't know how to deal with it, sorry!" Laughs.

Theoretical models (e.g., some cognitive/behavioural models and solution focussed) had elements that could both exacerbate or dissolve feelings of incompetence. These models offered what one participant called " maps"," benchmarks" and another "guideposts" which some therapists found comforting. They provided a plan which countered some forms of therapist anxiety. For other therapists the issue of having the responsibility of finding 'the solutions' or of 'administrating a treatment' set up the relational dynamics that made them susceptible to feelings of incompetence. They equated the level of direction required to operate within these intervention models with the roles and stance prone to magnifying feelings of incompetence, in particular the expert's role. Opinions regarding the relative importance of these processes were divided; roughly half the therapists embraced a model that gave therapeutic imperatives and where the therapists' role is directive, while the other half shun these types of models in favour of models where the structure was looser. The latter wanted to avoid crippling themselves with a level of perceived control over the other that was uncomfortable and unnatural for them. Perhaps theoretical models were helpful in countering feelings of incompetence to the extent that they allowed the therapist to maintain a level of authenticity. Therapists' generally endorsed models that they perceived as representative of their beliefs, values and more importantly for the present study - models that did not place them in harm's way. Thus therapists who described themselves as cognitive/behavioural and solution focussed valued the structure and maps as protective against feelings of incompetence while the proponents of more collaborative models focussed on the issues of boundary and responsibility. Their models addressed what were for them the more sensitive issues of attribution and power.

Generally, there appears to be a trade off between responsibility, attribution, and directiveness. Models that propose a role definition that is more directive offer reassuring guidelines and protection against ambiguity yet they increase therapists' responsibility for client change and hence make them more vulnerable to feelings of incompetence stimulated by responsibility and attribution sources. Models that propose a role definition which is less directive release the therapist from overriding responsibility for client growth and progress yet offer little in terms of self-evaluation criteria and valuable "benchmarks".

Impostor Phenomena

Discrepancy between what the therapist perceived as expectations from others and their self-perceived level of ability caused some particular weakness and sense of incompetence. Even the most experienced therapists, who generally felt successful, described moments of feeling like they were misrepresenting themselves, fear of being exposed as fraudulent, of perhaps deviously having led others to believe that they were endowed with powers they completely lacked. Three therapists spontaneously made reference to the Impostor Phenomena and to the occasional irrational notion of being the only one who harbours moments of feeling incompetent:

Cameron offered the following irrational fear:

Participant ... there's always that anxiety...

Interviewer: yeah

Participant: ...that: "Oh my God! I am the only one who doesn't know what the hell they're doing!!!!

Interviewer: (Laughs).

Participant: Everybody else has it perfectly under control. I am an idiot!

It appears that this syndrome described by Clance and O'Toole (1985) is commonly experienced by highly trained, very effective professionals who at times feel what Susan described as "having the credentials but not really having the expertise".

Pressure

The last group of mediating factors that interceded between sources of feelings of incompetence and depth of experience was pressure. Therapists experienced internal and external constraints, stress, and influences that interfered with their feelings of competence during the course of their functions as psychologists, counsellors.

Internal Pressure

Internal pressure is a self directed message, barrier, or prescription. Therapists in our sample described the following elements as conducive to pressure: internal commands to "do something" to "fix it", self-evaluative criteria, ethics, and performance anxiety.

Do something and fix it.

Of the internal pressures described by therapists, the most prominent and potent was the command to "do something!" to "fix it!" which was reported by seven therapists during the interviews.

Ralph provided an example of this internal command:

Interviewer: And what would it sound like? What would the internal...?

Participant: "What the hell are you gonna do with this guy?" (Laughs).

Interviewer: (Laughs). You better figure this out!

Participant: "Come on Ralph, do something! Say something brilliant! OK, this is it! Just cut the bullshit..."

Criteria for self-evaluation.

Other types of internal dialogues closely mirrored this sentiment and were a result of one's expectations and standards. All therapists had established criteria upon which they based a personal/private performance evaluation. These criteria varied; therapists focused on the quality of the relationship, the level of (client) need fulfillment, outcome variables, feedback, and client return rate among others. The therapists' self-evaluative practices obviously filtered or fed feelings of incompetence that were introduced in the sessions.

Ethical principles.

Every therapist in the sample was strongly invested in ethical principles that, while guiding them, also exerted some types of internal pressure. Very strict and inflexible views were expressed around the ethical principle of "primo non nocere"- above all do no harm- and the related praxis of working strictly within the limits of one's training and expertise. As such, the tendency was to err on the side of conservatism, that is to judge oneself as incapable or inadequate prematurely rather than not. There seemed to be among participants very little tolerance for risk taking, for overextending oneself and consequently, a deep value for the practices of consultation and referral.

For all therapists, some internal pressure stemmed from issues of integrity and accountability. Several had worked on teams where responsibility could be diffused. Susan for example shared her thought on accountability:

Participant: It wasn't a big shift because I had had to be responsible for people. I mean, I had people that, if I turned my back on them, were at high risk for stabbing themselves. I am talking risk in terms of only having myself to count on, you know, as a resource, as not being able to turn around and say, just in my own head: "Well, there were a lot of other people who played into the situation as well. Yeah, they didn't do so great but I did the best I could, but you know a lot of other people ..."

Interviewer: We're talking about accountability

Participant: Shared kind of accountability. Now, it's me and it's this person here. And I have to be very in touch with what's going on here and to be very aware and open to it and if I'm not doing well or the other person is not doing well, I have to be very attentive to that and I have to be able to be honest and say: "This isn't going well".

Being solely accountable and being sensitive to ones' accountability produced an internal climate conducive to feelings of incompetence.

Performance anxiety.

Several conditions could lead the therapist to feel performance anxiety. Although some of these therapeutic parameters could be considered external, the interpretation of these and the resulting anxiety clearly belonged to the therapists. Performance anxiety made five therapists more susceptible to feelings of incompetence often by making them overly conscious, hypervigilant about their every gesture and intervention. This state of exaggerated self-awareness was seen to detract form the therapists' ability to be authentic,

to focus on the process and the client. This performance anxiety was at times produced by the presence of external stressors.

External Pressure

External pressures are external conditions that cause stress for the therapist. The therapist in our sample divulged that the following conditions magnified their vulnerability to feeling of incompetence; threats to reputation, visibility and accountability, and third party involvement.

Threats to reputation.

When a therapists' reputation was potentially at risk, they were much more sensitive to issues of incompetence. All therapists reported a variety of situations that created this possibility; dissatisfied clients that were referred by a valued colleague, clients that were highly visible and newsworthy in the community (example politicians or victims of highly publicized crimes), or clients that were very vocal about their discontent and eager to involve others in their grievance processes. The latter were particularly likely to invoke a sense of vulnerability in the therapist who at once was confronted with a client's negative feedback and the need to both protect and justify themselves.

Visibility and accountability.

The following example displays a typical scenario where a high profile case is experienced as stressful and the added visibility considered not a causative factor in Cameron's feelings of incompetence but a magnifying factor. Herein is an elegant display of how the mediating factor's function is to magnify or minimize feelings otherwise produced.

Participant: Yeah! Yeah! Or an issue being big, like I had a client whose parents, the father recently murdered her mother. And it's like big news in X (city), It's an X(ethnic group) community thing and it's big news in the X community and it's very hum....

Interviewer: High profile...

Participant: High profile case and the daughter is a high profile person to boot and so this is like, like, you know, so I want to make sure that I'm doing the right thing because I know that the community's watching.

Interviewer: Ok...

Participant: Not me so much cause they don't know who I am but they are watching the agency and therefore they are watching me. So that type of case, I want to make sure. And yet, where are we going? Nowhere, because there's nowhere to go to change. The fact that her father murdered her mother is still there. So it's harder in some ways because you can't set clearly defined goals, but I try to.

Interviewer: Hmm, hmm, yeah, you feel you need them more...

Participant: Exactly, and yet what are the goals? To not... to get over the grief, to get over the anger, to... you know. So that's hard and I'm finding that case probably more anxiety producing and the feelings of incompetence more there, just because of that.

In this scenario the visibility accompanied by a high profile case made feelings of incompetence stemming from process issues more acute.

Third parties.

A large number of situations presented by clinicians as worrisome involved third parties; all participants related one or another of such experiences. Employee assistance programs, supervisors, evaluation processes, doctors, lawyers, client's relatives, professional and licensing bodies were all cited as external sources of pressure that triggered feelings of incompetence. At times these intermediaries introduced therapeutic constraints (example number of sessions allowed) that were seen as unnatural and interfering with the therapists' clinical judgment. At other times these third parties clouded the therapists' sense of loyalty and allegiance. Incompetence stimulating conflicts often resulted from competing definitions of optimal treatment, timing issues, progress, and goals. Having to expose and justify what was considered a private and by some therapist a privileged interchange and relationship left therapists feeling strained.

Summary of the Section on Mediating Factors

Therapist's feelings of incompetence stemmed from different sources and these sources had the potential to evoke more or less intense self-doubts and self-recriminations. The level of intensity and depth of feeling actually experienced by the therapist on a moment-by-moment basis and in the long run was dependent on several factors that mediated and influenced the impact. These mediating factors could operate as catalysts, magnifiers, or as protective shields and diffusers. They were listed as: a) cognitive management of F.O.I., b) experience and regression, c) role and stance adopted by therapists, and d) pressure/stress.

The previous four sections reviewed the definitional properties of F.O.I., the levels of depth and intensity, the causative and the mediating factors. The following section structures and summarizes the informants' responses to queries of impact.

Aftermath

What were the consequences when therapists felt incompetent? Aside from the immediate emotional and cognitive reactions previously described, F.O.I. influenced immediate choices and plans, the therapeutic relationship, and had both growth enhancing and destructive after-effects on the therapist and the therapeutic relationship.

Imminent Actions

When therapists felt incompetent it invariably affected what they decided to do next. A majority of therapists immediately recognized the emotion and were able to make a strategic decision about its' management. The three most common actions were using the feelings of incompetence in therapy (all therapists), change of pace and timing issues (six therapists) and reconsider commitment to therapeutic relationship (seven therapists).

Using the Feeling of Incompetence in Therapy

All therapists (eight) declared having regularly used their feelings of incompetence in therapy and for therapeutic purposes in the following ways: disclosure, confrontation, and asking for feedback. The most common response was to incorporate the experience in the therapeutic exchange by disclosure. Therapists felt that the feeling could be useful as a tool or manoeuvre and transformed an uncomfortable internal state into a therapeutic opportunity. At times this disclosure was accompanied by requests for feedback or more direct forms of confrontation. Results stemming from this move were the liberating of the client to discuss their own hopelessness, helplessness, and confusion,

a clarification of expectations and roles, and an overall feeling of rapprochement. Clients welcomed the therapists' authenticity; therapists did not divulge a single negative client reaction to these disclosures.

Chance Pace/Timing Issues

A therapist in the midst of an incompetence feeling moment at times altered the pace of therapy. Six therapists spoke in terms like "slowing down", "buying time", "changing gears", and "backing up". This was related to the issue of therapeutic stance reviewed earlier. In these instances the therapists attempted to adapt a different stance. Some therapists spoke of becoming rigidly concrete and directive in their orientation whereas others relied on a more passive style and ensuing techniques such as empathic listening. Therapists consciously altered their approach to timing issues in order to regain solid ground.

Reconsidering Ones' Commitment to the Therapeutic Relationship

Putting into question the viability of the therapeutic relationship was a common response; seven of the eight therapists interviewed spoke of either termination or referral as an option when feelings of incompetence arose. Katherine offered an honest account of moments when she no longer wanted to be involved with particular clients.

> Participant: Wanting to runaway because it's no use. I'm maybe thinking of three clients that are like that over the years and the worst situation would be...I remember two situations so extreme and wanting to runaway, because well to runaway, to break up the relationship. Like coming to a point were like, no way. It's not helping the person in my perception, but the person keeps coming back. It's not helping the person

and the person is really making my life stressful. So wanting not to see the person again, break the bond, having a feeling of wanting to break the bond, to get rid of that person, transfer to somebody else. I remember one case in particular and another that I still have on my caseload now.

It is beyond the scope of this study to determine whether these terminations and referrals were indeed warranted and/or timely. The therapist's duty to avoid harming clients was held as a priority and often led the feeling of incompetence to be translated into an obligation to refer. Several therapists indirectly alluded to the possibility that perhaps at times this conclusion was reached prematurely. Cameron described this in the following way:

Participant: Sometimes it'll actually make me want to refer the client elsewhere and will.

Interviewer: Mhmm

Participant: I feel, looks like it's just not within the scope that I can handle. I'll refer on, *whether or not I needed to or not, that's another question* (my emphasis).

Interviewer: Mhmm..

Participant: I don't know if I could... you know, I can't make that judgement because I don't see, I don't usually stay with clients I don't think I can handle.

And again from Cameron;

Participant: Easy. I always make, I don't, you know, I don't like swimming in the deep end.

Interviewer: So, when the anxiety gets a little higher, you...

Participant Yeah...That's it! I quit! (Laughs).

Interviewer: You quit?

Participant: I mean... refer on. (Laughs)

The impact of referral on these clients is unknown. Whether a negative impact results from therapists' feeling of incompetence is also debatable. No unanimous opinion emerged.

Impact on Therapists' Feelings About Client

Seven therapists conceded harbouring begrudging emotions towards clients with whom they had felt incompetent. Common experiences were dread, dislike, resentment, blaming, and anger. Mary's statement below echoes a common sentiment.

Participant: Yeah...Oh God! They're coming in an hour ... I hope they cancel...

Therapists readily confessed these negative emotions towards clients although they admitted feeling guilty about them. In the next example, guilt follows closely behind the initial and spontaneous feeling of relief experienced when a client with whom Susan had felt incompetent discontinued therapy.

Participant: But the first feeling I had was just "Oh Great! She's not coming back!" and then probably the next feeling that came in was guilt at having even thought that because I could see that the same, I mean this is her pattern, this is her... the fact that people, I mean my reaction to her it could have been used if I could have channelled it properly. I think it lay with me to kind of use that.

Therapists also felt challenged, humbled, and expressed increased intimacy with clients after disclosing feelings of incompetence. Two therapists expressed an appreciation for clients with whom they felt F.O.I. stating that these clients allowed them to keep growing, stimulated their interest, curiosity, and motivation to develop further. One therapist felt a deeper satisfaction and a more profound sense of accomplishment when successful with clients who challenged her.

Impact on Client and Relationship

Impact on Client

Although most therapists readily admitted their negative feelings, few considered that clients reciprocated likewise. Six therapists claimed that clients felt liberated after their F.O.I disclosures and that clients generally accepted therapists' limits. One therapist mentioned an increase in client anxiety, while another concluded that clients took on responsibility for impasses when made aware of F.O.I. Generally therapists seemed to struggle with the questions aimed at uncovering the impact of therapist F.O.I on clients. They paused longer before responding, were more tentative and less clear. This portion of the interview resulted in the least consistent responses.

Impact on Therapeutic Relationship

Despite these nebulous and tentative appraisals of impact on clients, therapists categorically decried the deleterious influence on the therapeutic relationship. Other than outright rejection of the client, which was uncommon response in our informants (nevertheless mentioned twice), therapists examined the following: detachment and withdrawal from client, avoidance, emotionally shutting down, distraction, and distance.

The most outstanding damage to the therapeutic relationship occurred when therapists withdrew or detached from the client. Therapists spoke of situations where their feelings of incompetence motivated them to "shut down" emotionally and to avoid an intimate authentic contact with the client. These situations were painfully difficult and always either caused or resulted in the deepest forms of self-doubt and incompetence.

Distance was also introduced in the relational sphere when therapists' concern for self and F.O.I. were so prominent that they overrode therapeutic considerations. Therapists spoke of how focussing on the internal struggle with F.O.I. created distance from the client. Self-preoccupation interfered with the therapists' ability to be present, attentive, and empathic. The internal dialogue of the therapist was often seen as an unwanted distraction and efforts to screen it out were common.

Long Term Impact on Therapist

Over and above their immediate, in therapy, and relational repercussions, longstanding and intense battles with feelings of incompetence were viewed by the participants as conducive to serious negative consequences such as: low self-esteem, loss of self-confidence, depression, burnout, premature career termination, self protection and self constriction, and immobilization.

Two therapists cited loss of self-confidence and low-self esteem as results of their experiences with F.O.I., while five others talked of actively protecting their self-esteem from such erosion. One therapist admitted that a recent depression was mostly due to intense and pervasive feelings of incompetence that left her completely immobilized and unable to function as a therapist. Indeed, she equated the magnitude of the impact with

self-destruction and practically decided to out rightly abandon her career as a result of these incapacitating self-doubts and putdowns.

Three therapists were brought to question their career choice and commitments in response to F.O.I. Although all the participants in the study were able to reaffirm their choices and to repair the damage caused by the erosion of their feelings of competence, stories were shared about those who were not as fortunate, the fallen comrades;

Participant: She just retired in June. She was consumed by the inordinate responsibility being a counsellor was. She had to quit private practice because she was consumed with it. She took it very seriously, which we all do, but to the end. She was totally responsible for every client that walked in. There was self-doubt. There was self-recrimination. There was always an underlying sense of inadequacy. She very readily admitted it and she agonized over it for years until she had to cut the private practice because at least there was liability in a school board. That was really... and I saw that and I know she's an excellent counsellor. She's wonderful but she had that sense of inadequacy that moved from being a learning experience to being a paralysis. OK and I learned from that, from watching that because that inordinate responsibility is not to be carried alone. It's a joint one between client and therapist. I look at it that way and I always see it as a dynamic. I don't see it as a personal... the onus is not on me personally. I don't have that burden. I don't have that responsibility. Her experience, I look at that and if I ever had a tendency to

> dwell I'd think of her. That is not useful and how do I manage these feelings in a more useful and productive way.

Other therapists reported stories of burn out and premature career termination among peers and colleagues. They clearly related F.O.I. to those events.

These dramatic consequences stand in stark contrast to the more insidious but perhaps more pervasive long-term consequences of prolonged F.O.I. Immobilization was mentioned in the discourse above and repeated by other therapists. Immobilization took many forms from immediate in session "feeling stuck" to the overriding inability to motivate oneself to grow and learn within the profession. Several therapists spoke of having experienced moments where their volition to evolve as therapists was arrested. Cameron shared how debilitating a recent episode of F.O.I. had been:

> Participant: It didn't even... It touched it off so big, that I didn't even have... Like now, I feel incompetent a little bit, I'll do research. I'll find out. I'll ask about it in supervision. I'll look. I'll try to gather more information to get my self a better idea. At that moment, I was defeated. No matter how much anybody ever taught me it wouldn't be enough. I had no volition to learn, to read, to do anything. That was it. It was done.

Others carried deep wounds that made them both vulnerable to subsequent F.O.I. and overly cautious and self-protective. Limiting one's activities and interventions was often the result of this need to remain within what the therapist considered a safe domain. Therapists restricted the type and number of clientele they agreed to see, avoided certain problems, and kept to a few select techniques in some cases. Deep wounds were left

behind by some more extreme experiences with F.O.I. and caused some types of permanent constriction in therapists' practices.

Although many of these accounts were profound and painful therapists immediately dispelled the notion that feelings of incompetence were unequivocally experienced as negative and damaging. From the very first interview it was clear that therapists not only shunned feelings of incompetence but also rather wisely consulted them as a guide for future growth and development plans.

Positive Outcomes

Aside from using their feelings of incompetence as a therapeutic tool, therapists welcomed and honoured their inner self-doubting experiences as points of departure for personal and professional self-growth. Therapists revealed that feelings of incompetence motivated learning in a variety of ways; therapists sought training, supervision, and reviewed literature. They consulted with colleagues, sought feedback, and support. Other therapists admitted an increased investment in clients and therapy when the "going got tough". This was described alternatively as working harder, being more interested, curious, and creative. Ella said:

> Interviewer: OK. What other impact do feelings of incompetence have other than being bored?
>
> Participant: They probably make me a better therapist.
>
> Interviewer: OK.
>
> Participant: Because when I feel inadequate or whatever, I attend a lot more than I probably would when I feel competent. Because I want to overcome this feeling, so I will become alert. What is making me feel that

way? How am I helping? How is it moving? I am much more aware of the process.

The tendency to learn and grow from F.O.I. seemed to be stronger when the feelings of incompetence were in the mild to moderate range and when they stemmed from professional and process issues. The deeper levels of F.O.I. and those that were more pervasive seemed to provoke despondency, discouragement, and eventually immobilization. Generally, therapists who experienced outright feelings of incompetence that affected them at the level of self and identity and that touched personal issues isolated and insulated themselves. Some described situations that resembled experiential crises from which they emerged slowly and remained scathed to this day. In other words, therapists were damaged rather than improved by extreme and deep episodes of F.O.I.

Summary of Aftermath

Feelings of incompetence can be instructive or destructive. The nature of the outcome depends partially on the source and depth of feelings of incompetence along with several other factors such as therapists' personal factors and cognitive management of feelings of incompetence. Among the most devastating consequences experienced directly or vicariously by participants are depression, burn out, low self-esteem, F.O.I. precipitated career changes, and immobilization. The therapeutic relationship can also be contaminated by therapists' feelings of incompetence most commonly by some form of therapist withdrawal or detachment.

Most therapists learned to honour these emotions and to harness them for growth purposes. Therapists invariably reframed feelings of incompetence as an opportunity to address therapeutic impasses with the client, to clarify issues of responsibility and

boundaries, to call attention to expectations. Therapists also valued feelings of incompetence for the motivation it provided them to grow professionally and personally: They welcomed the feeling as a challenge.

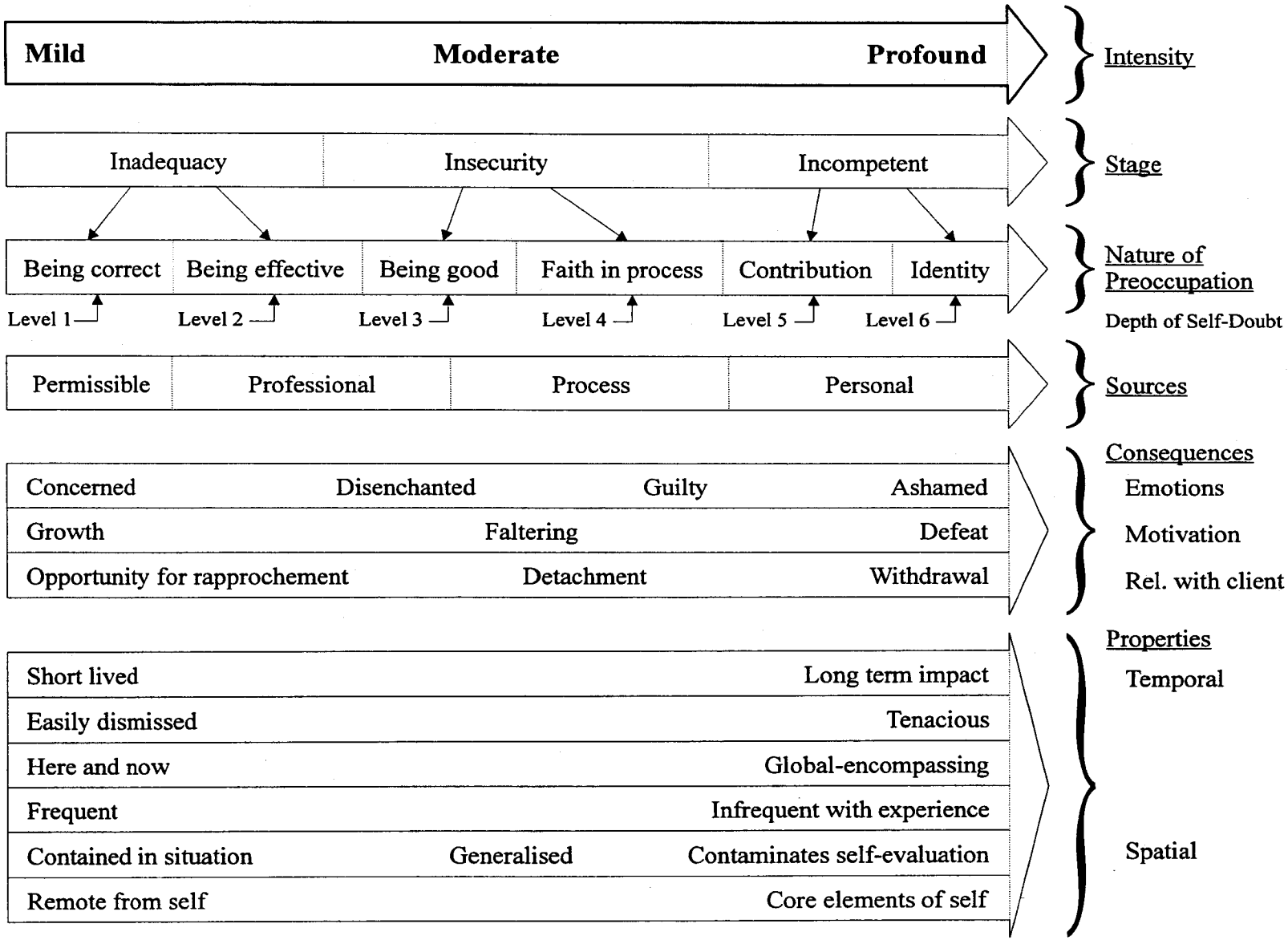
Substantive Theory

The preceding pages outlined and illustrated the crucial dimensions of feelings of incompetence; range of experience, depth of self-doubt, sources, mediating factors, and outcomes. These elements although presented discretely are in fact intricately woven together. The following discussion and diagram represented an initial understanding of these interrelationships between dimensions or elements and form a substantive theory. (See figure 1).

Intensity is the critical idea around which this fitting together of the elements is based. Indeed, there are a multiplicity of feelings of incompetence ranging from the most benign to the most malignant. All participants directly or indirectly referred to this spectrum concept and attributed differing characteristics to the points along this continuum, hence, the plurality of the basic experience of feeling incompetent. The other dimensions, depth, sources, and consequences can tentatively be organized along this continuum. The mediating factor will eventually have an impact on where along this continuum the therapist's lived experience can be classified. That is the relationship between intensity, sources, depth, and consequences is not absolute and can be either magnified or reduced to result in more or less profound experiencing along the spectrum.

Contrasting scenarios representing these extremes will further illustrate the dynamic interplay between these dimensions and properties. These scenarios are fictitious. The first example represents an experience that would be situated at the left end

Figure 1: Axial Representation of Relational Trends



of the continuum while the second example represents the right end- the most profound experience. For the sake of simplicity the effects of the mediating factors have been omitted in the first examples. As previously mentioned the mediating factors will intervene between a situation and its resulting actual emotion. The first example will be revisited with mediating factors later.

Scenario 1

Therapist A does not have any experience dealing with a particular issue. In Figure 1 , refer to sources-professional. This will cause him/her to have some self-doubts relating to being correct in his/her understanding of the problem and interventions. In Figure 1, see depth of self-doubts-level 1. This may motivate the therapist to seek supervision, support, or training (see consequences-motivation- growth). Herein lies an opportunity to grow. The intensity is mild . The therapist is living a first stage F.O.I.- inadequacy. The experience is easily dismissed (see properties-temporal) and the ramifications are few.

Scenario 2

Therapist B feels unable to follow through on a decision to confront a certain patient. The therapist backs down because of his/her own discomfort/fear stemming from historical issues (see source- personal). The therapist begins to doubt whether he/she has personal handicaps/shortcomings that will make it impossible for him/her to be a good therapist. (see depth self-doubts-level 6). The therapist begins to hope this client will cancel and eventually withdraws emotionally(see consequences- relationship with client). He/she may feel ashamed and unforgiving towards himself/herself (see consequences- emotions). This will be a case that will contribute to a more pervasive feeling of incompetence (see

properties-temporal). An accumulation of these could damage his/her career related self-esteem and he/she could (prematurely) opt for a career change.

This simplified and static illustration of polarities in the experiencing of oneself as incompetent is but a glimpse of a complex, dynamic interplay between internal and external factors, elements, dimensions, and properties.

A brief elaboration will show how the mediating factors add complexity and movement to our fictitious therapist's emotions.

Scenario 1 (above) replayed with the mediating factor called cognitive mismanagement. The therapist interprets his/her not knowing about the client's issue as a liability. He/she immediately begins to engage in'mind racing' – a frantic intellectual exercise destined to uncover some pertinent knowledge and to come up with a solution to 'fix it'! Unable to locate a bank of stored knowledge, the therapist becomes anxious and preoccupied about his performance and the effectiveness of therapy, specifically and generally (self-doubts, three and four). The feeling is transformed from inadequacy to insecurity. Again we see how the mediating factors intercede in an incompetence inducing moment.. They are not causative factors per se but act as buffer or booster for feelings stemming elsewhere.

Summary of Findings Chapter

This chapter condenses and structures the responses provided by participants to a series of semi structured questions aimed at eliciting information about therapists feelings of incompetence; experiential issues, correlates, consequences, and developmental issues were of interest. A conceptually rich description of critical aspects of this experience from the therapists' perspective was elaborated. The findings section culminates in an

axial display of the relationship discovered between dimensions and properties of feelings of incompetence and the elaboration of a substantive theory.

Chapter 5

DISCUSSION

Brief Overview of Findings

The pan-theoretical and multidimensional theory suggested by the findings of this study confirmed that indeed feelings of incompetence vary in degree, in nature, and in kind. These feelings can be seen as an experiential range of emotions having to do with not being good enough as a therapist. The most critical dimension of this experience is depth. Feelings of incompetence can be experienced from levels considered mild through levels considered to be more profound and intense. The other dimensions identified relate directly to depth. That is sources of the feelings or root causes, types of associated self-doubts, emotional reactions, impact, and consequences consistently depended on and reflected the particular depth of the experiencing of oneself as incompetent in the role of therapist/counsellor (see Figure 1). However, the relationships between these dimensions were not seen as absolute. Certain variability was introduced in these relationships by mediating factors. A mediating factor intervened to intensify or weaken the experience thereby influencing the final outcome of how the feeling of incompetence will be really experienced.

The mildest form of feeling incompetent was labelled inadequacy as a result of in vivo coding; the informants directly labelled them as such during the interviews. This level of feeling of incompetence usually resulted from professional issues such as questioning ones knowledge, skills, training, and ability to help the client on a general level. Human fallibility also accounted for a part of this type of feeling. Therapists usually expected to feel this at times. They viewed this type of incompetence as

permissible and positive when they provide an opportunity for enrichment. The impact of feelings of inadequacy is usually mild, neutral, or positive for the experienced therapist. (see Figure 1).

As we move towards the deeper levels of this continuum, informants described more intense feelings of incompetence herein labelled insecurity. These types of feelings related to ones' confidence in oneself as a therapist and also spoke about faith in the process of therapy. These self-doubts usually stemmed from process issues such as relationship issues, lack of consistency between the process and outcome of therapy, and communication obstacles. These forms of feelings of incompetence led the therapist to entertain doubts that moved towards more central elements of the self. They were more disturbing, more difficult to assimilate and accept. Therapists who could address these issues internally and in therapy could use them to grow.

The most intense, uncomfortable, and damaging forms of feelings of incompetence were the emotions that arose from personal issues. The nature of the self–doubts targeted core elements of the self and as such the wounds could be described as more narcissistic. Major themes that represented these were contribution/attribution and identity issues. When therapists questioned their worth as a therapist to this extent they also question their worth as a person. Therapists who could not identify ways in which they have helped clients, or who feared doing harm and questioned their personal shortcomings and weaknesses were vulnerable to experience this most painful sort of F.O.I. Obviously, these feelings were more pervasive and difficult to process. At times, they led to depression, burn out, and other forms of immobilization.

Certain mediating factors intervened to influence the actual depth of emotion experienced by the therapist. The mediating factors served to heighten or decrease the final emotion. The participants conceded that their own cognitive management of the self-doubts as they arose could intercede and assuage the feeling. Their responses also depended on internal and external pressures placed on them. Another potent mediator was experience- therapists retrospectively described an evolution away from constant feelings of incompetence that resulted from the professional and permissible causes. As therapists evolved, the angst arising from these sources and the associated self-doubts abated. Therapists admitted however that their self-judgment criteria became more inflexible as they accumulated years of experience and also that the bouts of extreme feelings of incompetence, although more infrequent, were more damaging and long lasting. The foci had shifted from the permissible and professional sources of feelings of incompetence to process and personal causes. Finally, the role and stance adopted by the therapist influenced where on the continuum of intensity their experience with feelings of incompetence would fall. The role and stance adopted by the therapist was in a state of continual internal negotiation with shifts occurring within and outside the sessions in terms of the choice of theoretical model and the related demand for varying levels of therapist implication. This mediating factor was seen as a dynamic, ongoing force actively mediating in the therapists' experience of therapy.

Links to Previous Knowledge Base

The substantive theory proposed by the integration of these findings and outlined above qualifies and clarifies prior attempts to understand therapists' feelings of incompetence. Although elements of this theory can be linked tentatively to what others

before have described under a myriad of related concepts, true amalgamation and building from prior knowledge is not possible. The lack of common definitions both theoretical and operational have created what Dewey calls the " indeterminate situation": "The indeterminate situations are disturbed, troublesome, ambiguous, confused, full of conflicting tendencies" (Dewey, 1938. p.105 cited in Strauss & Corbin, 1998). The aim of this discussion is to identify and qualify such links as can be made and then propose a move away from unidimensional, dichotomous portrayals of how therapists feel about themselves in their role towards a more complex, dynamic theory. Because the literature on feelings of incompetence is scarce, the following discourse will look further afield to examine related theoretical concepts and research.

The most obvious resemblance between theoretical concepts similar to F.O.I. and theoretical concepts proposed in this study is between Bandura's (1977) construct of self-efficacy and the construct of inadequacy. The similarity rests in the sources of this type of F.O.I., which are tied into the therapists' repertoire of knowledge, skills, and training. According to Bandura the therapists' self-efficacy stems primarily from the therapists' past performance accomplishments (knowledge & skills) and their vicarious or observational learning (training). When these are positive the therapist is expected to hold the "conviction that she/he can successfully execute the behaviour to bring about a desired outcome." (Bandura, 1977, p.193). The therapists in the study seemed to agree that the opposite is also true; that is when one feels that ones' skills, knowledge, and training are judged to be insufficient, the experienced therapist will be vulnerable to the mildest forms of feelings of incompetence-inadequacy. A parallel is thus identified between Bandura's self-efficacy (or lack thereof) and the very first level of intensity of

FO.I. where the preoccupation is with being correct (see stage one, level 1). The similarity ends there.

Counselling self-efficacy theory does not address factors that therapists have identified as critical to feelings of incompetence , for example, process issues, the client-therapist relationship, communication, and personal issues such as historical wounds and intrapsychic conflicts. These issues appear to provoke even more important feelings of incompetence in the experienced therapists. The therapists interviewed alluded to the fact that knowledge, skills, and experience are fundamental and that their accumulation do counter the most elemental feelings of inadequacy. However, knowledge, skills, and training or professional issues were not considered to be sufficient or central in the more profound feelings of incompetence defined here as insecurity and F.O.I. proper. The present description of feelings of incompetence as a range partially acknowledges low self-efficacy and then moves beyond it in range and scope. It is possible that research findings that fail to support the theoretical hypotheses linking an accumulation of positive past accomplishments with increased feelings of self-efficacy reflect the theory's inability to account for other major sources or causes of low self-efficacy.

Perhaps the discrepancy between theoretical predictions on the relationship between past performance accomplishments and self-efficacy and research results can be explained through the second major premise of the self-efficacy theory; the concept of outcome expectation. This notion pertains to the therapist's "personal estimation that a given behaviour will lead to certain outcomes" (Bandura, p.193, 1977). This equation between therapist output and performance of skills and therapeutic outcome may be simplistic. In fact, during the research interviews, therapists repeatedly remarked on the

discrepancy between expected outcome and actual outcome both globally and on a moment by moment, in session basis. The relationship between emitting a specific behaviour and a particular outcome is entirely too crude to be applied to therapeutic interventions. The issues of timing, context, degree of pathology of the patient, relationship issues such as boundaries and responsibility, client individual factors such as expectations, level of insight, and understanding are just a few of the variables that therapists mentioned as elements that interceded between the emission of a specific therapist behaviour and the outcome. Therapists may very well feel that they can perform certain behaviours without the concomitant "convictions" that these will bring about desired changes, if any change at all. Indeed, the therapists often find it difficult to clearly identify the nature of the impact they have had and what the outcome of their intervention or series of interventions has been. This introduces the issue of contribution and attribution. Therapists in this study struggled to determine what their contribution was on a global level and attempted to disengage from attaching micro or macro outcomes solely to their therapeutic behaviours.

The substantive theory then partially corroborates Bandura's theory in that it gives some credence to the performance accomplishments and vicarious or observational learning as potential sources of feelings of self-efficacy. Indeed, all informants divulged low-level intensity F.O.I. or feelings of inadequacy and doubts about their effectiveness when their experience, knowledge, and training were lacking. However, the substantive theory proposed expands the notion of self-efficacy to include a wider range of emotion and sources of emotion and elaborates on the dynamic nature of these self-evaluative practices. A therapists' feelings of incompetence are not predetermined but are

constructed, as they are lived, by a complex process of internal negotiations between the power of the sources from which they stem and the mediating factors such as experience, cognitive management techniques, and the role the therapists ascribe to themselves.

The informants with experience ranging from 10 to 25 years unequivocally stated that they continued to experience feelings of incompetence and self-doubts of varying intensities and kinds. The findings provide compelling information about seasoned therapists' experiences of therapy which are neglected in developmental theories that often concentrate on describing early years developmental processes. The almost exclusive focus on trainees' security and confidence leads to the faulty assumption that seasoned therapists no longer struggle with insecurity, self-doubts, and related emotions. Furthermore, it equates experience with confidence without elaborating on how therapists evolve and neglects the ongoing, dynamic, internal encounters and negotiations with feelings of incompetence.

The statistics put forward by Orlinsky, Hansruedi, Botermans, Davis, Ronnestad, Willuttzki, Cierpka, and Davis (1999) certainly lend support to this proposition. Their attempt to link "perceived therapeutic mastery" with experience in a sample of 3900 therapists led to the conclusion that "the observed relationship between years in practice and perceived therapeutic mastery (are) a reflection of a genuine developmental trend" (Orlinsky et al., 1999, p.211). Despite this sweeping conclusion the authors report that 72 percent of the variance in perceived therapeutic mastery is unaccounted for by years of experience and that that the percentage of therapists who judge themselves to have low mastery remains above 35% until they have gained at least 10 years of experience. In fact 7.6 % of therapists with experience ranging from 23 to 52 years continue to judge

themselves to have low mastery. These figures are significant: the results of this study also indicate that many very experienced therapists feel incompetence.

The presence and importance of F.O.I. described by the eight seasoned therapists supports the notion that therapists continue to doubt their competence to varying degrees and with a variety of consequences well into their careers. Indeed, it can be proposed from the findings in this study that questioning ones' competence is the sine qua non of being a therapist. The issue is not whether one will experience F.O.I. but rather at what level of depth it will be experienced, how it will be processed, and what type of consequences will result from the therapist's encounter with F.O.I. Retrospective analyses by participants led to the finding that experience does change how therapists process self-doubts about their competence. Initially, feelings of incompetence were easily triggered and often profound. Sources of F.O.I. which were eventually linked with less intense feelings of incompetence such as lack of knowledge or experience were described as more difficult in early stages of therapists' careers. Therapists continued to have level one (being right) and level 2 doubts (being effective). In fact one therapist admitted that every intervention might lead the therapist to such self doubts. However, these types of self-doubts became acceptable to therapists and with time did not produce important levels of anguish. Experienced therapists may ask themselves the same questions as novices would ("Am I doing the right thing here and now?") but these doubts do not contaminate their self-judgment. The experience seems to be more easily contained. However, this may not be true for the deeper levels of self-doubt and experiences of feelings of incompetence. Therapists did not seem to develop an accepting attitude towards more intense levels of feelings of incompetence.

Self-doubts stemming from issues of attribution and personal issues such as historical wounds or psychodynamic issues continued to be quite potent despite years of experience and had the potential to wreak havoc for the therapists and the therapy. Perhaps this is what is reflected in the developmental literature and in the research linking confidence with experience. The difficulty and confusion in establishing an uncontested strong relationship between feelings of incompetence and experience may be caused by the unidimensional definitions and failure to consider that some forms of insecurities and feelings of incompetence may abate with time while others do not. In fact, perhaps some forms of insecurities and feelings of incompetence become aggravated over time. Although this is beyond the scope of this study, several therapists reported that their self-evaluative criteria had in fact become more stringent and severe and that their self-expectations were higher. This made them more vulnerable to more profound feelings of incompetence at times. Furthermore, therapists can under certain particular conditions or sets of conditions be brought back or "regress" to previous levels of vulnerabilities and ways of experiencing themselves and their incompetence that are more typical of their earlier years.

The findings then lead me to qualify the linearity of the correlation between experience and feelings of incompetence. First, it may not be true for all forms of feelings of incompetence. Then, the assumption that more experience is better needs to be challenged. Finally, the findings challenge the assumption that the feeling of mastery is static. The view that confidence is like a milestone that one has reached and can now move beyond and build upon is not reflected in my findings. Subjective self-evaluation is an ongoing dynamic process that reflects both maturational and other processes cognitive

and emotional. Furthermore, the tendency to have self-doubts is never ending and therapists are in a continual state of self-monitoring and self-evaluation that calls forth a host of self-reflective mechanisms. These have an immediate bearing on the ebb and flow of the therapists' feeling of incompetence and on the global judgment of self as competent in the role of therapist.

Counsellors' spontaneous descriptions of themselves at times included depictions of harsh self-judgment criteria. Five therapists elaborated on their perfectionist traits or highly demanding standards for practice. This would suggest that Lietaer & Neirinck's (1986) statement that counsellors generally are highly intropunitive may be worth considering. These therapists also perceive this tendency to be a trait. The relationship between trait and self-efficacy was established by Johnson, Baker, Kopala, Kiselica, and Thompson (1989) and later disclaimed by a 14-study review (Larson & Daniels, 1998).

Therapists described many situation-bound feelings of incompetence as well, emotions that were not necessarily related to trait factors but more to state factors such as fatigue, personal chaos, and momentary frustration. The results suggested that feelings of incompetence could be elicited or compounded by both state factors and trait factors. It is possible that further inquiry will specify which levels of F.O.I. are state dependent and which levels reflect therapists' traits, particularly intropunitiveness. More research is needed to expound on these possible links.

The relationship between counselling performance and counsellors' low opinion of their competence has traditionally been inconsistent or counterintuitive. Generally, the literature that examines related concepts show no consistent links between feeling competent and behaving competently. For the interviewees, the inverse was true:

therapists may doubt their competency on grounds other than performance. In fact performance related factors accounted for only the mildest levels of F.O.I. Three participants spontaneously endorsed Clance and O'Toole's (1987) Impostor Phenomena and related periodical fears of being discovered and exposed as fraudulent. Despite the accumulated experience and successes and despite the outstanding reputation of all therapists in the study who had successful private practices (5), who managed programs and supervised others (2), who were hired by the leading private schools (1), and universities (2), the therapists continued to experience feelings of incompetence. A devil's advocate question presented the possibility of a link between feeling incompetent and being incompetent to therapists during the interview. Only one therapist endorsed this relationship. All other therapists had vivid negative reactions and were vexed by the proposition. To the therapists, it seemed entirely plausible that objective and subjective incompetence are two entirely different matters. This non-relationship is reflected in the literature that examines similar concepts. In fact, research on the relationship between self-efficacy and performance concludes that increasing self-efficacy does not improve therapist performance and neither does improving performance increase self-efficacy. In fact , in certain instances the relationship can be inversed: the informants declared that feelings of incompetence could improve their performance at times by presenting them with a challenge or stimulating their curiosity. The relationship between feeling incompetent and being incompetent remains mysterious. Can a therapist feel incompetent and believe that he/she is performing competently at the same time? This enigma is perhaps not so irreconcilable as it appears on the surface if we return to the definition of F.O.I. as a cluster of emotions only the most superficial of which are related to

performance/professional issues. The therapists' propensity to experience F.O.I. is not entirely neutralized by self-judgments of adequate performance. For example, therapists may feel confident about their choice and performance of a technique, yet feel incompetent because they are unable to build a cohesive relationship with the client.

Although therapists were reluctant to equate F.O.I. with incompetent performance, they readily offered instances were the feelings had impacted the therapy. They agreed that F.O.I. had an impact on the client, on the therapists' imminent actions, on their feelings about the client, and on the therapeutic relationship. Therapists were very forthcoming and frank in their disclosures of disliking and resenting clients, dreading appointments, and limiting their investment in some relationships. These results support conclusions reported by Howard and Orlinsky (1975) who noted that therapists who experience a sense of inefficacy may behave in a critical, restrained manner and by Farber and Heifetz (1982) who reported that therapists can become cynical towards clients and blame them for their difficulties.

Loganbill, Hardy, and Delworth proposed (1981) premature termination as a negative outcome of insecure feelings. Therapist-driven premature termination was uncommon among participants. Only one therapist reported such an instance. However, all therapists did report referral as a common strategy although the therapists in our sample based that decision on the ethical responsibilities of not harming clients and on working within ones' limits that feelings of incompetence give rise to. Whether these referrals were justified is uncertain and several participants raised the question.

By far the most disconcerting outcomes were related to therapists' own state of mental health. Several therapists had experienced job related burn out, one had suffered

depression, and one therapist described a close friend and colleague's experience of being handicapped throughout her career by relentless feelings of incompetence leading to an early retirement from direct client care. These were severe but uncommon, reflecting statistics reported by Maslach (1982). Common negative experiences were anxiety, stress, negative self-appraisals, and self-esteem attacks. These were pervasive across interviews.

Generally then therapists endorsed some of the negative outcomes described by previous researchers and elaborated on others. While all therapists offered instances of these negative outcomes, they invariably qualified such statements by offering instances were the feelings were transformed from a liability to an asset. That is, therapists insisted on the dual nature of feelings of incompetence; they were perceived as both a hindrance and an opportunity for growth.

Description of positive offshoots from F.O.I. included therapist' feelings of being challenged and motivated to learn. Therapists identified moments of F.O.I. as opportunities for growth, sought supervision, training, and support. Seven out of eight therapists disclosed their concern to clients and saw therapeutic benefits result from sharing F.O.I. with clients. Benefits included modeling honesty and self-disclosure, addressing therapeutic impasses directly, clarifying client expectations, and responsibility boundaries (i.e., who is responsible for change), liberating clients to discuss own insecurities, and rapprochement among others. None of these potential benefits are explored in the literature that unilaterally focuses on the damage therapists' negative feelings can have on clients and on therapy. The therapists held a profound belief that indeed these emotions were "gist for the therapeutic mill" and as one participant succinctly stated that the responsibility "laid with her (me) to use that". Thus therapists

aimed to transform their F.O.I. into experiences from which both they and their clients could gain benefit. In fact, the interviews brought forth a number of positive affirmations from the participants.

Therapists directly and indirectly referred to coping mechanisms for dealing with F.O.I. Some of these were described under cognitive management of F.O.I. Three therapists referred to training situations that directly addressed therapists' feelings of incompetence. Therapists valued these training moments that ranged from a few minutes to several hours exploring the issue of F.O.I. They provided a context from which to understand their experience with F.O.I. Therapists were able to protect themselves from deeper impacts by having tools to acknowledge, analyze, and classify these emotions. Two therapists had received formal training on dealing with emotions similar to F.O.I. in graduate school (at the master's level) while another had attended a workshop that dealt with insecurity.

Six therapists made a striking and spontaneous declaration of love for their profession. They professed an ongoing commitment to psychotherapy and enjoyed their work. Being a therapist was central in their definition of self and also seen as a force in their lives. They continued to embrace this profession. Therapists also overwhelmingly presented an authentic concern for the welfare of clients. Much as narcissistic concerns were a component of their F.O.I., not harming clients was unequivocally a priority. Self-aggrandizement not once superceded client welfare in all examples presented. F.O.I. seemed to call forth the qualities of conscientiousness, self-reflection, responsibility, and humility.

This positive note concludes our discussion of how the findings of the present study qualify, corroborate, elaborate, and introduce new ideas in the literature dealing with a variety of concepts related to the construct of F.O.I. (insecurity, low self-efficacy, inadequacy, ineffectiveness, low mastery).

Limitations and Assumptions

A preliminary caution to note is that the collection of phenomenological data depends on the ability and willingness of the subjects to faithfully disclose the experience under investigation. Many factors may influence the depth and honesty of the therapists' verbal exploration of professional self-doubt; the least of which is their awareness of this internal struggle and the ability to articulate it to the interviewer. The relationship between the sensitivity of the subject matter and the degree of censorship exercised by the subjects is obvious. However, subjects in the study were forewarned about the subject matter before being asked to participate and other precautions were taken to minimize such interference. For example, the participants were promised that their consent would be sought before including their interview material in the writing of the thesis. Thus, they would retain the power over the fate of their spoken words even after having disclosed their thoughts during the interview.

For different reasons therapists graciously agreed to participate in the study. They offered their time, their insights, and often their office space willingly with only the promise of better self-understanding and an opportunity to help in exchange. These therapists became conversational partners and in essence research assistants as their disclosures were scrutinized and prompted for deeper and more comprehensive meaning. The researcher's own experience as a therapist contributed to these exchanges in terms of

level of empathy reached, trustworthiness, and ability to follow up with relevant prompts. Indeed many of these exchanges were quite pleasant and at times downright funny as high levels of comfort were easily established despite such a sensitive topical area. Witness the following exchanges:

Participant: Yeah, a*u début là* (at the beginning), a lot of praying:" Oh god! Please help me! Help me! Help me!!!!!!"

Interviewer: Did he?

Participant: Yeah. I have a straight line! Laughs.

Interviewer: You'll have to give me that number...

Mutual laughter.

Such exchanges were frequent and refreshing. A high level of collegiality and collaboration developed between researcher and participants. Several participants declared a deeper level of self-understanding at the end of the interview.

Because seven of the participants were friends and acquaintances the initial level of trust between participant and interviewer was probably higher than between strangers. This made it easier for the participant to disclose personally and possibly professionally threatening material. These interviews were detailed and the levels of emotions expressed were profound. However, the potential pitfall in such a situation is that participants will provide friendly data; they will attempt to give answers that reflect their best guess about what the researcher is driving at. They want to help and may modify and inadvertently distort the rendering of their experiences. Validity would be thus threatened.

Validity in this study could also have been enhanced by a process of triangulation, particularly, investigator triangulation (Denzin, 1970). This type of triangulation where

several different evaluators are used to analyze the data verifies that the explanations offered fit the data. In this study, limited resources forced the analysis of transcripts to be a solo endeavour. No external auditor corroborated the fit between the initial themes and categories and the statements that gave rise to them. Instead, the empirical assertions were supported by the inclusion in the manuscript of large segments of the interviews. The direct quotations support the validity of the categories by allowing each reader to bear witness to their credibility. By giving ample and detailed transcriptions the reader is drawn "so closely into the subject's world that it can be palpably felt" (Adler & Adler, p.381, 1994). This style of writing is one approach to the issue of versimilitude or the question of whether the text is telling the truth.

Apart from the style of writing which relies heavily on the participant's voice to support the analysis and investigator triangulation as described above several other methods are commonly used to increase the validity of interview studies. One which would have been particularly à propos for this study is the practice of getting the participants to corroborate and evaluate the fit between the interpretation of their disclosures and their experience. The member check (Janesick, 1994) is a powerful contribution to a study's credibility. Unfortunately, limited resources of the most banal kind, time and money, did not make this possible. A logical next step in the pursuit of knowledge about feelings of incompetence is obviously to engage the participants in either individual or group conversations on their responses to and their criticisms of the substantive theory that proposes to interpret their lived experience. The theory would both be refined and gain authority from such a process.

As it stands the substantive theory can be viewed as one plausible explanation of the feelings of incompetence as they are experienced by seasoned therapists. The limitations that are inherent in this assumption are twofold. The first limitation is conceptual. In grounded theory methodology, a theory is considered to be "an interpretation made from a given perspective as adopted by a researcher" (Strauss& Corbin, p.279, 1994). As such, the theory makes no claim to being infallible but rather relies on the judgments of soundness and usefulness as measures of its' strength. This is in keeping with this methodology's rejection of the positivistic claim to have access to a reality out there as opposed to bearing witness to a truth that is constructed and enacted. The second limitation is more practical and pragmatic. The theory is seen as being limited to a time and a people. The substantive theory is based on a set of eight participants that represent experienced clinicians. The definitions of experience and clinical activity were clear but arbitrary. The theory may not apply to others whose characteristics do not match the same criteria.

Because the level of experience varied greatly, from 10 to 25 years, it is also possible that important experience-related information was lost by approaching this group as if they were homogeneous. Future studies might focus on comparing these groups on the basis of more rigorous experience distinctions. The information gathered would lend finesse and conceptual density to the explanation of the role of experience in feelings of incompetence.

Implications for Counselling Psychology

Counsellor self-care issues have been identified as a priority by the few researchers who have focused on the area of therapists' experience of therapy and on the

stresses inherent in our work. (Dryden,1992, Farber and Heifetz,1982, Yalom,1989). This study has begun to address the issue of counsellors' judgments about their lack of competence; an issue that has been linked to stress, burnout, depression, premature career abandonment, and other therapists' problems identified in the literature and confirmed by the results of this study. An obvious use of the results would be as an educational tool; to prepare therapists in training for the inevitable encounters with feelings of incompetence. Therapists armed with knowledge and understanding of the nature of this experience, its' components, and its' inevitability may be able to avoid being damaged by the experience. Enlightened therapists may benefit from a process of normalization that an educational approach would offer. Perhaps, these therapists could use this information and knowledge in a prophylactic and preventative approach to F.O.I. The three therapists who spontaneously mentioned having dealt with such issues in their training certainly appeared to endorse the notion that they felt prepared to deal with such experiences when they arose and that this prior knowledge facilitated their efforts to cope.

The entire issue of coping was an obvious offshoot from this study but left aside for further research projects. An elaboration of this unexplored component would complete the present study and allow the addition of a proactive element to educational efforts. The development of a therapist training module that would address lifelong or career long issues with feelings of incompetence could describe in depth what the feeling is like, what the components are, what the consequences can be, and what can be done about it. Such a training module could be included in the standard curriculum as part of a course dealing with self-care issues. Alternately, it could be offered through professional associations and other post university training centres.

The theory of feelings of incompetence can also be useful to individual supervisors to the extent that they are supervising seasoned clinicians or are able to extrapolate and use the information provided to better understand the variety, nature, and complexity of feelings of incompetence in their supervisees. Understanding the multiple components of F.O.I. and its' dynamic nature may help supervisors move beyond simply equating confidence or security with experience and motivate them to help therapists develop mechanisms to cope with feelings of incompetence that will arise despite their years of experience. This brings us to the issue of future research.

Implications for Future Research.

Research on how therapists cope with feelings of incompetence would naturally help us to apply the results of this study. Knowing that they continue to plague experienced therapists at different levels of depth and with varying levels of destructive force, we naturally need to know how therapists manage the battery of emotions related to F.O.I. in the short and long run. This study began to offer some indications as to how this is done: cognitive containment, seeking support, and disclosures to clients. Much more needs to be explored in a structured and focused way; which coping mechanisms work best for which type of F.O.I., how are these developed or acquired, what signals the therapist to initiate a coping response, when does it fail and what then? Do these evolve over time, with training, or through trial and error? Do therapists seek therapy for their F.O.I.? When? How? With whom? What are the results?

Further research could confirm the veracity of the components and their relationships and subsequently expand beyond this sample. For example, reproducing the findings using a less experienced group would enlarge the substantive area addressed by

the theory. A series of such reproductions with different parameters would eventually allow the theory to move from being a substantive theory to a formal theory; a theory that applies to all psychotherapists regardless of their experience level. Having a wider range of applicability would enhance the theories' appeal as a teaching and prophylactic tool. Perhaps reproducing the study with a cross sectional approach could accomplish this. Interviewing therapists across experience levels would allow future researchers to evaluate the range of applicability of the theory and answer the question: Does this spectrum theory of F.O.I. apply only to therapists with a minimum of ten years of experience or is this an accurate illustration of F.O.I. for all therapists?

Questions about developmental issues in this study would suggest that the components and their interactions are standard for all therapists and that experience is a mediating factor. That is, experience may alleviate or exacerbate feelings of incompetence but not cause them. Further studies are needed to gain more exact knowledge of how experience functions as a mediator. Is it because therapists develop better coping mechanisms, process emotions more easily and quickly, recognize when boundaries are being violated and are quick and firm in re-establishing appropriate boundaries? The participants suggest all these yet in indirect and retrospective ways. Perhaps a cross sectional study would identify a more robust pattern or sequence in the evolutionary stages.

Finally the question of how therapists judge their worth and effectiveness calls forth an inquiry on therapists' general self-evaluative practices. Therapists in our study shared a variety of criteria used to determine whether they were successful with a case or not. These were strikingly inconsistent from one therapist to the next: fulfillment of client

need, return rate, reaching agreed upon goals, depth of relationship with client, client growth, positive feedback from client, etc. Several therapists decried the lack of tangible criteria by which they could actually establish a global evaluation of their 'goodness'. This is particularly compelling in that therapists want to help and want to feel that they have contributed to client growth. They would prefer to avoid using outcome as the sole measure of their competence but seem to have no way of approaching the issue of self-evaluation sanely, realistically, and safely.

Perhaps then, the issue of feelings of incompetence could reside under the umbrella construct of self-evaluative practices which itself would stem from the area of therapist self-care. The accumulation of knowledge on feelings of incompetence could contribute to the domain of self-evaluative practices by preparing therapists for the encounter with different forms of self-doubt and by showing how to manage feelings of incompetence.

Final Summary

What is offered is a substantive theory of feelings of incompetence; a theory which is relevant to psychotherapists with at least ten years of experience and who are actively practicing psychotherapy. This theory is empirically based; it arises from the analysis of eight in depth interviews with seasoned therapists. It is dynamic in that it describes an ongoing moment-by-moment process of doubting ones' competence and examines that which influences this process. The theory has multiple components organized around a central category which is intensity of experiencing. The components are: depth and nature of self-doubt, sources, mediating factors, and consequences. Each of these components has multiple dimensions. The perspective from which the theory is

evoked is emic; the theory describes feelings of incompetence as they are subjectively experienced and communicated by the therapists themselves.

These qualities of the theory help to resolve some of the problems that have been identified in the scattered body of literature that addresses the issue of therapists' experience of doubting their worth as therapists. It provides a complex, in depth, comprehensive definition and description of feelings of incompetence. It examines emotional, cognitive, and behavioural manifestations of the experience. It confirms that experienced therapists continue to have these feelings well beyond the initial years of training and practice and shows how they experience it. It moves beyond static and unidimentional constructs to propose a fluid theory with multiple components that interact with each other to result in the therapists' unique construction of the experience of feeling incompetent.

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Appendix A

Structured Questionnaire

Please fill out the following questionnaire and return it to the researcher at the interview meeting.

Personal Data

1- Name:

2- Sex:

3- Age: 20-30____ 30-40____ 40-50___ 50-60___

Over 60___

Professional Background

1- What is your current profession? Student?___ Counsellor?___ Clinical Psychologist ?___ Social Worker?___ Other title?_____

2- How many years of experience have you had as a clinician?_____

3- How many years of counselling experience have you had prior to graduate school?____ After?____

4- What are your theoretical approaches? (rank order)

1)_____ 2)_____

3) _____

5-Have you personally had therapy for training or other purposes?

Length of involvement in therapy? _____

6-Are you currently being supervised?_____ Profession of Supervisor? _____

Approximate # of supervised hours?____

7-What, if any , is your area of specialization?

8-How many hours per week do you engage in direct service to clients/patients?

9- Please indicate your educational background.

10- What is your current employment status? Indicate employer's name and your role in the organisation.

Appendix B

Interview Protocol

A-PHENOMENOLOGY- the impact of the feeling of incompetence on the therapists' experience of therapy.

1-Defining the experience- thoughts and feelings

- The literature suggests that many therapists experience moments where they feel uncertain about what they are doing in therapy, feelings of being momentarily inadequate. Does this sound familiar/ have you had these types of feelings?
- Under what conditions would you be more susceptible to experience this type of self-doubt?
- Some of the words that have been used to describe this experience are blocked, puzzled or unsure about what to do next- what are some other words that you find represent your experience?

2- Providing examples

- Could you describe to me a situation where you were in a session with a client and where questions about your competence came up?
- How did you experience this? What would you say are the most important aspects of this experience for you?
- When you find yourself in one of those moments where your confidence in yourself as a therapist is undermined what would be the internal dialogue that might be going on at that moment?

3-Dimensions and depth

- Would you say that feeling incompetent is a singular kind of experience or are there different dimensions/components?
- Are there qualitatively different experiences of feeling incompetent?
- Are there different levels of depth in the experiencing of yourself as inadequate in your role as a therapist?

4-Interpretations and impact

- What type of consequences does feeling incompetent have for you? In the short term? In the long run?
- What happens after the session with these feelings and/or thoughts? How are they processed?
- How do you interpret, make meaning of the feelings of incompetence once they have subsided?
- Is there a relationship between the moment by moment situation specific mastery beliefs and an overall sense of mastery?
- Are the feelings about being incompetent different after the session than during the session?
- From your perspective, what is the nature of the feeling of incompetence encountered by therapists? If you had to explain it to another, how would your understanding of these experiences be described?

B-PRAXIS- HOW DOES THE FEELING AFFECT THE THERAPISTS' INTERVENTIONS?

- Do you perceive a relationship between feeling uncertain and what happens next? How does it affect your interventions with a client? What is the impact of feeling incompetent?
- Example- Impact on therapists' actions/choices

  I'd like you to imagine a scene now where the feeling of inadequacy is present. Can you guide me through the thought process of where you go from here? How do you decide what to do next? What happens 'out there' while you are feeling this inside?
- What is the difference in how you feel about your clients when you are feeling competent vs. incompetent? (Probe for issues of liking, respect, trust)
- What is the difference in how you accomplish the tasks that you see as your role in therapy when you are feeling competent vs. incompetent?
- What is the difference in how you and your clients set goals when you are feeling competent vs. incompetent?
- Do you think that your feelings of incompetence are picked up by your clients? If so, what impact does that have on your relationship with them?
- The next question is a devil's advocate type of question: Some people would say that if you feel inadequate then you probably are. What would you say to them?

C-DEVELOPMENTAL ISSUES

- How long have these feelings been part of your therapeutic experience?
- Do you remember the first time you felt inadequate or incompetent?
- Have these feelings changed over time? How?

- Has the way you view yourself and your competence as a therapist evolved with practice?
- Are you aware of fluctuations in the intensity or duration of these types of emotion? Does experience alter the way you evaluate yourself as a therapist in any way?

D-CLOSURE

- How does it feel to talk about this experience with me?
- Does talking about feelings of inadequacy change your perception of that experience in any way?
- Is there anything you would like to add?
- Would it be OK with you if I contacted you at a later point in time for clarification or if any further questions arise?

Appendix C

Information and Consent Form

The Research Program

A qualitative study of therapists' feelings of incompetence during therapy is being conducted in partial fulfillment of the requirements of a Ph.D. program in counselling psychology. The aim of the research is to increase understanding of the therapists' experience of self-doubts, its antecedents and effects and to discover the components of this common yet often inaccurate self-appraisal process.

What it Involves

A researcher will conduct interviews of approximately one to one-and-a-half hours duration. These interviews will be tape-recorded. Your role will be to answer questions and to elaborate in as much detail as you can on what you have personally experienced in terms of questioning your effectiveness as a therapist. As a participant, you have the freedom to contribute our understanding of this phenomenon and to guide the researcher into an exploration of what you consider to be the focal points of the issue.

Confidentiality

The interviews will be kept in strict professional confidence. No one on the staff of the institution you are either studying at or working in will see or hear your responses. These will be transcribed and analyzed by the main researcher and research team members sworn to confidentiality. Your identity will be safeguarded through the following measures: (a) You will be assigned a code and the key linking your name/identity to the code will be stored under lock and key in the main researchers office. (b) If the researcher wishes to use a response or part of a response to illustrate a concept

in the thesis presentation your permission will be sought directly and your name will never be included in any such display.

Your decision as to whether or not to participate will not prejudice your relations with McGill University, nor the institution where you are currently employed.

Request

I would like to request your cooperation in the conduct of this study on therapists' experience of the feeling of incompetence in the course of conducting therapy. Should you decide to agree to an interview, you are completely free to withdraw consent and discontinue at any time. Conversely, you are also free to expand the scope of the study by leading the researcher to personally salient aspects of this issue. If you have any additional questions or comments please contact me at 506-735-4767 or at 506-737-5197. Thank you.

Anne Thériault, Ph.D. candidate.

You may keep the top part of this form.

.....

I have decided to participate in a study of therapists' experience of feelings of incompetence. I understand that I will be interviewed and that the interview will be recorded, transcribed, and analyzed. My signature indicates that I have read the information above and accepted the conditions under which the study will be carried out. I realize that I may withdraw without prejudice at any time after signing this form should I decide to do so.

Signature: _____ Date :_____

Appendix D

Preliminary Themes from Interviews 12, 22 and 31

Try to focus

Self-soothing

Prayer

Confusion

Cognitive containment

Process/outcome discrepancy

Emotional precursors

- Fear/lack of courage
- Mistrust
- Helplessness
- Hopelessness

Therapist emotional response

- Anger
- Feels cheated, victimised
- No return on investment
- Insecurity, stress
- Anger, aggravation
- Hate
- Dread
- Dislike
- Disbelief

- Emotionally depleted
- Drained
- Anxiety
- Frustration
- Self-depreciation
- Distraction

Self-doubt

- Levels of intensity

Poor relationship

Premature termination

Damage/ harm to client

Client expectations

Awareness

External pressure and evaluation

Reputation

Feeling stuck

Immobilized

Having a plan/map

Thought/action discrepancy

Internal critic- self-evaluation, self-depreciation

- Outcome dependent
- No scale
- Difficulties

Role of tools and techniques

Change gears

Impact on relationship

- Rejection
- Distraction
- Referral

Overkill, mind racing, struggling, chasing vs. relinquishing struggle, go with flow

Clumsy

Being in control vs. out of control

Positive results

- Learning
- Spurs to action

Long-term impact

- Career change, abandon career
- Loss of confidence
- Avoidance/self-protection
- Depression

Vindication/self-justification

Avoidance

Projective identification

Expectations

Frequency and duration -

- Ongoing

Internal pressure

Standards

Integrity

Ethics

Assessment

Vague, abstract intangible vs. concrete

Ambiguity

Cognitive containment-

Letting self off hook

Modeling

Cognitive constraint- self-control-self directives- keep self-on track

Buy time

Deep wounds

Communication obstacles-

Culture

Language

Religion

Sex

Rumination

Attribution

Cognitive containment

- Focus on client
- Focus on here and now

- Focus on goals
- Focus on needs
- Focus on contract

Rigidity

Contradictions

Expert vs. dummy

Being versus doing

Powerful vs. powerless

Impact on client

Anxiety

None

Liberates

Take responsibility for impasse

Acceptance of therapist limits

Impact on relationship

Distance and self-preoccupation

Do something!

Knowledge

Experience

Boundary/responsibility

Projection/résonnance

Permissible/Normal/desirable/positive

Processing feelings of incompetence

High Profile-Status

Degree- intensity/depth

Inadequacy versus incompetence

Depends on source of incompetence

Related to experience

Related to protective mechanisms

Experience and self –evaluation

Standards higher

Less forgiving

External evaluations

Client negative feedback/criticism

Experience and structure

Business issues

Money

Paperwork

Training

Role related pitfalls

Isolation

Control

Timing

Contamination

Techniques, tools and theories

Stance and theory

- Stance and responsibility
- Resistance
- Feelings towards client
  - Dread
  - Blaming client to distance feelings of incompetence
  - Dislike
  - Welcomes challenge
  - Disclosure and closeness
- Personality dynamics
  - Vulnerability
- Maturity
- Using feelings of incompetence in therapy
  - Confrontation
  - Disclosure
  - Ask for guidance from client

Appendix E

Axial Coding and Category Scheme

1-DEPTH AND RANGE

Depth

Level 1- Being correct

Am I doing the right thing?

What is the best thing to do here?

Am I on the right track?

What went wrong?

Did I miss something?

Level 2- Being effective

Am I able to help the client?

Can I do what needs to be done?

Am I addressing the needs of the client?

Did it work?

Level 3- Being confident

Am I a good therapist?

Somebody could do better than me.

Am I in the right profession?

Is this within my area of competence?

Level 4- Faith in process

Does psychotherapy work?

How much impact do I actually have?

Level 5- Contribution and attribution

Am I doing any good?

Am I doing any harm?

Am I responsible for success?

Am I responsible for failure?

Am I producing change?

Level 6- Identity

Do I have what it takes?

What is wrong with me?

I have no right being in this field

Is it about my weakness?

Range-

Insecurity vs. incompetence,

Inadequacy vs. incompetence

Related to source

Depends on experience

Depends on theoretical orientation/role

Depends on protective mechanisms

2- SOURCES

1- Professional

Lack of knowledge and skills

Lack of experience

Insufficient training

Business

Money

Paperwork

Taxes

2-Personal

Personality dynamics

Characteristics/traits

Psychodynamic issues

Vulnerabilities and blind spots

Historical wounds

Values

States

Maturity

Contamination

3-Permissible/ conditionally positive

Normal

Just learning

Only human

Part of the game

4- Process issues

Relationship

Responsibility

Boundaries

Resistance/distance

Trust/empathy/warmth

Projection/résonnance

Therapist picks up on client :

Helplessness

Defeat

Confusion

Fear

Projective identification

Process/outcome discrepancy

Thought/action incompatibility

Communication obstacles

Culture

Language

Sex

Degree of pathology

3- MEDIATING FACTORS

1- Pressure

A-Internal pressure

Integrity and accountability

Work within limits

values

Ethics

Worry about doing harm

Performance anxiety

Self-evaluation

Standards

Expectations

Self critic

B-External pressure

Reputation

High profile cases/visibility & accountabiltiy

3rd party

EAP

Supervisor

Evaluation

Social contacts

Doctors/lawyers

Parents

Earning one's fee

Client negative feedback

2- Cognitive management of F.O.I. and ensuing anxiety

Attribution

Self- control

Give self- directives

Focus on client

Focus on here and now

Focus on goals

Focus on contract

Focus on client needs

Cognitive containment

Self- soothing

Prayer

Modelling

Letting self off hook/normalizing

Cognitive mismanagement

Distancing from emotion-

Put a cap on it

Diffusing responsibility

Give up

Avoid

Labelling

Blame client

Self-justification/self-depreciation

Rumination/dwelling

Rigidity

Overkill- mind racing

Self-preoccupation and distance

3-Role and stance

Isolation

Imposter phenomena

Contradictions

Expert vs. dummy

Being vs. doing

Powerful vs. powerless

Last hope vs. elective

Theoretical prescriptions for role

Maps and techniques

4-Awareness and insight

5-Experience and regression

Set clearer boundaries

Responsibility

Self-evaluation

4- AFTERMATH

1-Therapist emotional response

Anger

Feels cheated

No return on investment victimized

Insecurity- stress

Aggravation

Hate

Dread

Dislike

Disbelief

Depleted

Drained

Anxiety

Frustration- it's a nightmare!

Distraction devalued

Clumsy

Challenged- threatened

Discouraged-disapointed

Bored

Exploited- sucking you dry

2-Imminent actions

Using feelings of incompetence in therapy

Confrontation

Disclosure

Asking for feedback

Change gears

Slow down

Backing up

Buy time

Refer

Termination

3- Positive consequences

Seeks feedback/supervision/consultation

Motivates learning and creativity

Spurs to action-when not too profound, otherwise immobilises

Growth-imperative and responsibility of therapist

Seeks training

4-Feelings about client

Dread

Blaming

Dislike-hate

Resent

Welcomes challenge to learn

Closeness after disclosure

5-Impact on client and relationship

Client anxiety

Client liberated after disclosure

Client takes responsibility for impasse

Acceptance of therapist limits

Rejection of client

Referral

Distraction and distance

Detachment and withdrawal

Avoid

Shut down

6-Long term impact on therapist

Low self esteem

Depression

Loss of self-confidence

Immobilization

Avoidance and self-protection- limits activities

Deep wounds

Abandon career

Discussion

- Spontaneous declaration of coping mechanisms and need for action
- Definition of success varies
- Clear concern for welfare of clients over narcissistic concerns
- Majority had very positive feelings towards their work
- Dread and avoid feelings of incompetence- seen as dangerous

Appendix F

MCGILL UNIVERSITY
FACULTY OF EDUCATION

CERTIFICATE OF ETHICAL ACCEPTABILITY FOR RESEARCH INVOLVING HUMAN SUBJECTS

A review committee consisting of **three** of the following members:

1. Prof. Evelyn Lusthaus
Department of Educational and Counselling Psychology

2. Prof. John Leide
Graduate School of Library and Information Studies

3. Prof. Margaret Downey
Department of Physical Education

4. Prof. Lise Winer
Department of Second Language Education

5. Prof. Claudia Mitchell
Department of Educational Studies

6. Prof. Kevin McDonough
Department of Culture and Values in Education

has examined the application for certification of the ethical acceptability of the project entitled:

Therapists' Feelings of Incompetence: A Phenomenological Inquiry.

as proposed by:

Applicant's Name Anne Thériault Supervisor's Name Dr. T. Maroun

Applicant's Signature, Supervisor's Signature

Degree Program Ph.D. Counselling Granting Agency

The review committee considers the research procedures as explained by the applicant in this application, to be acceptable on ethical grounds.

(Signatures)

a) Date 98/11/24

b) Date 981125

c) Date Dec 1, 98

Associate Dean (Academic) Dec 2/98

Revised October, 1998